STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility documentation review, geriatric psychiatric (geri-psych) hospital documentation review, observation, and interviews, the facility failed to protect 1 resident (Resident #103) of 6 residents reviewed for abuse from sexual abuse which resulted in actual Psychosocial Harm to Resident #103. The findings include: 1. Review of the facility's policy titled, Abuse & Neglect of Residents and Misappropriation of Residents' Property, dated 1/22/2025, revealed .Every resident has the right to be free from .sexual .abuse .Residents must not be subjected to abuse by anyone, including, but not limited to .other residents .Sexual Abuse .includes but is not limited to sexual harassment, sexual coercion, or sexual assault .understanding behavioral symptoms of Residents that may increase the risk of abuse. Residents that may be at increased risk .Confused residents .Behaviorally disturbed residents- aggressive, agitated .Residents whose personal histories render them at increased risk for abusing other residents .The facility will strive to identify, correct, and intervene in situations in which abuse .is more likely to occur .The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms . ˆ 2. Review of the medical record revealed Resident #103 was admitted to the facility on [DATE] with diagnoses including Dementia, Anxiety Disorder, and Depression. Review of the comprehensive care plan for Resident #103 dated 3/21/2025, revealed .MOOD AND BEHAVIORS .dx [diagnosis] of Insomnia, Depression, and Anxiety .COGNITION: I participated in an admission BIMS [Brief Interview for Mental Status] on 3/10/2025 w/ [with] a score of 05/15 which is indicative of severe cognitive impairment and I currently have a dx [diagnosis] of Unspecified Dementia at my time of admission to [facility]. I am not currently prescribed any medications related to my cognition at this time. I am alert to myself and my confusion fluctuates and changes in severity throughout the day . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #103 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment.ˆ Review of a nurse progress note for Resident #103 dated 7/1/2025 at 11:52 PM (actual time the note was created was 7/2/2025 at 4:53 PM), revealed .was involved in a resident to resident incident. She [Resident #103] was present in her room when resident [Resident #21] .entered her [Resident #103] room, removed his [Resident #21] lower clothing, then.[Resident #21].proceeded to remove.[Resident #103].bed covers, and grope.[Resident #103].left breast.[Resident #103] stated she made contact with her hand (fist) to .[Resident #21's] 'lower half' as hard as she [Resident #103] could and yelled.[Resident #103].was visibly distraught.was accompanied by.[Certified Nursing Assistant (CNA) E].for some time until . [Resident #103] was comfortable to return to her [Resident #103] room .Order was obtained for Hydroxyzine [antihistamine medication used to treat anxiety] 50 mg [milligram] by mouth x 1 [times 1 dose].[Resident #103] .did not receive or need medication as she is now calm and resting without any further noted anxiety. A skin assessment was performed and did not result in any alterations in .[Resident #103's] .current status. House supervisor, administrator, DON [Director of Nursing], provider, appropriate authorities, and family (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
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	aware . Review of the facility investigation documentation for the resident to resident altercation between Resident #103 and Resident #21 which occurred on 7/1/2025, revealed .[CNA E] heard.[Resident #103].yelling and as .[CNA E] .was headed to the room saw the perpetrator [Resident #21] walking down the hall with no pants on.[CNA E] went into resident's [Resident #103] room and.[Resident #103].said that.[Resident #21].had been in her [Resident #103] room and attempted to touch her [Resident #103] left breast.[Resident #103].said she then punched.[Resident #21].in his genitals. Perpetrator's [Resident #21] pants were found on the victim's [Resident #103] floor . Resident #21 was sent to the emergency room. Upon his return, he was kept on one-to-one observation until he was transferred for psychiatric hospitalization. The facility determined .inconclusive as there were no staff witnesses and neither resident is cognitively intact enough to make accurate reports. Out of precaution, we [facility administration] are providing supportive counseling for [Resident #103].and [Resident #21] .sent to geri-psych for evaluation and treatment of inappropriate behaviors . [Resident #21] was moved to another unit upon his return to the facility. Review of the facility's incident report witness statement completed by Registered Nurse (RN) A for Resident #103 dated 7/1/2025, revealed .Resident to Resident .informed by CNA she heard.[Resident #103] .yelling and observed.[Resident #103].startled and visibly distraught because.[Resident #21] .entered her room. CNA informed .she did see.[Resident #21] .ambulating down the hall back to his [Resident #21's] room and noted he did not have shorts on .[Resident #103] .stated that.[Resident #21] .took off his short [shorts], removed her [Resident #103] covers.groped her left breast.[Resident #103] .then stated she began yelling and that she made contact with the intruding resident's [Resident #21's] .'lower half' as hard as she could .resident [Resident #21] left the room .writer [RN A] spoke with .[Resident #103] .and assured her that she would be safe with the staff. Resident [Resident #21] .was placed on one to one observation, the house supervisor was notified. She notified the on call provider [telehealth], the Administrator and the DON. Administration notified the authorities .[Resident #21] .was sent to the ED [Emergency Department] for further medical evaluation .family was notified of incident .No injuries observed at time of incident . Review of CNA E's Employee Statement of Incident dated 7/1/2025, revealed .heard .[Resident #103].yelling for help. While walking down the hallway observed.[Resident #21].walking down hallway with no clothes on from the waist down .[Resident #103].was in her room.[Resident #103] was very distraught . Review of a Telehealth Progress note for Resident #103 dated 7/2/2025 at 12:04 AM, revealed .remains with increased anxiety due to incident .Hydroxyzine 50 mg PO [by mouth] for anxiety. Will update rounding to evaluate . Review of the facility document, Orders - Administration Note for Resident #103 dated 7/2/2025 at 2:59 AM, revealed . hydroxyzine.Oral Tablet .Give 50 mg by mouth one time only for anxiety disorder for 1 Day . Review of a Social Services Progress Note for Resident #103 dated 7/2/2025 at 3:34 PM, revealed .[Social Services Director (SSD)] and DON met w/pt's [with patient's-Resident #103] daughter's today regarding resident to resident [Resident #21 to Resident #103] incident from last night. SSD confirmed referral to counseling services would be made for additional psychosocial support as needed. Review of a nurse progress note for Resident #103 dated 7/3/2025 at 12:15 AM, revealed .unable to sleep due to having increase [increased] anxiety regarding the incident [between Resident #21 and Resident #103] that took place on 07/02/2025 [7/2/2025] [actual incident occurred on 7/1/2025]. reassured the resident [Resident #103] she is safe . Review of a Social Services Progress Note for Resident #103 dated 7/3/2025 at 2:13 PM, revealed Social Serviced Director (SSD) .visited w/[with] [Resident #103] today to provide her w/ any needed emotional support.[SSD] has referred [Resident #103] .for further counseling as needed.[SSD] will continue to remain available for emotional support as needed . Review of a Psychiatric Periodic Evaluation note for Resident #103 dated 7/8/2025, revealed .was seen today face-to-face during a private conversation post incident that happened over the weekend. One of the male residents [Resident #21] who has been transferred out to a geriatric psych facility entered.[Resident #103].room during the night apparently 'in a state of undress' and pulled.[Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#103].covers off of.