STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445504	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport TN Opco LLC	135 Generation Drive Newport, TN 37821

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observations, and interviews, the facility failed to maintain a safe, clean, homelike environment for 15 resident rooms (#213, #217, #223, #211, #103, #124, #127, #219, #119, #310, #312, #115, #125, #224, and #210) of 68 resident rooms observed, 3 of 5 hallways observed, and 1 of 1 activity rooms observed. The findings include: Review of the facility's policy titled, Resident Environmental Quality, undated, revealed .It is the policy of this facility to be .maintained to provide a safe .sanitary and comfortable environment for residents .and the public . During an observation on 8/18/2025 at 10:00 AM, revealed the floor of the 200 hallway was unclean and had a dirty residue. During an observation on 8/18/2025 at 10:13 AM, revealed the floor of the 300 hallway was unclean and had a dirty residue. During an observation on 8/18/2025 at 10:21 AM, revealed the floor of the 100 hallway was unclean and had a dirty residue. During an observation on 8/18/2025 at 11:50 AM, revealed 3 lights over the sink in resident room [ROOM NUMBER] were not working. During an observation on 8/18/2025 at 11:55 AM, revealed 3 lights over the sink in resident room [ROOM NUMBER] were not working. During an observation on 8/19/2025 at 8:25 AM, on the 100 hallway revealed the floor in front of the entry door to personal care room [ROOM NUMBER] had a dark dirty residue. Further observation revealed the door and door frame had missing/chipped paint and there was brown paint (the color the doors used to be) showing where the paint had been chipped. During an observation on 8/19/2025 at 8:27 AM, revealed the floor in front of the entry door to personal care room [ROOM NUMBER] on the 100 hallway had a dark dirty residue. The door frame had missing/chipped paint and there was brown paint (the color the doors used to be) showing where the paint was missing. Further observation revealed the baseboard next to the door had an unknown brown substance. During an observation on 8/19/2025 at 8:30 AM, revealed the baseboard in the 100 hallway between resident room's 106 and 108 had an unknown brown substance. During an observation on 8/19/2025 at 8:32 AM, revealed the entry door and doorframe to resident room [ROOM NUMBER] had missing/chipped paint and there was brown paint (the color the doors used to be) showing where the paint was missing. During an observation on 8/19/2025 at 8:36 AM, revealed the entry door, doorframe, and bathroom door to resident room [ROOM NUMBER] had missing/chipped paint and there was brown paint (the color the doors used to be) showing where the paint was missing. During an observation on 8/19/2025 at 8:40 AM, revealed the floor in resident room [ROOM NUMBER] had a dark dirty residue. During an observation on 8/19/2025 at 8:45 AM, revealed the unit 1 nurse's station floor had a dark dirty residue. During an observation on 8/19/2025 at 9:30 AM, revealed the ceiling in resident room [ROOM NUMBER] had 2 large brown rings. During an observation on 8/19/2025 at 1:50 PM, revealed the floor in resident room [ROOM NUMBER] had a dark dirty residue. The bathroom floor around the toilet had missing linoleum, and some of the popcorn sprayed texture at the light fixture was missing. Further observation revealed loose and missing pieces of the cove base (a vinyl trim installed at the bottom of a wall where it meets the floor) to the left of the bathroom door. During an observation on 8/19/2025 at 1:56 PM, revealed the floor and bathroom floor in resident room [ROOM NUMBER] had a dark dirty residue. Further observation revealed excessive damage exposing the corner bead behind the sheet rock mud to the right of the bathroom door and the cove base was loose from the wall. During an observation on 8/19/2025 at 2:00 PM, revealed the floor in resident room [ROOM NUMBER] had a dark dirty residue. During an observation on 8/19/2025 at 2:12 PM, revealed the floor at the entrance door to resident room [ROOM NUMBER] had a dark dirty residue. Further observation revealed the entrance door was scuffed and had missing wood pieces. During an interview on 8/19/2025 at 2:50 PM, Housekeeping Aide B stated the floors to the facility .look terrible .they have been like this for the past year or two .the facility would look so much cleaner if the floors were stripped and cleaned . During an interview on 8/19/2025 at 3:20 PM, Certified Nursing Assistant (CNA) C stated the floors had looked dirty in the facility for .at least 2 years . During an observation on 8/19/2025 at 3:30 PM, revealed the entrance door to resident room [ROOM NUMBER] had multiple layers of clear tape affixed to the right upper corner of the door. During an interview on 8/19/2025 at 3:35 PM, Housekeeping Aide D stated the facility had an employee several years ago (unsure of the exact date) who .used wax to clean the floors and ruined them .that is why the floors look nasty . During a telephone interview on 8/19/2025 at 3:38 PM, Licensed Practical Nurse (LPN) F stated the facility floors had looked dirty for the past couple of years and were getting worse. The facility had been in negotiations with her spouse's company for approximately 3-4 weeks to strip and wax the hallways

