STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445382	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Mountain Post-Acute and Rehabilitation Cente	415 Cole Drive Pigeon Forge, TN 37863

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(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	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** 39794 Based on facility policy review, facility investigation review, police report review, medical record review, observation, and interview the facility failed to protect the residents' right to be free from physical abuse by a resident for 2 of 14 (Residents #7 and #3) sampled residents reviewed for abuse. The facility failed to protect the residents' right to be free from abuse on 6/13/2023 when Resident #12 open handed slapped Resident #3 on the hands, wrists, and lower forearms and when Resident #14 hit Resident #7 in the upper left arm causing multiple bruises on 6/1/2024 which resulted in actual HARM for Resident #7. The finding include: Review of the facility's undated policy titled, Abuse, Neglect and Exploitation, revealed .It is the policy of this facility to provide protections for .each resident by developing and implementing written policies .that prohibit and prevent abuse .'Abuse' means the willful infliction of injury .with resulting physical harm .which can include .resident to resident altercations .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm .'Physical Abuse' includes .hitting, slapping, punching, biting, and kicking . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Hypertension, Muscle Weakness, Cognitive Communication Deficit, and Abnormalities of Gait and Mobility. Review of an Order Summary Report physician's order for Resident #7 dated 12/6/2022, revealed the resident was taking Apixaban 5 milligram (mg) twice a day for anticoagulation (slowing of the clotting of the blood). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 scored a 6 on a Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had severe cognitive impairment. Review of a Comprehensive Care Plan for Resident #7 dated 6/1/2024, revealed Resident #7's resident to resident altercation was addressed. The care plan was person centered and interventions were appropriate to address the issue. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse's Progress Notes for Resident #7 dated 6/1/2024 at 1:15 PM, revealed Resident #7 was heard yelling for help from the resident's room. The nurse observed Resident #14 assaulting Resident #7. The nursing note revealed Resident #7 was hit in the left upper arm and the left side of the face with a closed fist. Licensed Practical Nurse (LPN) A and Certified Nursing Assistant (CNA) C separated the residents, LPN A notified the police, Emergency Medical Services (EMS), Assistant Director of Nursing (ADON), and Manager on Duty of the altercation. Resident #7 was sent to the emergency room for assessment. Review of the Nurse's Progress Notes for Resident #7 dated 6/1/2024 at 3:29 PM, revealed Resident #7 was moved to a different room as an intervention to prevent future altercations with Resident #14. Review of the emergency room (ER) Documentation for Resident #7 dated 6/1/2024, revealed Resident #7 had .soft tissue swelling and bruising over the left upper extremity . No other injuries were found during the emergency room (ER) examination. Resident #7 was discharged back to the facility from the ER. Review of the Encounter Note for Resident #7 dated 6/3/2024 at 1:00 PM, revealed Resident #7 was assessed by the Family Nurse Practitioner (FNP). The FNP documented Resident #7 had .Multiple black bruises to bilateral upper extremities . During an observation in the outside courtyard on 6/17/2024 at 11:30 AM, Resident #7 was observed in a wheelchair with other residents. Resident #7 was wheeling her chair towards the door to go into the building. Resident #7 was alert and calm. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Dementia with Psychotic Disturbance, Adult Failure to Thrive, Anxiety Disorder, and Tremors. Review of a quarterly MDS assessment dated [DATE], revealed Resident #14 scored a 9 on the BIMS assessment, which indicated the resident had moderate cognitive impairment. In addition, the MDS revealed Resident #14 had exhibited no behaviors during the assessment period. Review of a Comprehensive Care Plan for Resident #14 revised 6/1/2024, revealed the resident to resident altercation was added to the Behavior Care Plan on 6/1/2024. The goal and interventions were person centered and appropriate for Resident #14's behavior issues. Review of the Nurse's Progress Notes for Resident #14 on 6/1/2024 at 1:15 PM, revealed the resident was in an altercation with Resident #7 and