[Resident #103].exposing himself [Resident #21] to.[Resident #103].and exposing herself [Resident #103] to him.When asked about sleep issues she replied, 'fine'. When it came time to discuss the incident, the resident became tearful and stated 'it was horrible. I want you to know that nothing happened between us.I am a little bit scared and nervous here. I was able to fight him off. I also want to let you know that I was not harmed because I was able to get away. He is in prison now.' .[Resident #103] was visually distressed by talking about the incident however, her memory is in decline and she very quickly returned to her normal state of affect after we stopped discussing the incident . Review of an Interdisciplinary Team (IDT) Members Note dated 7/10/2025 at 2:49 PM, revealed .psychosocial support was provided by [SSD] x [times/for] 3 days .[Resident #103] .is being followed by Team Health for additional support and she was seen by Psych NP [Psychiatric Nurse Practitioner] on Tuesday 7/8 [7/8/2025] and will be seen by LCSW [Licensed Clinical Social Worker] next week. Perpetrator [Resident #21] is currently in geri-psych facility. Review of the Psychological Diagnostic Interview for Resident #103 dated 7/14/2025, revealed .Social worker referral to assess/treat for anxiety and depression due to an incident where another resident [Resident #21] exposed himself to patient [Resident #103] and pulling covers off to expose her to him (per chart report). Patient became anxious and tearful when this was brought up, but was easily redirected and overall denied symptoms of depression and anxiety, although she also expressed anxious feelings and worry.Patient scored negative on PHQ-9 [a set of questions to assess depressed mood] therefore no follow-up is needed . Review of a Psychiatric Periodic Evaluation for Resident #103 dated 8/1/2025, revealed .Follow-up Evaluation (Acute).Family requested visit.Increase of insomnia.Spoke with.[Resident #103].and her daughter.[Daughter].informed me [Psych NP] that.[Resident #103].had not slept all night in 1 or 2 nights.Staff reports that she will go to bed and then get right back up and come back out to the common area.Her [Resident #103] daughter request that we [Psych NP] look at melatonin [over the counter medication used to treat insomnia] for her sleep. She is currently on 3 mg and it appears ineffective.will increase it to 6 mg at bedtime. And continue to monitor.[Resident #103] .cognitively impaired and therefore the scoring of a.PHQ-9 may or may not be an accurate representation.Behaviors.Cooperative.Restless.Hallucinations.None.Delusions.None.Provide reassurance and support. Review of a Psychiatric Periodic Evaluation for Resident #103 dated 8/5/2025 (35 days after the resident to resident incident with Resident #21), revealed .Follow-up Evaluation (Acute).Reason for Follow-up: Staff placed resident on psych NP acute board.Chief Complaint.Increase of insomnia.[Resident #103] was seen in the dining hall socializing with other residents.Staff has informed me [Psych NP] that she is still not sleeping and has not slept in approximately 2 nights. Resident endorses the same.I had recently increase melatonin to 6 mg and it has obviously not been effective.After speaking with the resident and the IDT it is agreed upon to increase her mirtazapine/Remeron [antidepressant medication] from 7.5 mg to 15 mg.It is recommended that the patient [Resident #103] continue to receive supervision and assistance to maintain safety. Review of a NP progress note for Resident #103 dated 8/6/2025 (36 days after the resident to resident incident with Resident #21), revealed .CHIEF COMPLAINT .Significant change in behaviors; Agitation, sleeplessness, inability to concentrate, aggression .Patient was started on Remeron on 07/18/25 [7/18/2025] [17 days after the resident to resident incident]. Nursing staff reports significant change in behaviors; Agitation, sleeplessness, inability to concentrate, aggression .UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE.Nursing staff reports significant change in behaviors; Agitation, sleeplessness, inability to concentrate, aggression. Discontinued Mirtazapine Oral Tablet 7.5 MG. Patient not tolerating medication. Increased behaviors, agitation, aggression, sleeplessness, inability to concentrate. Monitor for improvements in behaviors. If behaviors improve, Mirtazapine will not be restarted and a different medication will need to be prescribed for an appetite stimulant . Review of a nurse progress note for Resident #103 dated 8/6/2025 at 11:40 PM, revealed .Resident has a new (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	order for Melatonin 6mg. Currently in bed at this time. Call light within reach . Review of the Social Services Progress Note dated 8/25/2025 at 4:16 PM, revealed . SSA [Social Services Assistant] spoke with .[Resident #103's family] .and informed her of the Psych NP recommendation to start Doxepin [an antidepressant medication used to treat Major Depressive Disorder, Anxiety Disorders, and Insomnia] 10 mg due to sleep trouble [Resident #103's daughter] .asked that the Melatonin dose be increased prior to starting a new medication. SSA agreed to let IDT know . During an observation on 1/5/2026 at 11:00 AM, revealed Resident #103 up in her wheelchair in the common area socializing with other residents. 3. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Adjustment Disorder with Anxiety, and Cognitive Communication Deficit. Review of the comprehensive care plan for Resident #21 dated 8/19/2024, revealed MOOD AND BEHAVIOR .At times I am experiencing exit seeking behaviors due to my wandering .wander guard .experiencing increased confusion . Review of the comprehensive care plan for Resident #21 dated 8/27/2024, revealed .MOOD AND BEHAVIOR .There are times when I have difficulty sleeping and wander at night . with interventions including .Wander guard in place .Assist me in identifying any unmet needs that I have and aid in problem-solving ways to communicate my needs other than engaging in disruptive or inappropriate behaviors .Attempt to identify and remove potential triggers in my environment for recurring issues .Observe me for changes in my mood that may put me at risk for behaviors to occur .COGNITION: I have a diagnosis of Alzheimer's disease and Dementia. My cognition is severely impaired and I was unable to participate in my BIMS assessment at time of my admission to [facility] .Refer me to psych services as needed . Review of a nurse progress note for Resident #21 dated 9/10/2024 at 9:19 PM, revealed .came out of his [Resident #21] room in t-shirt and no pants .resident .responded [to a staff member] 'You can suck my [explicative].' And I Really need some [explicative] .resident came out of his room again .when asked if .he needed assistance .responded .yes but you already said you were not going to help me with that . ^ Review of a nurse progress note for Resident #21 dated 9/11/2024 at 1:30 PM, revealed .came out of bedroom with only a t-shirt on, no pants .housekeeper .encouraged him to go back to room .resident said .I need you to suck my [explicative] .he saw the housekeeper again and said I just wanted to get you in my bed, I need some [explicative] . ^ Review of a nurse progress note for Resident #21 dated 9/25/2024 at 11:01 AM, revealed .stated to CNA .you have a nice butt .stated to housekeeper .I want to suck your [explicative] .directed to go .put pants on . ^ Review of a nurse progress note for Resident #21 dated 10/9/2024 at 5:23 AM, revealed .making inappropriate comments to female staff .going into other residents [residents'] rooms . ^ Review of a nurse progress note for Resident #21 dated 10/12/2024 at 11:24 AM, revealed .stated to CNA .you know you have beautiful breast . ^ Review of a nurse progress note for Resident #21 dated 10/14/2024 at 6:45 PM, revealed .wandering in and out of other resident's [residents'] room .Resident making comments to female residents and staff stating they have nice breasts or asking to look down their blouses . ^ Review of a nurse progress note for Resident #21 dated 10/15/2024 at 10:02 AM, revealed .in another resident's bed [with no other residents] with only his boxer briefs on . ^ Review of