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) manual review, medical record review, and interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 resident (Resident #53) of 24 residents reviewed. The findings include:Review of the MDS 3.0 RAI Manual version 19. 1 dated 10/2024, revealed . J1800 .Any Falls Since Admission/Entry or Reentry or Prior Assessment .Code 1, yes: if the resident has fallen since the last assessment .Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including Dementia, Diabetes, and Hypothyroidism. Review of the Nurse Note for Resident #53 dated 4/14/2025, revealed .Resident found on floor .doorway . Resident sitting on her bottom .Review of a quarterly MDS assessment dated [DATE], revealed Resident #53 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further record review revealed Resident #53 had not fell since the previous assessment.Review of the comprehensive care plan for Resident #53 revised 7/6/2025, revealed .Fall 4/14/25 .During an interview on 8/20/2025 at 2:58 PM, the MDS Coordinator confirmed Resident #53's quarterly MDS assessment dated [DATE] was inaccurate.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to resubmit a Pre-admission Screening and Resident Review (PASARR) timely after a new mental health diagnosis for 1 resident (Resident #25) of 5 residents reviewed for PASARR. The findings include:Review of the facility's policy titled, Coordination with PASARR Program, undated, revealed .This facility coordinates assessments with the . (PASARR) program .to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services .appropriate to their needs .any level II resident who experiences a significant change in status will be referred promptly to the mental health or intellectual disability authority for additional resident review .Review of a PASARR Level 1 screen for Resident #25 dated 8/31/2023, revealed the resident had a mental health diagnosis of Depression (mild or situational).Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnosis including Hypertension and Muscle Weakness. Continued review revealed the resident received a new mental health condition of Post Traumatic Stress Disorder (PTSD) and Major Depressive Disorder on 6/1/2024.Review of the Comprehensive Care Plan dated 4/24/2025, revealed Resident #25 had a care plan for Major Depressive Disorder and PTSD.Review of a quarterly Minimum Data Set (MDS) assessment for Resident #25 dated 6/12/2025, revealed Resident #25 had an active diagnosis which included Depression and Post Traumatic Stress Disorder (PTSD).Review of the medical record revealed a new PASARR for Resident #25 was not submitted after a new mental health diagnosis of Post Traumatic Stress Disorder and Major Depressive Disorder was added.During a record review and interview on 8/19/2025 at 3:21 PM, the Medical Records Licensed Practical Nurse (LPN) stated she was responsible for referring to the state designated agency for PASARRS after new mental health conditions were identified or diagnosed. During further interview the Medical Records LPN confirmed she failed to refer Resident #25 to the state designated agency for PASARRS after the new mental health conditions were added.During an interview on 8/20/2025 at 8:19 AM, the Director of Nursing (DON) confirmed the facility policy for referring to the state agency for PASARRS after identifying new mental health conditions was not followed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation and interview, the facility failed to revise the care plan for 2 residents (Resident #53 and #11) of 24 residents reviewed for care plans. The findings include: Review of the facility's undated policy titled, Care Plan Revision guidelines, revealed .The purpose .provide consistent process .for reviewing and revising the care plan .residents experiencing a .change .A resident's . care plan will be reviewed and revised as necessary . Review of the facility's undated policy titled, Fall Prevention & Management Program guideline, undated, revealed .high fall risk identified .facility will develop plan of care .plan of care will be revised as needed . Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including Dementia, Diabetes, and Hypothyroidism. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #53 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan for Resident #53 revised 7/6/2025, revealed .Night light to be place . During an observation on 8/19/2025 at 10:30 AM, revealed Resident #53 sitting up in chair in room and a night light was not observed in the room. During an observation on 8/20/2025 at 7:50 AM, revealed Resident #53 was sitting up on side of bed and a night light was not observed in the room. During an observation and interview on 8/20/2025 at 9:42 AM, the Director of Nursing (DON) confirmed a night light was not in Resident #53's room, the night light had been discontinued on 7/6/2025, and the care plan had not been revised to reflect discontinuation of the night light. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, and Abnormal Weight loss. Review of the comprehensive care plan for Resident #11 dated 5/27/2025, revealed .the resident is able to eat independently after set up, cues, and oversight . Review of an Occupational Weight Loss Screen dated 8/5/2025, revealed .patient needs assistance/supervision with all self-feeding . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE], revealed the assessment was in progress. Further review revealed Resident #11 scored a 1 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review revealed Resident #11 was dependent on staff for eating assistance. During an interview on 8/18/2025 at 1:05 PM, Certified Nursing Assistant (CNA) G stated Resident #11 required total assistance with eating. During an observation on 8/18/2025 at 1:15 PM, revealed staff were assisting Resident #11 with eating the lunch meal. During an interview on 8/20/2025 at 3:10 PM, the MDS coordinator confirmed the facility failed to revise Resident #11's comprehensive care plan to reflect the resident's dependence on staff with eating assistance.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, and interview, the facility failed to meet safety and sanitation requirements for 2 residents (Resident #60 and #74) personal refrigerators of 5 resident personal refrigerators observed. The findings include: Review of the facility's undated policy titled, Refrigerators in the Residents' Rooms, revealed .The Administrator will designate the staff who will be responsible for cleaning the refrigerator weekly and discard any foods that are out of compliance .Foods with use-by dates shall be discarded accordingly . Review of the medical record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Malnutrition, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease (COPD) and Muscle Weakness. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #60 scored an 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. During an observation on 8/18/2025 at 11:55 AM, in Resident #60's room, revealed the residents room contained a personal refrigerator. The refrigerator contained tangerines in a plastic container with an expiration date of 4/5/2025. During an observation on 8/19/2025 at 1:30 PM, in Resident #60's room, revealed the residents room contained a personal refrigerator. The refrigerator contained tangerines in a plastic container with an expiration date of 4/5/2025. During an interview and observation on 8/19/2025 at 2:30 PM, in Resident #60's room, the Director of Nursing (DON) stated it was the responsibility of the housekeeping staff to maintain personal refrigerators in resident rooms. The DON confirmed Resident #60 had a container of tangerines with an expiration date of 4/5/2025 and was available for resident consumption. Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Diabetes, Stroke, Major Depressive Disorder, Osteoarthritis and Diverticulitis. Review of an annual MDS assessment dated [DATE], revealed Resident #74 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. During observations on 8/18/2025 at 12:02 PM and on 8/19/2025 at 1:35 PM, in Resident #74's room, revealed the residents room contained a personal refrigerator. The refrigerator contained a 6 ounce (oz) bottle of mustard half full with an expiration date of 10/31/2024. Further observation revealed a 4 oz unopened container of jello with an expiration date of 5/19/2024 and a 4 oz unopened container of chocolate pudding with an expiration date of 4/25/2024. During an interview and observation on 8/19/2025 at 2:35 PM, in Resident #74's room, the DON stated it was the responsibility of the housekeeping staff to maintain personal refrigerators in resident rooms. The DON confirmed Resident #74 had a container of jello and chocolate pudding which had expired and was available for resident consumption.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on facility policy review, observation, and interviews, the facility failed to follow infection control practices during 1 of 2 medication administration observations.The findings include: Review of the facility's undated policy titled, Medication Administration Policy and Procedure, revealed .Perform hand hygiene . During an observation of medication administration on 8/19/2025 at 8:00 AM, revealed Licensed Practical Nurse (LPN) A prepared medications for Resident #42, entered the resident's room, administered the medication, and exited the room without washing or sanitizing the hands. LPN A returned to the medication cart, prepared medications for Resident #63 entered the resident's room, handed the resident a plastic cup of medications, and the resident dropped an over the counter (otc) pain medication on the floor. LPN A picked up the medication, placed the medication in a plastic cup, ensured all the resident's other medications were administered, exited the room, and discarded the medication without washing or sanitizing the hands. Further observation revealed LPN A prepared another otc pain medication for Resident #63, entered the resident's room, administered the medication, and exited the room without washing or sanitizing the hands. During an interview on 8/18/2025 at 8:09 AM, LPN A confirmed she failed to wash or sanitize her hands during medication administration and after she retrieved the medication off the floor. During an interview on 8/18/2025 at 8:20 AM, the Director of Nursing (DON) confirmed LPN A failed to follow proper infection control practices when she failed to wash or sanitize the hands during medication administration.