was transferred to the ER.The nursing note also revealed the ADON and Manager on Duty had been notified. Review of the Nurse's Progress Note on 6/1/2024 at 10:47 PM, revealed Resident #14 returned to the facility that night. Review of the emergency room Documentation for Resident #14 dated 6/1/2024, revealed Resident #14 had no abnormal lab results for blood and urine, and Resident #14 was free from injury. Resident #14 was observed for 6 hours at the emergency room and discharged back to the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse's Progress Notes for Resident #14 on 6/2/2024 at 5:11 AM, revealed the resident was being placed on 1 to 1 supervision for behaviors. Review of the facility investigation of the incident between Residents #7 and #14 dated 6/1/2024 at 4:30 PM, revealed at 1:15 PM staff heard a resident screaming. The staff entered the room where Residents #7 and #14 resided and saw Resident #14 hitting Resident #7 in the left upper arm. The staff separated the residents. CNA C stayed with Resident #14 in the room. LPN A moved Resident #7 out of the room to the nursing station. Resident #7 was assessed for injuries. Residents #7 and #14 were sent to the local hospital ER for evaluation. Review of the Witness Statement from CNA C dated 6/1/2024, revealed Resident #14 was agitated the morning of 6/1/2024 about missing clothes. Resident #7 (Resident #14's roommate) was assisted to get up and dressed. CNA C assisted Resident #7 to the nursing station. The witness statement revealed Resident #7 wheeled herself back to her room. The CNA heard a resident yelling and went to Resident #7's room and witnessed Resident #14 hitting Resident #7. Review of an undated Witness Statement from LPN A revealed .[CNA C] .alerted this nurse that .[Resident #14] saying someone took her clothes .[Resident #7] spent the rest of the morning .around the nurses station until .[Resident #7] wheeled herself back into her room .[LPN A] heard [Resident #7] yell for help. [LPN A] turned back to look .and observed [Resident #14] hitting [Resident #7] in the left upper arm and left side of face with a closed fist . During an observation in the resident's room on 6/17/2024 at 11:25 AM, Resident #14 was observed lying in bed. Resident #14 was on 1:1 supervision 24 hours a day. Resident #14 was calm and smiling. During a phone interview on 6/17/2024 at 2:26 PM, LPN A stated she was right outside Residents #7's and #14's room when she heard a scream. LPN A went into the room and observed Resident #14 closed fist hitting Resident #7 on the left arm and left side of the face. LPN A stated CNA C assisted LPN A to separate the residents. LPN A stated CNA C stayed with Resident #14. CNA C reported to LPN A that Resident #14 was aggressively trying to get away from her to get to Resident #7. During a phone interview on 6/17/2024 at 3:18 PM, the Family Nurse Practitioner (FNP) stated on 6/3/2024, Resident #7 was evaluated due to the incident that happened on 6/1/2024 between Residents # 7 and #14. The FNP stated Resident #7 had bruised on both arms. The FNP stated Resident #7 did remember being hit but did not know why. The FNP stated a resident hitting another resident was considered abuse, and the bruises Resident #7 received from being hit by Resident #14 were considered harm. During a phone interview on 6/18/2024 at 9:36 AM, CNA C stated in the morning on 6/1/2024, Resident #14 was agitated about her clothes missing. CNA C stated Resident #14 often gets upset about clothes are in the laundry and thinks someone took them. CNA C stated Resident #7 (Resident #14's roommate) was trying to get out of bed at the time. CNA C stated she assisted Resident #7 to get cleaned up, dressed, and removed from the room. CNA C stated she reported to LPN A about Resident #14's agitation. CNA C stated after lunch Resident #7 went back to her room on her own. CNA C stated she heard a scream and went to the Resident #7's and #14's room and observed Resident #14 was hitting Resident #7. CNA C stated a nurse was attempting to separate the residents. CNA C assisted the nurse, and then stayed with Resident #14. During that time with Resident #14, CNA C stated that Resident #14 wanted to be let out of the room to get to Resident #7. