STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E132	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennova Newport Convalescent Center	450 College St Newport, TN 37821

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, medical record review, review of facility investigation, and interview, the facility failed to report an allegation of abuse to the State Survey Agency for 2 residents (#1) and (#2) of 7 residents reviewed for abuse.The findings include: Review of the facility's policy titled, Abuse Prevention - Reporting and Investigation Policy, dated 7/2/2025, revealed .In response to allegations of abuse .the facility must .Ensure that all alleged violations involving abuse .are reported immediately according to state and federal requirements . Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Chronic Pain and Osteoarthritis. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 9 on the Brief Interview of Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Medical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Dementia and Depression. Review of a quarterly MDS assessment dated [DATE] revealed Resident #2's scores a 4 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the facility's investigation dated 1/29/2026 at 6:10 PM, revealed Resident #1 reported to License Practical Nurse (LPN) D Resident #2 had smacked him [Resident #1] in the face. No redness, bruising or injury was noted to Resident #1 or Resident #2. The allegation of abuse was reported to the State Survey Agency on 1/31/2026 at 2:43 PM (a total of 44 hours and 23 minutes). During an interview on 6/16/2026 at 12:20 PM, the Administrator confirmed the allegation of abuse for Resident #1 and Resident #2 had not been reported to the State Survey Agency within 24 hours as required by State law.

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