a nurse progress note for Resident #21 dated 10/15/2024 at 1:29 PM, revealed .continuing to experience sexual in nature behaviors . ^ Review of a social service progress note for Resident #21 dated 10/15/2024 at 4:53 PM, revealed .Psych NP .recommended geri-psych [psychiatric services for adults aged 60 and over] referral to see if he is appropriate for placement due to his sexual in nature behaviors . Review of a nurse progress note for Resident #21 dated 10/16/2024 at 10:25 AM, revealed .verbally redirected .to put on pants .attempted multiple times to go into other resident's room [multiple residents' rooms] .asking staff if they would kiss him . ^ Review of a nurse progress note for Resident #21 dated 10/17/2024 at 10:38 AM, revealed .came out into common area .staff .walked up to her [staff member] and stated .Can I touch your breast . ^ Review of a nurse progress note for Resident #21 dated 10/17/2024 at 1:50 PM, revealed Resident #21 .found in another resident room .in .resident bed [with no other resident] completely naked . Review of a nurse progress note for Resident #21 dated 10/21/2024 at 9:45 AM, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	revealed .going thur [through] stop sign [Velcro sign on a resident's door to alert other residents not to enter] on residents [residents'] rooms still getting in bed with clothes off with resident in room . ˆ Review of a nurse progress note for Resident #21 dated 10/21/2024 at 1:51 PM, revealed .still wondering [wandering] into other residents [residents'] room .made comment to cna [CNA] today that she looks very beautiful and went to touch her . ˆ Review of a nurse progress note for Resident #21 dated 10/21/2024 at 2:08 PM, revealed .out to hospital .for evaluation at psych . Review of the geri-psych hospital documentation for Resident #21 dated 10/21/2024, revealed the resident was admitted on [DATE] .patient has been making inappropriate comments to females asking to see their breast, requesting kisses. He has been sexually inappropriate to female staff, other residents, and female visitors [at the facility] . Review of a geri-psych hospital patient care note for Resident #21 dated 10/24/2024 at 5:49 AM, revealed, .patient up wandering around unit .intrusive at times going in ladies' bedroom making them anxious and afraid, redirected out of room placed in dayroom in chair .grabbed another patients [patient's] breast when in dayroom .staff to continue q15 [every 15] min [minute] checks . Review of the geri-psych hospital Patient Discharge Summary Report dated 11/1/2024, revealed .PAROXETINE (PAXIL) [an antidepressant medication] take 20MG BY MOUTH ONCE DAILY .sexually inap. [inappropriate] beh. [behavior] . Review of a nurse progress note for Resident #21 dated 11/1/2024 at 2:49 PM, revealed .arrived [to facility] .from behavioral hospital . Review of a physician's order for Resident #21 with a start date of 11/2/2024 for .Paxil .oral tablet 20 mg .one time a day for sexually inappropriate behaviors . ˆ Review of a nurse progress note for Resident #21 dated 11/2/2024 at 10:16 AM, revealed .continues to wander .into other resident's [residents'] rooms . ˆ Review of a nurse progress note for Resident #21 dated 11/2/2024 at 4:35 PM, revealed .continues to wander .into other resident's [residents'] rooms uninvited . ˆˆ Review of a nurse progress note for Resident #21 dated 11/14/2024 at 11:14 AM, revealed .going in other resident room [rooms] is very agitated . ˆ Review of a Physician Progress Note for Resident #21 dated 11/15/2024, revealed .very agitated recently .mirtazepine .is not helping with mood or sleep .started on paxil for dementia with sexually inappropriate behavior .needed Ativan [anti-anxiety medication] adjusted due to aggressive behavior toward staff and other patients . ˆ Review of the quarterly MDS assessment dated [DATE], revealed Resident #21 had severely impaired cognitive skills for daily decision making. Resident #21 exhibited physical behavioral symptoms directed towards others on 1 to 3 days of the 7 day look back period and wandering behaviors occurred daily. ˆ Review of a nurse progress note for Resident #21 dated 12/13/2024 at 7:32 PM, revealed .came out of room .walked over to .nurse and stated .You have a nice bottom, can I touch it . ˆ Review of a nurse progress note for Resident #21 dated 12/21/2024 at 4:04 PM, revealed .was found in another residents [resident's] bed .stated .i [I] know this is not my room . ˆ Review of the medical record for Resident #21 revealed the resident was sent to the emergency room (ER) on 12/28/2024 for aggressive behaviors and returned to the facility on [DATE]. ˆ Review of an IDT Note for Resident #21 dated 12/30/2024 at 12:05 PM, revealed .resident became aggressive upon being redirected from peers [other residents'] room .sent to ER for psych eval [evaluation] . ˆ Review of a nurse progress note for Resident #21 dated 1/22/2025 at 8:20 AM, revealed .in room [another resident's room] naked and laying in resident's bed [the resident who resided in the room was not present at the time] . Review of the quarterly MDS assessment dated [DATE], revealed Resident #21 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment. Resident #21 exhibited wandering behaviors daily. ˆ Review of a quarterly MDS assessment dated [DATE], revealed Resident #21 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Resident #21 had exhibited other behavioral symptoms not directed toward others for 1 to 3 days of the 7 day look back period. ˆ Review of a nurse progress note for Resident #21 dated 6/3/2025 at 8:34 AM, revealed .reached up and grabbed .nurses [nurse's] breast and voiced you have nice breast . ˆ Review of a Psychiatric Periodic Evaluation for Resident #21 dated 6/3/2025, revealed .was seen today face-to-face for assessment of .sexually inappropriate commentary and behavior .resident is (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	still participating in behaviors that are inappropriate for the environment and are in an eminent safety risk for other residents and staff members as well as the resident himself .the Paxil have [has] decreased those behaviors and have made him safer .recommended that the patient continue to receive supervision and assistance to maintain safety . Review of a nurse progress note for Resident #21 dated 7/1/2025, revealed .involved in a resident to resident incident. At approximately 2145 [9:45 PM] .wandered into the room of [Resident #103] .Per the report, from [Resident #103], this resident [Resident #21] exposed himself by removing his shorts, which were found on the floor of [Resident #103] room, heremoved [he removed] her [Resident #103] covers, and per report, groped her [Resident #103] left breast. Per report, he [Resident #21] was struck by [Resident #103] in his lower region. Upon a full skin assessment, there were no noted s/s [signs and symptoms] of contact or bruising. This resident [Resident #21] also has no recollection of the incident. Resident [Resident #21] was placed on one to one care until he was sent via EMS [Emergency Medical Services] to the ED for further evaluation. The House Supervisor, Administrator, DON, family, and appropriate authorities were notified . ˆ Review of the facility's incident report completed by RN A for Resident #21 dated 7/1/2025, revealed .Resident to Resident .was informed by.[CNA E].she heard.[Resident #103].yelling and observed.[Resident #103].to be startled and visibly distraught because.[Resident #21].entered her room.[CNA E] .did see resident [Resident #21] ambulating down the hall back to his room and noted he did not have shorts on .spoke with.[Resident #21] .had no recollection of the incident .spoke with.