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/18/2024 at 10:55 AM, the Director of Nursing (DON) stated the plan was for Resident #14 to remain on 1 to 1 supervision the mental health nurse practitioner could complete another assessment to make sure it was safe. The DON stated Resident #14 had no violent episodes since 6/1/2024. The DON stated Resident #14 hitting Resident #7 was abuse, and the injuries Resident #7 received from Resident #14 hitting her met the definition of harm. During an interview on 6/18/2024 at 12:50 PM, the Power of Attorney (POA) for Resident #14 stated the facility called right away to notify him of the incident on 6/1/2024. POA stated he had been updated on the care plan interventions and completely agreed with them. During an interview on 6/18/2024 at 12:56 PM, the Emergency Contact (EC) for Resident #7 stated she was notified of the incident that occurred between Resident #7 and Resident #14 on 6/1/2024. The EC was updated right away after the incident. The EC stated she was updated on the room change and agreed with that change. During an interview on 6/18/2024 at 1:10 PM, the Administrator stated she was out of the facility on 6/1/2024. The Administrator stated she went to the facility as soon as she could. The Administrator stated she was told there was a resident to resident altercation caused by Resident #14 thinking Resident #7 stole her clothes. The Administrator stated she was told Resident #14 hit Resident #7 multiple times in left arm. Staff told the Administrator they separated the residents immediately, the residents were sent to the ER for evaluation, and the DON, Manager on Duty, 911, police and families were notified of the incident. The Administrator stated Resident #14 hitting Resident #7 was considered abuse, and the bruises Resident #7 received from Resident #14 were considered harm. Review of the medical record revealed Resident #3 was admitted to facility on 1/8/2024 with diagnoses including Cerebral Infarction, Hemiplegia and Hemiparesis and Bipolar Disorder. Review of a quarterly MDS assessment dated [DATE], revealed Resident #3 scored a 00 on the BIMS assessment which indicated severe cognitive impairment. The resident had verbal behavioral symptoms directed towards others on 1-3 days of the 7 day look back period and had no pain. Review of the physician's orders for Resident #3 dated 4/24/2024, revealed .Divalproex Sodium [a mental health medication for mood] Oral Tablet Delayed Release 125 MG .by mouth three times a day for mood stabilizer .Quetiapine Fumarate [an antipsychotic medication] .Oral Tablet 50 MG .by mouth two times a day for behaviors . During an observation and interview on 6/17/2024 at 1:05 PM, in Resident #3's room, the resident was dressed in a wheelchair, and stated he didn't remember anyone hitting him or trying to hit him. When asked other questions about his care, he stated .I don't know I don't know anything . Review of a Psychotherapy Progress Note for Resident #3 dated 5/24/2024, revealed .Pt [patient or resident] denied feeling overly sad or anxious. Pt was alert, coherent but minimally engaged. No perceptual disturbances observed .Pt seems stable .he is satisfied with the care here .No recommendations at this time . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's investigation documentation for Resident #3 dated 6/13/2024, revealed a resident to resident altercation happened when Resident #3 was .trying to come into courtyard door to dining room . [Resident #12] .attempting to get out to courtyard .[Resident #3] didn't move to let the other resident out . [Resident #12] began yelling incoherently and open hand slapping .residents were separated and taken for assessment . The FNP, family and law enforcement were notified. Review of a Nurse's Progress Note for Resident #3 dated 6/13/2024, revealed .this resident involved in incident with another resident. family and physician notified .initial report submitted. Investigation initiated. Witness statements taken. Final investigative report will be submitted .within five days. Skin and emotional assessments initiated . Review of a Nurse's Progress Note for Resident #3 dated 6/13/2024, revealed .nurse performed skin assessment after resident involved in altercation with another resident. No bruising or impaired areas identified at this time . Review of facility documentation of Resident #3's witness statement dated 6/13/2024, revealed DON and Risk Manager interviewed resident about an altercation. Resident #3 nodded he was OK, when asked if it was a fight, Resident stated no, [expletive] The resident stated he wasn't hurt, he felt safe and he didn't hit first. He showed an open hand when asked how he was hit. Review of a Comprehensive Care Plan dated 6/14/2024, revealed .[Resident #3] have little or no awareness or boundaries related to other's personal space/preferences . with intervention of .Staff will redirect [Resident #3] when he is attempting to redirect other residents . Review of an FNP Progress Note for Resident #3 dated 6/14/2024, revealed .[Resident #3] was involved in an altercation with another resident [Resident #12] and nursing staff is requesting evaluation .He is wheelchair-bound. Yesterday [6/13/2024] another resident [Resident #12] was trying to exit a door into the Courtyard when he [Resident #3] tried to stop the resident .