

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445504	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2024
NAME OF PROVIDER OR SUPPLIER Newport TN Opco LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 135 Generation Drive Newport, TN 37821	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49568</p> <p>Based on facility policy review, facility investigation review, medical record review, and interview, the facility failed to protect the resident's right to be free from verbal abuse by staff for 1 resident (Resident #76) of 15 residents reviewed for abuse.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Abuse, Neglect, Misappropriation of Property, Exploitation, and Injuries of Unknown Source, dated 9/26/2023, revealed .It is the organization's intention to attempt to prevent the occurrence of abuse .Abuse includes .verbal abuse .Verbal abuse is use of oral .gestured language that includes any threat, or any frightening disparaging or derogatory language to residents .regardless of their .ability to comprehend or disability .</p> <p>Review of the medical record revealed Resident #76 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Depression.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #76 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #76 required a wheelchair for mobility and was dependent on staff for transfers.</p> <p>Review of the medical record revealed Resident #56 (witness) was admitted to the facility on [DATE] with diagnoses including Hemiplegia (one sided paralysis or weakness) Affecting Left Nondominant Side, Absence of Right Leg Below Knee, Abnormalities of Gait and Mobility.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #56 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Resident #56 required a wheelchair for mobility and required substantial/maximal assistance from staff for transfers.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation documentation revealed there was an altercation on 6/12/2024 at approximately 7:00 PM, at the west wing nurses' station. Licensed Practical Nurse (LPN) G asked Certified Nursing Assistant (CNA) L (agency employee) to complete her charting prior to leaving her shift. CNA L began yelling loudly explicit language towards staff. CNA L stated she did not need this [explicit language] place and needed to be in Chattanooga. Residents #56 and #76 were seated in wheelchairs outside the nurse's station and witnessed the confrontation between CNA L and LPN G. Resident #56 told CNA L to leave LPN G alone. CNA L then leaned over nurse station and told Resident #76 It's none of your business and you can meet me out in the parking lot. LPN K was at the east wing nurses' station and heard the commotion and responded to the west wing to see what was going on. LPN K arrived at the west wing nurse's station and observed CNA L cursing at facility staff with residents close by. LPN K told CNA L she needed to leave the facility and escorted CNA L out of the building. CNA L continued to speak poorly about the facility and staff while walking out. LPN G immediately assessed Residents #56 and #76 with no injuries noted. Resident #76 stated she was scared initially during the confrontation and stated she was fine and no longer afraid after CNA L was escorted out of the facility. The facility staff immediately notified the Director of Nursing (DON) and Administrator, and an investigation was started. CNA L was placed on Blocked from working list. The Administrator notified CNA L's staffing agency, Adult Protective Services, police, and the Ombudsman of the altercation.</p> <p>Review of CNA H's witness statement dated 6/13/2024, revealed .I was walking up [NAME] 2 Hall going to the Nurses Station .[LPN G] was trying to help [CNA L] Log in to .[computer program] and [CNA L] started screaming and cussing saying she didn't have time to chart .she had to leave and was told [CNA L] she needed to finish her charting before she left .it was part of the CNA Job .[CNA L then jumped up swinging her arms .up in [LPN G's] face .the residents was .screaming get out of our nurse's face .[CNA L] then turned .Cussing .[Resident #76] .Nurse came from East Hall and walked [CNA L] out the door .[CNA L] was Screaming down the hallway, she didn't need this place and we were all [NAME] Crackers .</p> <p>Review of RN I's emailed witness statement dated 6/14/2024, revealed .Incident took place on the evening of June 12, 2024 .As I [RN I] came up the hallway .could hear shouting coming from the nursing station . witnessed .[CNA L] and [LPN G] involved in an altercation .[CNA L] was verbally attacking .