STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E446	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Rest Hardin County Health Center	85 Shelby Drive Savannah, TN 38372

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 policy review, facility investigation review, medical record review, and interview, the facility failed to report an allegation of abuse and failed to report to local law enforcement, Adult Protective Services (APS), and the Long-Term Care Ombudsman, within 24 hours for the allegations of suspected abuse for 5 of 5 (Resident #11, #12, #17, #19, and #25) sampled residents reviewed for abuse and resident rights. The findings include: 1. Review of the facility undated policy titled, Resident Rights, revealed The resident has the right to a dignified existence, self-determination .The resident has the right to be treated with respect and dignity . Review of the facility undated policy titled, ABUSE, NEGLECT, AND EXPLOITATION, revealed Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation . Residents must not be subject to abuse by anyone, including but not limited to .facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving resident, family members, legal guardians, friends or other individuals .Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse should .Respond to the needs of the resident and protect them from further incident (document) .Notify the Director of Nursing and Administrator (document) .Initiate an investigation immediately .Contact State Agency and the local Ombudsman office to report the alleged abuse .If a crime, or suspicion of a crime has occurred, notify the local law enforcement agency .Each covered individual shall report to the State Agency and one or more law enforcement entities .any responsible suspicion of a crime against any individual who is a resident of or is receiving care from the facility .Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause suspicion result in serious bodily or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury . 2. Review of the Facility Reported Investigation dated 3/11/2025, revealed an allegation of physical and verbal abuse when Certified Nursing Assistant (CNA) C reported to the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) that while working with CNA B on 3/9/2025, CNA B handled Resident #12 in a rough manner when assisting CNA C with repositioning Resident #12 and when CNA B ripped off Resident #19 ' s brief in a rough manner and spoke to the Resident in a harsh tone. CNA C did not report the occurrences until 3/11/2025, 2 days later. As a result of the facility ' s investigation, it was determined that Residents #11, #17, and #25 were all subject to abusive behavior from CNA B while receiving care and services and it was not reported. (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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Dementia, Muscle Weakness, Anxiety, Depression, Diabetes and Benign Prostatic Hyperplasia. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #11 has a Brief Interview for Mental Status (BIMS) score of 5, indicated the resident had severe cognitive impairment, dependent on staff for Activities of Daily Living skills (ADLs), and incontinent of both bowel and bladder. 4. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Alzheimer ' s Cerebrovascular Disease, Hemiplegia and Hemiparesis, Catatonic Disorder, and Psychomotor Deficit. Review of the annual MDS dated [DATE] revealed Resident #12 had a BIMS score of 8, indicated the Resident had moderate cognitive impairment, dependent on staff for ADLs, and incontinent of both bowel and bladder. 5. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Alzheimer ' s, Rheumatoid Arthritis, Urinary Tract Infection, Dementia, and Anxiety. Review of the significant change MDS dated [DATE], revealed a BIMS of 14 which indicated the Resident was cognitive intact, required substantial/maximal assistance with ADLs, and incontinent of both bowel and bladder. 6. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE], with diagnoses including Alzheimer ' s, Muscle Weakness, Dementia, Age Related Debility, Adjustment Disorder, and Pain in Right Hip. Review of the significant change MDS dated [DATE], revealed no BIMS score assessed and Resident with short-long term memory problems and severely impaired for cognitive skills for daily decision making, dependent on staff for ADLs, and incontinent of both bowel and bladder. 7. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Diabetes, Age-Related Physical Debility, Muscle Weakness, Depression, and Incontinence. Review of the annual MDS dated [DATE], revealed a BIMS of 13 which indicated the Resident was cognitive intact, dependent on staff for ADLs, and incontinent of both bowel and bladder. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. During a telephone interview on 610/2025 at 11:32 AM, CNA F confirmed she had provided a written statement to the facility regarding the allegation of abuse involving CNA B. CNA F confirmed that she witnessed several incidents in the past involving CNA B and stated she did report to some nursing staff but was unsure their names. CNA F was read her witness statement and confirmed that she wrote the statement and all information in the statement was witnessed at various times and was unsure of the dates or times. CNA F confirmed she witnessed CNA B being rough, rude, and belittling residents. CNA F confirmed she witnessed CNA B speaking hateful and slapping Resident #25 on the leg telling him to straighten out his legs when giving him incontinent care. CNA F confirmed that in her statement she wrote that she witnessed CNA B being rough with Resident #11 and pointing her finger in his face aggravating him. CNA F confirmed that in her statement she witnessed CNA B talking and belittling Resident #17 for having an incontinent incident. CNA F confirmed she has witnessed CNA B being hateful and rude and she failed to report it and that she should have. During an interview on 6/10/25 at 1:57 PM, LPN D confirmed she had given a handwritten statement regarding CNA B and her attitude towards residents. LPN D confirmed she had spoken with CNA B on one occasion about her attitude towards residents especially how she responded to residents and was not being patient with residents. LPN D confirmed that residents had requested for CNA B not to come into their rooms to take care of them because of her attitude. LPN D confirmed she did not report that to the DON, ADON, or the Administrator, and that she should have. During an interview on 6/10/2025 at 2:15 PM, the ADON confirmed that CNA C reported on 3/11/2025 to both her and the DON that CNA B had been both physically and verbally abusive to Resident #12 and #19 on 3/9/2025. The ADON confirmed that CNA C should have reported it the same day it occurred and not 2 days later. The ADON confirmed that initially they thought it may have been that CNA B was having a bad day but as they began to speak with other staff it was disclosed that other residents were involved and that it was more than a bad day. The ADON confirmed the other 3 residents that were involved were Resident #11, Resident #17, and Resident #25, with staff alleging physical and verbal abuse from CNA B. During an interview on 6/10/25 at 2:18 PM, the DON confirmed that on 3/11/2025 CNA C told both him and the ADON that she witnessed some disturbing behavior from CNA B on 3/9/2025 involving 2 residents. The DON confirmed that the staff member was CNA B and the initial residents involved were Resident #12 and Resident #19 and the date of occurrence was 3/9/2025. The DON confirmed that CNA C did not report the occurrences to anyone until 3/11/2025 when she returned back to work and then an investigation was started. The DON confirmed that once the investigation began that other staff reported other incidents that they witnessed that involved other residents. The DON confirmed the other residents were Resident #11, Resident #17, and Resident #25. The DON confirmed that it was reported that CNA B was rude, hateful in speaking with residents, and was very rough when caring for the residents. The DON confirmed that neither Adult Protective Services, Local Law Enforcement, and/or the Ombudsman were notified of the occurrences. The DON confirmed that it should have been reported by staff on 3/9/2025 when it was witnessed and an investigation should have been started on that date. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/25 at 3:22 PM, the Administrator confirmed that on 3/11/2025 he was told about an incident that occurred on 3/9/2025 that involved CNA B and 2 residents. The Administrator stated that when he was initially told he thought maybe it was just a staff member having a bad day but then after further investigation he realized it was more than that and it involved other residents. The Administrator confirmed the staff member was CNA B and the initial residents involved were Resident #12 and Resident #19 and that it was reported to him that CNA B was rough during care and had a bad attitude and by the 3rd or 4th staff statement that it was definitely an allegation of abuse. The Administrator confirmed that CNA C reported it to the DON and the ADON on 3/11/2025 but it occurred on 3/9/2025 and she should have reported to the nurse when it was witnessed. The Administrator Stated that all suspected allegations or any allegation should be reported immediately when witnessed and an investigation should be started at that time to include statements from staff and residents, assess the residents, skin sweeps, and informing the physician and the family. During an interview on 6/10/2025 at 3:46 PM, CNA C confirmed that on March 9th she was working with CNA B on Hall 2 and she asked CNA B for assistance in giving care to Resident #12 and Resident #19. CNA C confirmed they went into Resident #12 ' s room first to give her care and instead of unfastening the resident ' s brief she just ripped the brief off of the resident and then she assisted me in Resident #19 ' s room and was speaking rude and abusive to the resident. CNA C confirmed she was in disbelief of her actions in both rooms. CNA C confirmed that neither Resident #12 or Resident #19 could assist with their care or could give the care to themselves, or could make their needs or wants known, and that staff has to assist with all their care needs. CNA C confirmed she had heard that she was rough and had an attitude with residents but had never witnessed it until that day, 3/9/2025. CNA C confirmed that she did not report to anyone about the 2 occurrences until 3/11/2025 when she reported to the DON and the ADON, 2 days later when she returned back to work. CNA C confirmed that she should have reported to the nurse on the date she witnessed the incidents.