[Resident #12] slapped at him .Nursing staff report no injuries. Nursing staff intervened. He reports nothing happened yesterday and that he does not remember any incident . Review of a Pyschiatric (Psych) NP Progress Note for Resident #3 dated 6/14/2024, revealed .I am seeing the resident today as an initial visit for unspecified mood disorder. Staff request visit with resident after recent resident to resident altercation .He is able to answer some simple questions appropriately but does show some confusion with conversation. Staff reports that this resident [Resident #3] and another resident [Resident #12] were both attempting to go out of the door at the same time during scheduled smoke time . Resident reports that he feels safe and that staff treats him well. No known triggers to behaviors or modifying factors . Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Hypokalemia and Spinal Stenosis. Review of a quarterly MDS assessment dated [DATE], revealed Resident #12 scored a 4 on the BIMS assessment which indicated the resident had severe cognitive impairment, and the resident had no behaviors. The resident had no impairment to upper or lower extremities and ambulated with a wheelchair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a comprehensive care plan for Resident #12 revised 6/13/2024, revealed the resident had . Behavior Care Plan: Potential for impaired or inappropriate behaviors . refuses to discard chewing tobacco when asked .places used chewing tobacco in brief to be chewed later .[Resident #12] smacking at another resident [Resident #3] that was trying to prevent [Resident #12] from exiting the building to go into the courtyard . with intervention of .Intervene as necessary to protect the rights and safety of others .Divert attention. Remove from situation and take to alternative location as needed . Review of the facility's documentation for Resident #12 dated 6/13/2024, revealed a resident to resident altercation when Resident #3 was attempting to get out of dining room door into the courtyard and did not redirect to let another [Resident #3] in the door.[Resident #12] became agitated started yelling incoherently and open hand slapping the other resident [Resident #3] .residents were separated and taken to different areas. At the time of interview, he had no recollection of the event . Resident #12 was assessed and no injuries were noted . The FNP, family and law enforcement were notified. Review of a Nurse's Progress Note for Resident #12 dated 6/13/2024, revealed .skin and emotional assessments initiated . Review of Head to Toe Weekly skin check for Resident #12 dated 6/13/2024, revealed the resident had clear skin with no skin impairment. Review of a Psych NP Progress Note for Resident #12 dated 6/18/2024, revealed .Resident does not recall altercation .reports that he feels safe .at the facility . Review of facility's investigation and reporting documentation dated 6/13/2024, revealed .the allegation was reported to the resident representative .both resident's [residents'] family members were notified .[Resident #3] indicated that he recalled the incident .he was trying to come in from the courtyard when [Resident #12] hurried towards him .attempt to get outside .[Resident #12] started yelling .opened hand slapping [Resident #3], who started yelling .Summary of interviews .perpetrator, [Resident #12] fluctuates with cognition. Upon interview, he was unaware that anything had occurred .allegation is verified by evidence collected during the investigation .employees receive routine training on abuse prohibition policy .Submitted by .[Administrator] . Review of a police document showed report #24061317494 was investigated by an officer on 6/13/2024. Review of Tennessee Adult Protective Services submission report dated 6/13/2024 showed incident was reported at 3:13 PM. Review of facility documentation of the Dietary Director's witness statement dated 6/13/2024, revealed the Dietary Director walked out of the kitchen and saw Resident #12 trying to get into the courtyard through the door. She redirected the resident and left the room, but she heard yelling as soon as she turned the corner into the hall. She went back in and saw the 2 residents throwing punches. The residents were separated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of facility documentation of CNA D's witness statement dated 6/13/2024, revealed the CNA was in the dining room returning trays and witnessed Resident #12 fighting with Resident #3 in the courtyard doorway. The CNA rushed to separate the residents, and the Dietary Manager went to get the