[LPN G] . proceeded to step between them in an effort to deescalate the situation .two female residents in wheelchairs . were sitting across from the nursing station .asked .[CNA L] repeatedly to leave the facility .advised [CNA L] if she did not leave that I was going to call the Law at which time [CNA L] stated she was not going to leave . another nurse came .and was able to get .[CNA L] .to exit the building .[CNA L] continued with profane, insulting, and abusive language towards .[LPN G] and other staff .until [CNA L] .was out of my area of observation .</p> <p>Review of Resident #76's undated witness statement, revealed .at the end of shift I was sitting at the nurses desk and I looked over at [CNA L] and [CNA L] stated .I am going to get you [Resident #76] too, if you want to run your mouth you can meet me out in the parking lot .Then she [CNA L] started cussing LPN G out .</p> <p>Review of Resident #56's undated witness statement, revealed .[CNA L] stated she needed to leave to go home. [LPN G] was trying to help [CNA L] log in to .the computer to do her charting. Then [CNA L] started yelling at [LPN G]. [CNA L] called [LPN G] a Gay Cracker. [Resident #56] stated to leave [LPN G] alone and that [CNA L] needed to leave. [CNA L] got in [Resident #76's] face threatening [Resident #76] .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN G's undated witness statement, revealed .[CNA L] was upset she had to chart .[LPN G] asked [CNA L] to use the Desktop computer so [LPN G] could use the Laptop [computer] for .med pass [medication administration] [CNA L] proceeded to tell [LPN G] she didn't have a log in .[LPN G] explained . would text supervisor and get [CNA L] a log in .[CNA L] said everyone was being rude. [LPN G] told [CNA L] no one was being rude that she just needed to .finish charting .[CNA L] got upset and got up in [LPN G's] face .[CNA L] became angry and started screaming at staff and residents [no named residents] .nurse on East came down and was able to escort [CNA L] .out of the building .</p> <p>Review of CNA J's undated witness statement, revealed .On 6/12/2024 [CNA J] witnessed [CNA L] stand up and get in [LPN G's] Face screaming .Calling [LPN G] derogatory names .[CNA L] turned .to .[Resident #76] . screaming .Shut the [Explicit language] up .It's none of your business .[LPN K] .walked [CNA L] out of the building .</p> <p>Review of the Psychiatric Follow-Up Note for Resident #76 dated 6/12/2024, revealed .Patient was involved in an incident with the CNA who has since been dismissed from the facility. No signs of psychosocial harm at this time. She continues at her baseline resting in room .Patient stable .</p> <p>Review of the Nurse's Notes for Resident #76 dated 6/13/2024, revealed .f/u [follow up] with psychosocial wellbeing check; pt [patient] has been up in w/c [wheelchair], pleasant, laughing, interacting well with staff, has been attending activities; ate lunch in dining room; good appetite; no voiced needs or wants .</p> <p>Review of the Nurse's Notes for Resident #76 dated 6/14/2024, revealed .Psychosocial well check visit . Resident in great spirits this am out and about visiting residents, states to this worker she is feeling and doing well .</p> <p>Review of the Nurse's Notes for Resident #76 dated 6/17/2024, revealed . follow up with [Resident #76] to last week's incident states she is doing great and no lasting effects from the event .</p> <p>During an observation and interview on 6/24/2024 at 10:30 AM, Resident #76 was sitting up in a wheelchair at the nurses' station. Resident #76 rolled herself back into her room. Resident #76 stated there had been an incident a couple of weeks ago where a CNA was yelling at a nurse. Another resident (Resident #56) told the CNA to stop, and the CNA stated to the resident the CNA would meet Resident #76 out in the parking lot. Resident #76 stated she felt the CNA meant she wanted to fight the resident when she stated she would meet the resident in the parking lot. Facility staff escorted the CNA out of the building and the resident felt the facility staff acted promptly and had protected her. Resident #76 stated she felt safe during the incident and had not experienced any ill effects from it.