[Resident #103].and assured her she would be safe with the staff. Resident [Resident #21] was placed on one to one observation . Review of the ED record for Resident #21 dated 7/2/2025, revealed Resident #21 presented to the ED with the chief complaint .Agitation Pt. [Resident #21] grabbed another residence [resident's] boob [breast] .05:10 AM .no acute findings .will be returning to .nursing facility . Review of a nurse progress note for Resident #21 dated 7/2/2025 at 7:00 AM, revealed .returned to facility .no new orders noted .one to one care for safety . Review of the medical record for Resident #21 revealed the resident was transferred to geri-psych hospital on 7/2/2025. Resident #21 returned to the facility on 8/5/2025 with improvement in behaviors. During an observation and interview on 1/5/2026 at 4:45 PM, revealed Resident #21 in his room in his bed. He was easily roused when spoken to. Resident could not recall the incident and denied abuse. During an interview on 1/5/2026 (6 months after the incident) at 5:00 PM, Resident #103 could not recall the incident and denied ever being abused at the facility. During a telephone interview on 1/7/2026 at 9:11 AM, Resident #103's daughter stated she was notified by facility staff about the incident that occurred on 7/1/2025. Resident #103's daughter stated .it shook her [Resident #103] up . at the time and she [Resident #103] was ? .worried and cautious .' something might happen again . The daughter stated a staff member sat with her mother through the evening because .she had an increase in her anxiety that night.[Resident #103].saw a counselor after the incident. Resident #103's daughter stated she did not think her mother's reaction would have been any different if her cognition had been intact and this was very upsetting to her. During an interview on 1/7/2026 at 7:30 PM, RN A revealed she was passing medications when the incident between Resident #103 and Resident #21 occurred. RN A stated she did not remember the time but one of the CNAs told her Resident #21 was in Resident #103's room. Resident #103 told the CNA Resident #21 had touched her breast and was not wearing pants. RN A assessed Resident #103 with no injury or bruising noted. Resident #103 told RN A she woke up to Resident #21 standing over her and had grabbed her breast. Resident #103 stated she yelled out for help and gave Resident #21 a .wallop . in the lower region. Resident #103 expressed to RN A she was startled, upset, and nervous when she woke up and saw him standing over her. RN A stated there was a period of time after the incident when Resident #103 was more nervous and anxious. ˆ During an interview on 1/7/2026 at 8:00 PM, CNA D did not witness the altercation between Resident #21 and Resident #103 but had sat with Resident #103 in the dining room after the incident. Resident #103 was .shaking and frantic .and visibly upset. and kept saying to CNA D there was a man in her room. CNA D made Resident #103 a sandwich and stayed with the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resident until she calmed down. During an interview on 1/7/2026 at 8:30 PM, CNA E stated she heard Resident #103 yelling and saw Resident #21 come out of Resident #103's room back towards his room wearing only a t-shirt. CNA E went into Resident #103's room and observed Resident #21's pants lying on the floor next to Resident #103's bed. Resident #103 was .crying and her hands were shaking .and was very upset and fearful. Resident #103 stated she did not want to be alone and had a blanket gripped to her chest and under her chin and kept repeating she should be able to sleep without a man coming in her room and touching her. CNA E stated she notified the RN. CNA E stated CNA D stayed with Resident #103 in the dining room for a long time after the incident until she calmed down and was able to go to sleep. CNA E stated Resident #103 became nervous and anxious when the incident was discussed. ˆ During an interview on 1/9/2026 at 8:43 AM, the DON stated Resident #21 wandered into Resident #103's room while she was in bed and she screamed out.ˆCNAs went into Resident #103's room. Resident #21 was coming out of Resident #103's room with no pants on. Resident #21's pants were in Resident #103's room by her bed. The DON came to the facility after the incident and observed Resident #103 seated in the common area with staff. Resident #103 was calm and talking with staff at the time of the DON's observation. The DON did not speak with Resident #103. The DON confirmed Resident #21 exhibited sexual behaviors prior to the incident with Resident #103 including sexual comments and touching staff. Resident #103 exhibited wandering behaviors into other residents' rooms. The DON stated psych services had evaluated Resident #21,16 times since he was admitted with multiple interventions including medication changes and 2 admissions to an inpatient psych hospital and was sent to the ER on [DATE] for aggressive behaviors towards staff. The DON stated Resident #21 was prone to wander. During a telephone interview on 1/9/2026 at 11:40 AM, the Psych NP stated he evaluated Resident #103 after the incident with Resident #21. The Psych NP stated Resident #103 became tearful during the evaluation but could not recall all the specific details of the incident. The Psych NP stated he did not feel Resident #103 suffered any psychosocial harm or distress from the incident which occurred on 7/1/2025. The Psych NP stated Resident #21 wandered and had made nasty comments toward staff while they were providing care. The Psych NP stated he did not see an indication Resident #21 would exhibit inappropriate sexual behaviors to other residents prior to 7/1/2025. During an interview on 1/9/2026 at 12:15 PM, the SSD stated she was not present when the incident between Resident #103 and Resident #21 occurred. The SSD stated CNA E saw Resident #21 walking down the hall with no pants on. The SSD stated Resident #21 had wandered into Resident #103's room and touched her chest. The SSD and DON met with Resident #103 to provide emotional support on 7/2/2025. The SSD did not recall if she asked Resident #103 if Resident #21 had touched her. The SSD was unaware of Resident #21 touching any other residents inappropriately prior to the incident on 7/1/2025. The SSD reported Resident #21 was followed by psych services and required inpatient psych admission on [DATE] due to behaviors that were sexual in nature toward staff. During an interview and review of investigation documentation on 1/9/2026 at 2:12 PM, the Administrator stated a CNA reported they (staff) heard Resident #103 yelling and while responding to the room, observed Resident #21 walking down the hall with no pants on. Resident #103 told the CNA, Resident #21 had .tried . to touch Resident #103's left breast and Resident #103 punched Resident #21 in the genitals. Review of investigation documentation with the Administrator revealed the nurse progress note stated Resident #103 reported Resident #21 .groped . her left breast. The Administrator was unable to show investigation documentation to show that Resident #21 had only .tried . to touch Resident #103's breast. The Administrator stated she did not recall Resident #21 exhibiting inappropriate sexual behaviors toward residents prior to the incident on 7/1/2025 but Resident #21 had exhibited inappropriate sexual behaviors towards staff during direct care. The Administrator stated Resident #21 was discussed during the wee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility documentation review, and interview, the facility failed to ensure residents right to privacy for 1 resident (Resident #49) of 32 residents reviewed for resident rights. The findings include: Review of the facility policy titled, Dignity and Quality of Life Policy, dated 1/7/2013, revealed .Staff will respect residents private space by .not moving or inspecting residents personal property without permission . Review of the facility's admission packet dated 10/2022, revealed .You have the right to be treated with respect and dignity .The right to retain and use personal possessions .You have the right to personal privacy . Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Major Depressive Disorder, Anxiety, Suicidal Ideation, Delusional Disorder, and Post Traumatic Stress Disorder. