STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445481	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Place Kingsport	100 Netherland Lane Kingsport, TN 37660

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, pharmacy record review, observation, and interview, the facility failed to administer a prophylactic antibiotic [medication used to treat a bacterial infection, in prophylactic use it is used to help decrease the risk for a recurring bacterial infection] as ordered by the Physician for 1 resident (Resident #8) of 15 residents reviewed for medications.The findings include: Review of the facility's undated policy titled, Medication Administration Guidelines, revealed .Verify that the name & [and] dose of the medication are correct .Verify each medication against the MAR [Medication Administration Record] .Sign MAR immediately after administering the medications . Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Diabetes Mellitus, and Hypertensive Heart Disease. Further review revealed Resident #8 was hospitalized from [DATE]-[DATE], and from 1/1/2026-1/8/2026. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 0 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of a Physician's Order for Resident #8 dated 9/8/2025, revealed .Nitrofurantoin [medication used to treat certain bacterial infections] Macrocrystals [larger crystals to dissolve and absorb slower] Oral Capsule 100 mg [milligram] .one time a day .for prophylaxis . Review of the MAR for Resident #8 dated 9/8/2025 to 1/23/2026, revealed Nitrofurantoin Macrocrystals 100 mg daily was scheduled a total of 119 days for the time period, as there was 8 days the resident was in the hospital, and 18 days it was held for other antibiotic use. Review of the Pharmacy Delivery reports for Resident #8 dated 9/8/2025 to 1/23/2026, revealed Nitrofurantoin Macrocrystals 50 mg, quantity of 16 capsules, was delivered 9 times between 9/8/2025 to 1/23/2026, which equaled a total of 144 capsules delivered and not the needed supply of 238 capsules to equal the 119 scheduled doses. During an interview on 3/31/2026 at 11:30 AM, the Director of Nursing (DON) confirmed during medication administration, the medication should be compared to the order on the MAR to ensure the correct medicine and correct dose are administered. During an interview on 3/31/2026 at 2:00 PM, the Pharmacist stated Resident #8 was ordered Nitrofurantoin 100 mg as macrocrystals which was only available in the 50 mg capsules. The Pharmacist stated the pharmacy delivered Nitrofurantoin 50 mg capsules to the facility 9 times between 9/8/2025 and 1/23/2026 with directions to administer 2 capsules per dose. During an observation and interview on 4/1/2026 at 12:15 PM, the Administrator reviewed the MAR for Resident #8 from 9/8/2025 to 1/23/2026 which contained documented the Nitrofurantoin 100 mg daily as being administered. The Administrator confirmed there were 119 days in which Resident #8 should have received the medication dosage of 100 mg, the Pharmacy Delivery Manifests showed 144 doses of Nitrofurantoin 50 mg was delivered to the facility of which the resident should have received 2 capsules per dose, and confirmed Resident #8 did not receive the 100 mg daily dosage as ordered as there were not enough doses delivered to the facility by the pharmacy. During an interview on 4/1/2026 at 12:35 PM, the Nurse Practitioner (NP) stated Nitrofurantoin 50 mg was often the dosage used for prophylactic use, but the provider had continued the 100 mg dose as previously ordered for Resident #8. The NP further confirmed Resident #8 was in the hospital from [DATE] to 1/8/2026, and (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445481	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Place Kingsport	100 Netherland Lane Kingsport, TN 37660

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the urine culture obtained was resistant to the Nitrofurantoin. Urine cultures obtained at the facility on 1/27/2026 and 2/18/2026 were also resistant to Nitrofurantoin. The NP stated the Nitrofurantoin dosage of 50 mg administered instead of the prescribed100 mg did not have a negative impact on Resident #8.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interviews, the facility failed to maintain an accurate and complete medical record for 1 resident (Resident #8) of 15 medical records reviewed. The findings include:Review of the facility's undated policy titled, Medication Administration Guidelines, revealed .Verify that the name & [and] dose of the medication are correct .Verify each medication against the MAR [Medication Administration Record] .Sign MAR immediately after administering the medications . Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Diabetes Mellitus, and Hypertensive Heart Disease. Further review revealed Resident #8 was hospitalized from [DATE]-[DATE], and from 1/1/2026-1/8/2026. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 0 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of the Medication Administration Record (MAR) for Resident #8 dated 9/2025 to 1/2026, revealed multiple medications had not been initialed by the nurse as administered to the resident (the documentation areas were left blank). - 9/2025 - blanks on the MAR for multiple medications on 4 days (9/11/2025, 9/16/2025, 9/21/2025, and 9/25/205)- 10/2025 - blanks on the MAR for multiple medications on 7 days (10/13/2025, 10/14/2025, 10/18/2025, 10/19/2025, 10/23/2025, 10/24/2025, and 10/31/2025)- 11/2025 - blanks on the MAR for multiple medication on 7 days (11/2/2025, 11/6/2025, 11/10/2025, 11/11/2025, 11/12/2025, 11/20/2025, and 11/21/2025)- 12/2025 - blanks on the MAR for multiple medications on 10 days (12/2/2025, 12/4/2025, 2/6/2025, 2/11/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/26/2025, 12/27/2025, and 12/30/2025)- 1/2026 - blanks on the MAR for multiple medications on 6 days (1/10/2026, 1/12/2026, 1/15/2026, 1/16/2026, 1/24/2026, and 1/26/2026 During an interview on 3/31/2026 at 11:30 AM, the Director of Nursing (DON) stated the MAR should have been initialed by the licensed nurse when the medications were administered to the resident. The DON stated the nurses failed to accurately complete the documentation on the MAR at the time of the medication administration. During an observation and interview on 4/1/2026 at 12:15 PM, the Administrator confirmed the MAR for Resident #8 from 9/8/2025 to 1/23/2026 contained multiple blanks, the documentation was not complete, and there was no rationale to state if the medications had been omitted or held. The Administrator confirmed the scheduled medications were not documented by the nurse as administered appropriately.