</p> <p>During an interview on 6/24/2024 at 11:19 AM, Resident #56 stated she had not been abused or witnessed a resident be abused by anyone at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/25/2024 at 10:09 AM, CNA J stated on 6/12/2024 at approximately 7:00 PM she was walking towards west wing's Nurse's station. Resident #56 and Resident #76 were sitting at the nurses' station. LPN G asked CNA L to complete her charting before she left. CNA L stood up in LPN G's face, screaming at him and called LPN G derogatory names. LPN G told CNA L to complete charting before leaving the facility. CNA L screamed, .I don't need this [Explicit language] place . CNA L stated to LPN G, . You need to fix your hair you [Explicit Language] fag . CNA J stated LPN K came over from the other unit and told CNA L she needed to leave. CNA J stated that in the middle of this, Resident #56 leaned over the desk and tried to get CNA L away from LPN G. CNA J stated Resident #76 said something, and CNA L told Resident #76, .Well you can meet me out in the parking lot . LPN K escorted CNA L out of the building. CNA J stated she checked on Resident #76 and the resident reported feeling safe.</p> <p>During an interview on 6/25/2024 at 10:46 AM, CNA H stated on 6/12/2024 at approximately 7:00 PM, she was walking up to west wing nurse's desk and heard loud voices. LPG G was telling CNA L she needed to finish her charting before leaving. CNA L was screaming saying that she had to leave and go to [Explicit Language] Chattanooga and did not need this place. LPN G told CNA L that it was her job and CNA L got up in LPN G's face, started slinging her arms and cursing at LPN G. CNA H stated Residents #56 and #76 were seated outside the nurse's station during the confrontation. LPN G told CNA L nicely to please get out of his face and the residents were screaming .get out of our nurse's face . CNA L said to Resident #76, .it's not your problem and we can meet out in the parking lot . LPN K then came and walked CNA L to the door. CNA L continued to scream that she did not need this place and that we were all .white crackers . CNA H stated she checked on Resident #76 and initially she was scared but felt safe after CNA L was escorted out of the facility.</p> <p>During an interview on 6/25/2024 at 8:23 PM, LPN K (worked 7:00 PM-7:00 AM on 6/12/2024) stated she heard yelling from the west wing nurse's station and was concerned that it could be a resident and proceeded down hallway towards the west nurse's station. When LPN K got to the west wing nurse's station she observed Resident #56 and Resident #76 seated outside the nurse's station. LPN K stated CNA L was yelling and cursing at staff. LPN G told CNA L she needed to leave and if she didn't leave, they would call 911. LPN K perceived CNA L's behavior as hostile. LPN K escorted CNA L out of the facility. LPN K stated CNA L continued speaking with slanderous words about the facility and staff while escorting her out of the building.</p> <p>During an interview on 6/25/2024 at 3:15 PM, Resident #56 stated she had not been abused or cursed by anyone at the facility. The resident also stated she had not witnessed a resident be abused or cursed by anyone at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/26/2024 at 8:12 AM, LPN G stated he worked 7:00PM-7:00 AM on 6/12/2024. LPN G stated CNA L was sitting at the nursing station using a laptop computer. LPN G explained to CNA L he needed to use the laptop to complete a medication administration pass to the residents. LPN G asked CNA L if she could use the desktop computer and the CNA stated she did have a log in for the computer. LPN G explained he would contact a supervisor to obtain a log in for the CNA. CNA L stated everyone was being rude, did not have time to complete her documentation, and she needed to be in Chattanooga. LPN G explained to CNA L that no one was being rude, and her charting needed to be finished. CNA L was upset and got in LPN G's face. Residents #56 and #76 were seated outside the nurse's station and told CNA L .You better leave (LPN G) alone . CNA H arrived and told (LPN G) to walk away. The nurse on east wing, LPN K, arrived to escort CNA L out of the building. The supervisor notified the DON and Administrator of the altercation and the administrator came to the facility to start an immediate investigation.</p> <p>During an interview on 6/26/2024 at 1:20 PM, Resident #56 (when directly asked about an alleged incident from 6/12/2024) stated she remembered an incident which involved CNA L. Resident #56 and Resident #76 were seated at the nurse's station on the west wing around 7:00 PM. LPN G asked CNA L to complete her charting. CNA L got up in LPN G's face and stated she needed to go home. Resident #56 stated she told CNA L to be quiet and not talk to LPN G that way. CNA L turned to Resident #76 and said, .It's not your problem and you can meet me out in the parking lot . Resident #56 stated staff immediately protected her and Resident #76. CNA L was escorted out of the building. Resident #56 stated she was not affected from the incident.</p> <p>During an interview on 6/26/2024 at 4:15 PM, the Administrator confirmed CNA L verbally abused Resident #76 when CNA L used profanity and threatened the resident.</p>		