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #49 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of a document titled Items removed from [Resident #49] dated 7/24/2025, revealed the following:*2 Marijuana cigarettes in a cigarette pack *3 Zzzquil pills (sleep aid) *Open sandwich bag containing 55 mushroom gummies *Unopened bottle containing 60 mushroom gummies*3 Theracare Neck Pain patches (single-use heat wraps which provide deep, penetrating heat to relieve muscle and joint pain, stiffness, and strains*1 Herbal Sinus Ease Oral Spray (used to relieve sinus congestion) *1 bottle Hempvana Pain Relief Lotion with Lidocaine (over the counter-OTC medication used to temporarily relieve minor muscle, joint, and nerve pain)*1 Fields of Love No More Pain Roll-On (a topical pain relief product designed to alleviate muscle soreness, tension, and everyday aches)*1 Open tube of Cortizone 10 Cream (temporary relief of itching, redness, and swelling from minor skin irritations)*1 Diclofenac Topical Gel tube (used to relieve pain and reduce inflammation)*1 Vicks Vapocream tube (non-medicated cream which provides soothing, non-medicated vapors for comfort during cold symptoms, used by applying to the chest, back, and throat)*1 Lipoma Cream tube (used to reduce the size of benign fatty lumps *1 Vicks Vapoinhaler (provides temporary relief from nasal congestion, stuffiness, colds, coughs, and allergy symptoms)*1 Vicks VapoStick (portable nasal stick used for temporary relief of nasal congestion)*1 container Charlotte's Web Full Spectrum Hemp Extract Balm 450 milligrams (mg) (used to soothe discomfort)*1 partially used tub of Triamcinolone Ointment 454 mg (prescription-strength topical corticosteroid used to relieve the inflammation, redness, itching, and discomfort caused by a variety of skin conditions)*1 jar Turmeric Neck Cream (used to firm loose skin, reduce wrinkles, tighten sagging, brighten dark spots, and deeply moisturize the neck)*1 packet 0.24-ounce (oz) Arnica Plus Homeopathic Gel (used for the temporary relief of minor muscle aches, stiffness, joint pain, bruising, and swelling)*1 - 1/2 empty 4 oz. bottle of Children's Liquid Claritin (allergy medicine)*2 - 4 oz. Bottles of Natural Therapy Hemp and Cherry Oil Body Oil containing Cannabis Sative (herb plant-helps reduce pain, ease anxiety, improve sleep and support certain digestive issues)*1 - 1/2 empty bottle of Children's Benadryl Liquid (allergy medicine) found in Resident #49's refrigerator*4 Unidentifiable square purple patches*1 unopened and 1 opened Wixella Inhaler with 17 doses remaining (medication used to prevent wheezing and shortness of breath)*1 unopened bottle of Strattera 40 mg (medication used to treat attention deficit hyperactivity disorder-ADHD) 30 pills*1 opened tube of Estradiol Cream (medication for menopause) 0.01% 42.5 grams (gms) *1 bottle (30 pills) of Solifenacin 5 mg (used to treat bladder problems) *1 package (5 pills) of Belsomra 20 mg (used to treat insomnia)*1 bottle (7 capsules) of Azo Bladder Control (used to help control urge to urinate)*1 Sumatriptan Nasal Spray (used to treat migraine headaches)*1 package (7 capsules) of Benadryl 25 mg Liquid Gels*4 unopened/unlabeled plastic ampules (small bottle) containing .clear liquid .*1 unopened package (12 caplets) of Loperamide 2 mg (used to treat (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	diarrhea)*1 bottle with 10 chewable tablets of Tums Antacid Chewy Bites Cooling Sensation Ultra Strength 1,000 (used to treat heartburn and indigestion)*19 vials (small glass container) of Cyanocobalamin 1,000 micrograms/milliliter injectable solution (Vitamin B12)*1 opened bottle (64 tablets) of Tylenol PM 500 mg Acetaminophen/25 mg Diphenhydramine (used for minor pain and aids in sleep)*2 partially used bottles of roll-on Aroma Guru Muscle Ease (used to ease muscle discomfort)*1 opened Hyland's Natural Ear Drops 0.33 oz. dropper (eardrops used for pain or itching)*1opened Earache Relief PM Ear drops 0.33 oz dropper (eardrops used for ear pain)*1 opened Benzedrex Nasal Decongestant Inhalation Stick (allergy medicine)*1 bottle of Quetiapine Fumarate 50 mg (used to treat Schizophrenia and Depression) 26 tablets cut in quarters and 7 tablets cut in half*1 bottle (30 tablets) of Mirtazapine 7.5 mg (used to treat Depression)*1 opened 12 oz. tub of South Moon Bee Venom Pain Relief Bone Soothing Cream (used to relieve arthritis and bone pain)*6 individually packaged in manufacturers packaging Ubrelvy 100 mg tablets (prescription medication to treat migraine headaches)*1 bottle (58 capsules) of Renewlife Women's Care Probiotic Vegetarian Capsules (used to support urinary, digestive, and immune health)* .Ziplock baggie labeled Wednesday Night containing 3 pills (1 white circular tablet labeled 93 on one side and 716B on other side, 1 oval yellow tablet labeled IG on one side and 214 on the other side, 1 yellow capsule labeled MD 12 on one side and 10 mg on the other) .* .Stackable Weekly Pill Planner-missing Wednesday compartment-There are only medications located in Thursday container (2 identical white oblong tablets labeled G035) .* .7 compartment travel pill case which was unlabeled/unmarked-Medications located in 2 compartments (First Compartment contains 3 white circular tablets, largest tablet labeled P20, 2 identical smaller tablets labeled P10) (Second Compartment contains 1 white capsule labeled AZO, 2 identical red oblong tablets labeled S431) .* .Weekly Pill Planner with tray holder- missing Tuesday container and Wednesday container- (Sunday Container-Morning Compartment-1 oblong white tab [tablet] labeled G035, 1 white circular tablet labeled P20. Noon Compartment-1 white circular tablet labeled 71. Evening Compartment-1 white circular tablet unmarked/unlabeled, 1 yellow circular tablet labeled CE21). (Monday Container-Morning Compartment-1 oblong white tab labeled G035. Noon Compartment-1 white circular tablet labeled 71. Evening Compartment-1 white circular tablet unmarked/unlabeled, 1 circular tablet labeled CE21). (Thursday Container-Morning Compartment-1 white oblong tablet labeled G035. Noon Compartment-1 white circular tablet labeled 72. Evening Compartment-1 white circular tablet unmarked/unlabeled, 1 yellow circular tablet labeled CE21). (Friday Container-Morning Compartment-1 white oblong tablet labeled G035. Noon Compartment-1 white circular tablet labeled 71, 1 white oblong tablet labeled A60). (Saturday Container-Evening Compartment-1 white circular tablet unmarked/unlabeled, 1 yellow circular tablet labeled E21.) .*1 opened Fields of Love PMS (Premenstrual Syndrome) Relief Roller-ball applicator (used for menstrual cramps)*1 opened 3 oz bottle of Hythe Tranquility Sleep Mist (used for relaxation)*1 opened 4 oz bottle of Diva Stuff Help with Hives Lotion (used for relief and prevention of rashes, hives, and itchy skin)*1 small portable shovel with serrated edge in camouflage carrying bag*1 - 7.5 oz. Aerosol spray can of [NAME] Professional Nail Dryer*3 pairs of scissors with black handles, various sizes*1 black lighter*1 orange/black lighter*1 medium black switch blade utility knife*1 orange 3 outlet, outlet extension*1 butane (flammable gas) fueled Thermacell Bug Repellant apparatus (device to kill insects) Review of a comprehensive care plan for Resident #49 dated 7/30/2025, revealed .MOOD AND BEHAVIOR .Facility staff have spoken to me regarding my concerns w/ [with] keeping my room in a safe condition due to clutter relating concerns. I also will order .personal items even though I don't have room for the items . Continued review revealed Resident #49's care plan was updated on 9/20/2025 to include .In July of this year [2025] there were concerns related to me having items in my room that are unsafe . During a telephone interview on 1/6/2026 at 1:05 PM, the Ombudsman (a person who advocates for nursing home residents) stated facility staff had searched Resident #49's room/belongings without the resident's permission and not in the presence of the resident on an unknown date. During an interview on 1/7/2026 at 5:45 PM, the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Director of Rehabilitation Services stated she and other members of the leadership team had been asked to assist with searching Resident #49's room after unauthorized items had been observed in the resident's room. The Director of Rehabilitation could not recall where the items were found and stated .I only put my hands on a pair of scissors . During an interview on 1/7/2026 at 5:58 PM, the Director of Nursing (DON) stated Nurse Practitioner (NP) A had gone to Resident #49's room to look for an otoscope (instrument to examine the ear) which she thought she had left in