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to follow a physician's order related to contact isolation precautions for 1 of 2 residents sampled (Resident #12) reviewed for infection control. The findings include: 1. Review of the facility policy titled, Infection Control and Prevention Policy, dated 2017, revealed It is the policy of this facility to establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection by providing a safe and sanitary environment .A resident with an infection .shall be placed in isolation precautions . 2. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnosis including Alzheimer, Cerebrovascular Disease, Hemiplegia, and Polyneuropathy. Review of a Microbiology report dated 6/8/2025, revealed Resident #12 had a urine culture that grew out Extended-Spectrum Beta-Lactamases (ESBL) (bacteria is resistant to a wide range of antibiotics) in her urine. Review of a Physician's Order dated 6/8/2025, revealed an order for CONTACT ISOLATION PRECAUTIONS RELATED TO UTI (urinary tract infection) with ESBL . During an observation on 6/9/2025 at 11:25 AM and 4:41 PM, and 6/10/2025 at 7:50 AM, revealed on Resident #12's door a Personal Protective Equipment (PPE) door organizer with a purple square and code key that indicated Resident #12 was in enhanced barrier precautions. During an interview on 6/10/2025 at 10:48 AM, the Assistant Director of Nurses (ADON) was asked what kind of isolation Resident #12 was in. The ADON stated, Contact Isolation. The ADON was showed Resident #12's door that had enhanced barriers signage on it, she stated, It will be changed to contact isolation. During an interview on 6/10/2025 at 2:37 PM, the Director of Nurses confirmed Resident #12 was in Contact Isolation and the room signage was incorrect.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on policy review, facility working schedule review, calculated time by calendar day list review, Employee Timesheet review, and interview, the facility failed to ensure there was Registered Nurse (RN) coverage for 8 consecutive hours a day, 7 days a week, for 37 days ranging from January 2025 through June 2025. The census was 35. The findings include: 1. Review of the facility undated policy titled, Nursing Staff-Staffing Policy, revealed .The facility will assure that there is sufficient qualified nursing staff available at all times to provide nursing and related services to meet the resident's needs safely and in a manner that promotes each resident's rights, physical, mental and psychological well-being .The facility will provide at a minimum .55 hours of licensed nursing staff per resident day . 2. Review of the facility Nurses Working Schedule for January 2025, February 205, March 2025, April 2025, May 2025, and June 2025, revealed there was no RN scheduled for 1/4, 1/5, 1/11, 1/12, 1/18,1/19, 1/26, 2/1, 2/2, 2/8, 2/9, 2/15, 2/16, 2/22, 2/23, 3/1, 3/2, 3/8, 3/9, 3/15, 3/16, 3/22,3/23, 3/29, 3/30, 4/5, 4/6, 5/10, 5/11, 5/17, 5/18, 5/24, 5/25, 5/31, 6/1, 6/7, and 6/8. Review of the facility's Calculated Time by Calendar Day, report for May 2025, revealed there was no RN calculated time for RN hours worked on 5/10, 5/11, 5/17, 5/18, 5/24, 5/25, 5/31, and 6/1. Review of RN A ' s Employee Timesheet dated January 2025, February 2025, and March 2025, revealed RN A did not have any hours worked on 1/4, 1/5, 1/11, 1/12, 1/18, 1/19, 1/26, 2/1, 2/2, 2/8, 2/9, 2/15, 2/16, 2/22, 2/23, 3/1, 3/2, 3/8, 3/9, 3/15, 3/16, 3/22, 3/23, 3/29, and 3/30 which indicated there was no RN coverage for those days. Review of the Director of Nursing's (DON) Employee Timesheet dated January 2025, February 2025, and March 2025, revealed the DON did not have any hours worked on 1/4, 1/5, 1/11, 1/12, 1/18, 1/19, 1/26, 2/1, 2/2, 2/8,2/9,2/15, 2/16, 2/22, 2/23, 3/1, 3/2, 3/8, 3/9, 3/15, 3/16, 3/22, 3/23, 3/29, and 3/30 which indicated there was no RN coverage for those days. 3. During an interview on 6/10/2025 at 8:15 AM, the DON confirmed there was no RN coverage on the following weekends of 2025 for the dates 5/10, 5/11, 5/17, 5/18, 5/24, 5/25, 5/26, 5/31, and 6/1 on the licensure sheet. The DON was asked if the facility had RN coverage on any weekends. The DON stated, No. During an interview on 6/10/2025 at 8:29 AM, the DON was asked what the facility does when there is not an RN available to work the required 8 consecutive hours a day. The DON stated, If anything requires an RN, the charge nurse calls me or RN A. Our sister facility staffs an RN on weekends next door, and they can come if there is an emergency. During an interview on 6/10/2025 at 1:19 PM, the Administrator confirmed that the facility did not have RN coverage on any weekend. The Administrator stated, We applied for a waiver, but it hasn ' t been granted.