Resident #49's room. Resident #49 was not in the room when NP A entered the room. NP A noticed a prescription medication bottle in an open bottom drawer of the nightstand next to Resident #49's bed. NP A notified the unit nurse who called the DON. The DON stated she called the Director of Clinical Services and was told to remove the prescription medication bottle. The DON entered Resident #49's room to remove the prescription bottle observed by NP A in Resident #49's bottom drawer. The DON observed multiple pill bottles, OTC meds, and rolled marijuana were found. The DON confirmed Resident #49 was out of the facility when staff searched the resident's room and confirmed Resident #49 had not consented to staff searching her room. The DON stated .We were instructed to do [search Resident #49's room] based on the quantity and the nature of what we were seeing .the drawer was open .there was a multitude of pill bottles in the open drawer .we were told to search the room and see if anything else was in the room .which we did . During an interview on 1/8/2026 at 10:15 AM, Resident #49 stated .they [facility] jimmied the box open [pointing to the nightstand in her room] and found medication that was in the drawer . The resident reported the drawers were locked and she had the key. Resident #49 stated she was out of the facility when staff went through her room and she had not given consent for them to search her room. During an interview on 1/8/2026 at 1:02 PM, the Social Services Director (SSD) stated NP A had gone into Resident #49's room to look for an otoscope. While in the resident's room, NP A .saw something lying out in plain sight .I think it was a prescription med [medication] . The SSD stated .We [SSD and DON] found lots of medicine .prescription and over the counter, a small knife as well as a cigarette carton .I opened them [cigarette carton], upon opening I could tell they were not cigarettes .smelled like marijuana . The SSD stated the .executive office . was notified and local police were notified as directed by the .executive office . The SSD was unaware of what areas in the resident's room were searched with exception of the opened drawer of the nightstand. The SSD stated the items which were not permitted according to facility policy were removed from Resident #49's room. During an interview on 1/9/2026 at 7:55 AM, Licensed Practical Nurse (LPN) B stated she participated in Resident #49's room search, stating .there were several people in there [Resident #49's room] . LPN B stated .I think I checked the fridge [refrigerator] .I don't remember doing anything anywhere else .they were checking closets and other drawers . During an interview on 1/9/2026 at 8:02 AM, LPN A stated the DON was notified NP A saw medication in an opened drawer in Resident #49's room while she was looking for an otoscope.We all went down to the room [DON, Unit Manager for units 4, 5, and 6, LPN B, Resident #49's nurse, and NP A] . LPN A stated the Director of Clinical Services instructed staff to do a search of Resident #49's room. LPN A stated staff searched drawers, the resident's closet, bathroom, refrigerator, and a clear shoe hanger on the bathroom door (items in plain sight were only observed in the open drawer of the night stand in Resident #49's room). LPN A stated Resident #49 was out of the facility at the time her room was searched. LPN A stated Resident #49 was notified of the search immediately when she returned to the facility. LPN A stated the police were notified after marijuana was found in Resident #49's room. During an interview on 1/9/2026 at 8:09 AM, the DON confirmed Resident #49's nightstand drawers, including closed drawers, the dresser in the resident's room, and the hanging rack on the resident's bathroom door were checked for unauthorized items. The DON confirmed the facility did not get consent to search Resident #49's room from the resident and confirmed police were not present during the search of Resident #49's room. During an interview and review of the State Operations Manual (Appendix PP) on 1/9/2026 at 10:55 AM, the Director of Clinical Services confirmed facility should have only removed items which were visible from Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#49's room and confirmed staff should have obtained consent from Resident #49 prior to searching the resident's room. During an interview and review of the State Operations Manual (Appendix PP) on 1/9/2026 at 1:48 PM, the Administrator stated she was out of town during the time Resident #49's room was searched and had not been involved in the decision to search the room. The facility consulted with the corporate office and were instructed to search the room based off observed items. The Administrator stated it was determined for the safety of Resident #49 and other residents, the facility needed to make sure the medication and any other hazards which could affect other resident be removed from Resident #49's room. During continued interview, the Administrator stated .Based on the regulation, yes, they [staff] should have . gotten consent from Resident #49 to further search her room.Based on facility responsibility to keep residents safe, no, they shouldn't have waited for the residents' consent .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility documentation review, and interview, the facility failed to provide the required Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) for 1 resident (Residents #116) of 3 residents reviewed for beneficiary notices. The findings include: Review of the medical record revealed Resident #116 was admitted to the facility on [DATE] with diagnoses including Atrial Fibrillation, Muscle Weakness, Difficulty in Walking, and Fracture of Shaft of Humerus with Routine Healing. Review of the Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility staff indicated Resident #116 was discharged from a Medicare covered Part A stay with benefit days remaining on 11/8/2025 and remained in the facility. Review of the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review form for Resident #116 revealed .Medicare Part A Skilled Services Episode Start Date: 9/12/2025 .Last covered day of Part A Service: 11/7/2025 .The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted .Was a SNF ABN Form CMS [Centers for Medicare and Medicaid] -10055 provided to the resident .No .Not applicable .Was a NOMNC [Notice of Medicare Non-Coverage] (CMS 10123) provided to the resident .Yes . Review of Resident #116's Notice of Medicare Non-Coverage signed by the resident on 11/5/2025, revealed .THE EFFECTIVE DATE COVERAGE OF YOUR CURRENT MEDICARE A SERVICE WILL END ON Friday 11/7/2025 . Review of Resident #116's medical record revealed the SNF ABN had not been provided to the resident. Review of the Social Services Progress Note dated 11/10/2025, revealed .END OF MEDICARE PART A STAY .[Resident #116] was admitted .9/12/2025 from the hospital on Medicare Part A Stay. Last day of Medicare Part A was Friday 11/7/2025 and [Resident #116] became private pay effective Saturday 11/8/2025 . Review of the Social Services Progress Note dated 11/10/2025, revealed .DISCHARGE PLANNING MEETING .Meeting was held on 11/10/2025 .to discuss potential discharge planning. [Resident #116] attended this meeting and was joined by his adult children .granddaughter .also attended .[Social Services Director- SSD] this meeting w/ [with] Unit Manager, Director of Rehabilitation [Rehab], and Patient Account Representative [PAR] .[SSD] reviewed w/ [Resident #116] and his family that as of Saturday, [Resident #116] is now private pay. PAR provided education on daily basic per diem rate which is $231.95 .requirements/reason for NOMNC were also all discussed .Family understanding of currently needing to private pay and were wanting to discuss w/each other further about the next best appropriate steps . During an interview on 1/6/2026 at 8:00 AM, the Administrator stated Resident #116 received a NOMNC and stayed in the facility after he was discharged from the Medicare covered Part A stay. The Administrator stated .my understanding is they should have received an ABN [SNF ABN] .that has fallen through the cracks .we haven't been giving them . The Administrator confirmed SNF ABN notice was not given to Resident #116. The Administrator stated the Social Services Director was responsible for NOMNCS and SNF ABNs. During an interview on 1/8/2026 at 1:36 PM, the Director of Clinical Services confirmed Resident #116 remained in the facility after discharged from a Medicare Part A stay with benefit days remaining and was not provided a SNF ABN form. The Director of Clinical Services stated she had reached out to corporate for guidance and a SNF ABN should have been provided to Resident #116. During an interview on 1/8/2026 at 1:53 PM, the Social Services Director (SSD) stated she was responsible for NOMNCs. The SSD stated she was unaware who was responsible for SNF ABNs. The SSD stated she had only been educated on NOMNCs and was unaware who was responsible for providing the SNF ABN notices. The NOMNC was provided to residents by the SSD, and their appeal rights were explained. The NOMNC listed instructions for appeal and if the resident wanted to appeal and they lost, someone from the facility .we don't really have a specified person at the facility . would explain the costs if they wanted to continue services but no forms were provided. The SSD stated Resident #116 was receiving physical and occupational therapy and had completed his goals, so the NOMNC form was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	issued. Resident #116's family paid privately for a few days, and he was then discharged with home health for therapy. The SSD confirmed she did not issue Resident #116 a SNF ABN. During an interview on 1/9/2026 at 12:12 PM, the Director of Clinical Services confirmed the facility was only providing NOMNCs and did not have a facility staff member responsible for providing SNF ABN forms to residents. The Director of Clinical Services stated the facility did not have a policy regarding SNF ABN notices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 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 facility policy review, Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual review, medical record review, and interviews, the facility failed to ensure MDS assessments were accurate for 5 residents (Residents #107, #38, #96, #43, #54) of 22 residents reviewed for MDS assessments. The findings include: Review of the facility's policy titled, Minimum Data Set (MDS) Policy, dated [DATE], revealed .will utilize the Minimum Data Set (MDS) .for the Resident Assessment Tool .will have MDS assessments completed in accordance with OBRA [Omnibus Budget Reconciliation Act] and Medicare Guidelines .Completion of the MDS 3.0 assessments is a multi-disciplinary product and is overseen by the MDS Coordinator and assistants . Review of the Centers for Medicare & Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 2.0 User's Manual dated 10/2024, revealed .discharge date .Enter the date the resident was discharged .This is the date the resident leaves the facility . Continued review revealed .residents covered by Level II PASRR [Pre-admission Screening and Resident Review] process may require certain care and services provided by the nursing home .Steps for Assessment .Code .yes .if PASRR Level II screening determined that the resident has a serious mental illness . Review of the medical record revealed Resident #107 was admitted to the facility on [DATE] with diagnoses including Wedge Compression Fracture of 4th Lumbar Vertebra, Depression, Hypertension, Cardiac Arrythmia, Hyperlipidemia, Sleep Apnea, and Atherosclerotic Heart Disease. Review of the Nurses Note for Resident #107 dated [DATE] at 12:10 PM, revealed .1005 [10:05 AM] Time of Death . Review of the Nurses Note for Resident #107 dated [DATE] at 2:44 PM, revealed .1410 [2:10 PM] Funeral home arrived released to [named funeral home] . Review of the death in facility MDS assessment for Resident #107 dated [DATE], revealed .discharge date XXX[DATE] .Discharge Status .deceased . During an interview on [DATE] at 10:59 AM, the MDS Coordinator confirmed Resident #107 expired on [DATE]. The death in facility MDS assessment dated [DATE] stated Resident #107 was discharged on [DATE] and was not coded accurately. The MDS Coordinator confirmed the discharge date should have been [DATE]. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Depression, and Anxiety. Review of a PASRR dated [DATE] (prior to admission to the facility), revealed Resident #38 had a PASRR Level II Outcome related to a serious mental illness (Schizoaffective Disorder, Depression, and Anxiety). Review of a significant change MDS assessment dated [DATE], revealed Resident #38 scored a 00 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed the resident had active diagnoses of Schizoaffective Disorder, Depression, and Anxiety. Continued review revealed the resident was not coded for a PASRR Level II condition. During a medical record review and interview on [DATE] at 2:35 PM, Registered Nurse (RN) MDS reviewed the significant change MDS assessment dated [DATE] and the Level II PASRR dated [DATE] for Resident #38. RN MDS confirmed the significant change MDS assessment for Resident #38 was inaccurate and did not reflect Resident #38's PASRR level II outcome status. Review of the medical record revealed Resident #96 was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder (PTSD), Depression, and Anxiety. Review of a PASRR dated [DATE] (prior to admission to the facility), revealed Resident #96 had a PASRR Level II Outcome related to a serious mental illness (PTSD, Depression, and Anxiety). Review of a significant change MDS assessment dated [DATE], revealed Resident #96 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident had active diagnoses of PTSD, Depression, and Anxiety. Continued review revealed the resident was not coded for a PASRR Level II condition. During a medical record review and interview on [DATE] at 2:35 PM, the MDS Coordinator reviewed the significant change MDS assessment dated [DATE] and the Level II PASRR dated [DATE] for Resident #96. The MDS Coordinator confirmed the significant change MDS assessment for Resident #96 was inaccurate and did not include Resident #96's PASRR level II outcome status. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Adjustment Disorder, and Bipolar Disorder. Review of a PASRR dated [DATE], revealed Resident #43 had a PASRR Level II Outcome related to a serious mental illness (Bipolar Disorder and Trauma/Stress Related Disorder). Review of a significant change MDS assessment dated [DATE], revealed Resident #43 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident had active diagnoses of Bipolar Disorder and Post Traumatic Stress Disorder. Continued review revealed the resident was not coded for a PASRR Level II condition. During a medical record review and interviews on [DATE] at 3:00 PM, the Social Service Director and MDS Coordinator reviewed the significant change MDS assessment dated [DATE] and the Level II PASRR dated [DATE] for Resident #43. The Social Service Director and MDS Coordinator confirmed the significant change MDS assessment for Resident #43 was inaccurate and did not reflect Resident #43's PASRR level II outcome status. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder, Recurrent Depressive Disorder, and Impulse Disorder. Review of a PASRR dated [DATE], revealed Resident #54 had a PASRR Level II Outcome related to a serious mental illness (Major Depressive Disorder, Post Traumatic Stress Disorder and Antisocial (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Personality Disorder). Review of a significant change MDS assessment dated [DATE], revealed Resident #54 scored a 4 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review revealed the resident had active diagnoses of Impulse Disorder, Post Traumatic Stress Disorder, Depression, and Anxiety Disorder. Continued review revealed the resident was not coded for a PASRR Level II condition. During a medical record review and interview on [DATE] at 3:00 PM, the Social Service Director and MDS Coordinator reviewed the significant change MDS assessment dated [DATE] and the Level II PASRR dated [DATE] for Resident #54. The Social Service Director and RN MDS Coordinator confirmed the significant change MDS assessment for Resident #54 was inaccurate and did not reflect Resident #54's PASRR level II outcome status. During an interview on [DATE] at 3:05 PM, the Clinical Director of Operations confirmed the MDS assessments for Residents #38, #43, #54, and #96 were inaccurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure Transmission Based Precautions (TBP) were maintained for 1 resident (Resident #73) of 1 resident observed in TBP and failed to ensure appropriate Personal Protective Equipment [PPE] was donned (applied) for 1 resident (Resident #10) in Enhanced Barrier Precautions (EBP) of 4 residents observed in EBP. The findings include: Review of the facility's policy titled, Infection Control Manual, dated 4/25/2024, revealed .Transmission-Based Precautions [TBP] .should be implemented for Residents known or suspected to be infected with an infectious agent requiring additional control measures .Three types of TBP .contact precautions .PPE SUPPLY .Provide a table, cart, dispensing units .for 24 hour access to a supply of PPE .gowns, masks, gloves .Contact Precautions .used for Residents known or suspected to be infected with microorganisms that can easily be transmitted by direct or indirect contact .Enhanced Barrier Precautions .refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfers of MDROs [Multi-Drug Resistant Organisms] to staff hands and clothing .EBP are indicated for residents with .indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Indwelling medical device examples include .urinary catheters .EBP should be used for any residents who meet the above criteria, wherever they reside in the facility . All PPE should be used once and discarded before leaving the room . Review of the medical record revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Urinary Tract Infection (UTI), and Extended Spectrum Beta Lactamase (ESBL) Resistance. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #73 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #73 had an indwelling catheter and was not on isolation or quarantine for active infectious disease. Review of a physician's order for Resident #73 dated 1/5/2026, revealed .Isolation precautions while on ABT [antibiotics] .for ESBL in urine until 1/13/2026 . Continued review revealed an order dated 1/5/2026 for .Macrobid [antibiotic medication] Oral Capsule 100 MG [milligrams] .1 capsule by mouth every 12 hours for UTI for 5 Days . During an observation on 1/5/2026 at 11:47 AM, there was an isolation cart outside Resident #73's room with gowns, gloves, and facemasks. There were 2 signs posted outside the resident's room. The first sign read .Contact Precautions .Clean hands with alcohol-based hand rub or soap and water .Wear gown when providing direct care .wear gloves when providing direct care . The second sign read .STOP .CONTACT PRECAUTIONS .always wash hands before entering and after leaving .Visitors please see the nurse before entering . During an observation on 1/6/2026 at 9:17 AM, there was an isolation cart outside Resident #73's room with gowns, gloves, and facemasks. There were 2 signs posted outside the resident's room. The first sign read .Contact Precautions .Clean hands with alcohol-based hand rub or soap and water .Wear gown when providing direct care .wear gloves when providing direct care . The second sign read .STOP .CONTACT PRECAUTIONS .always wash hands before entering and after leaving .Visitors please see the nurse before entering . Certified Nursing Assistant (CNA) A and CNA B exited Resident #73's room wearing gowns and gloves. The CNAs interacted with other staff in the hallway and discarded the PPE worn in Resident #73's room in the hallway. During an interview on 1/6/2026 at 9:22 AM, CNA B confirmed Resident #73 was on Contact Isolation for ESBL in the urine. CNA B confirmed she had not discarded the PPE worn to provide care to Resident #73 prior to exiting the resident's room and stated PPE was to be discarded prior to exiting the room for residents in isolation. During an interview on 1/6/2026 at 9:23 AM, CNA A stated she and CNA B had been in Resident #73's room changing him. CNA A stated the resident required contact isolation precautions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445543	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee State Veterans Home- Cleveland	1940 Westland Drive Cleveland, TN 37311

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for ESBL in his urine. CNA A confirmed she and CNA B had not discarded their PPE prior to exiting Resident #73's room and had discarded it in the hallway. CNA A confirmed PPE was to be discarded prior to exiting the room of a resident in contact isolation. During an interview on 1/6/2026 at 4:31 PM, the Director of Nursing (DON) confirmed Resident #73 required contact isolation for ESBL. Staff were to don gown and gloves prior to entering the room for a resident on contact isolation and were to doff (remove) and discard the PPE prior to exiting the resident's room. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure, Obstructive and Reflux Uropathy, and Benign Prostatic Hyperplasia. Review of a physician's order for Resident #10 dated 9/19/2025, revealed .FOLEY CATHETER .DX: [diagnosis] Obstructive and Reflux Uropathy . Review of a physician's order for Resident #10 dated 10/11/2025, revealed .Enhanced Barrier Precautions related to foley catheter every day and night shift related to OBSTRUCTIVE AND REFLUX UROPATHY . Review of the quarterly MDS assessment dated [DATE] revealed Resident #10 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Resident #10 had an indwelling catheter. During an observation on 1/6/2026 at 9:13 AM, Restorative Aide C was in Resident #10's room transferring the resident and the resident's urinary catheter bag from the bed to the wheelchair. Restorative Aide C did not wear gloves or a gown during the interaction. There was a triangle with an exclamation point inside it outside the resident's door (the facility's indicator that the resident required EBP). During an interview on 1/6/2026 at 9:25 AM, Restorative Aide C confirmed she had transferred Resident #10 and his urinary catheter bag from the bed to the wheelchair so he could go to the dining room. Restorative Aide C stated Resident #10 had a urinary catheter and was not on Enhanced Barrier Precautions. Restorative Aide C stated .I don't think so . when this surveyor asked if residents with urinary catheters required PPE. Restorative Aide C stated she knew which residents required PPE by signage and PPE cart outside the resident's door. This surveyor asked Restorative Aide C what the triangle with exclamation point inside of it on the resident's door meant and she stated .it means he has a foley [urinary catheter] .I don't think it means he needs gown and gloves .just that he has a foley . Restorative Aide C confirmed she had not worn gown and gloves while transferring Resident #10 and his urinary catheter bag from the bed to the chair. During an interview on 1/6/2026 at 4:24 PM, the DON confirmed Resident #10 had a urinary catheter and required EBP including gown and gloves when providing direct care. Staff were aware that residents required EBP by a sign (triangle with exclamation point inside it) on the Resident's door and PPE was located in the room. The DON stated she did not think transferring a resident was considered high contact resident care activity. During an interview on 1/7/2025 at 11:52 AM, the Director of Clinical Services stated residents with urinary catheters required EBP for high contact resident care activities. High contact resident activities included transferring and contact with urinary catheter bags and would require gown and gloves during the interaction. The Director of Clinical Services confirmed EBP precautions were not maintained when Restorative Aide C transferred Resident #10 and his urinary catheter bag from the bed to the wheelchair without wearing gown and gloves. The Director of Clinical Services stated staff knew which residents required EBP by the triangle with exclamation point inside it on the outside of the resident's door. PPE was located inside the room in the closet. The Director of Clinical Services stated the facility used the CDC (Centers for Disease Control and Prevention) as guidance for EBP/TBP.