DON. During an interview on 6/17/2024 at 1:43 PM, the Dietary Director stated on the day of the resident to resident altercation, she had walked into the dining room and Resident #12 was trying to go out the door, and the Director told him to come back in so another resident could get in. She left the room and heard screaming. The Dietary Director came back into the dining room and saw the back of Resident #12 and arm motions only. She stated she saw CNA D was separating Residents #12 and #3. She stated she gave an eye witness account to the facility's management. During an interview on 6/17/2024 at 2:40 PM, CNA D stated she was bringing trays back to the dining room on 6/13/2024 after lunch when she noticed Residents #12 and #3 were having an altercation at the courtyard door of the dining room. The CNA stated she saw Resident #12 swing first and then closed fist punches were being thrown with hands, wrists and lower forearms getting hit. She did not know what was said to start the event. The CNA stated she pulled Resident #12 away from Resident #3, and the Dietary Manager went to get the DON. The CNA stated the event was resident to resident abuse. The CNA stated she took Resident #12 to his room. The CNA stated she noticed no new aggression or fear. During an interview on 6/17/2024 at 3:02 PM, Resident #27, who was cognitively intact, stated he witnessed the resident to resident altercation on 6/13/2024, and stated Resident #12 started the resident to resident altercation and was trying to go out the door to the courtyard in the dining room. He stated .[Resident #3] tried to stop [Resident #12] from going out the door, because he knew he shouldn't be out there .[Resident #12] started swinging and [Resident #3] had his hands up trying to protect himself . During a telephone interview on 6/17/2024 at 7:50 PM, Resident #3's representative stated she was informed of a resident to resident altercation involving her son (Resident #3) on 6/13/2024. The representative stated she was on her way to the facility when the staff called her to notify her of the incident, and she arrived not long after it happened. She stated when she arrived, Resident #3 didn't even remember the event and he did not show any signs of fear or distress. During an interview on 6/17/2024 at 10:09 AM, the DON stated she was made aware of the resident to resident altercation after it occurred at about 1:12 PM, and the residents had already been separated. The staff began interviewing residents that had witnessed the event. She stated staff and residents involved were interviewed, and nurses caring for the involved residents did skin checks on those residents. That was the beginning of the investigation. The staff did psychosocial assessments on residents who were interviewed to make sure they felt safe. The DON stated Psych and medical NPs, risk manager and families were made aware of the incident, and reports were made to State, APS, police and Ombudsman, which was standard for every resident to resident altercation. The DON was told there was physical contact. The DON confirmed that the incident on 6/13/2024 between Residents #3 and #12 was resident to resident abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/18/2024 at 11:00 AM, the FNP stated when there was an abuse allegation, she would assess the resident the next time she was in the building. The FNP stated the altercation between Residents #3 and #12 happened on 6/13/2024, and she assessed both residents the next day, and she did not note any physical or psychosocial harm or injury to either resident. During an interview on 6/18/2024 at 1:33 PM, the Administrator stated she was on a call at about 1:00 PM on 6/13/2024 and was made aware that a resident to resident altercation had taken place. The residents were separated immediately, and staff began skin and emotional assessments. The families of Residents #3 and #12 and the physician were notified, and no injuries or psychosocial harm were noted in either resident. She stated Resident #12 was the resident who struck out first based on witnesses. The Administrator confirmed it was resident to resident abuse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on review of facility policy, medical record review, review of the facility incident logs, review of facility fall investigations, emergency medical services (EMS), police records, police body camera (cam) footage, hospital records , observations, and interviews, the facility failed to provide supervision to prevent recurrent falls, review and revise the Care Plan, and implement fall interventions for 1 Resident (Resident #1) of 7 residents reviewed for falls. Resident #1, a severely cognitively impaired resident with a history of 6 falls since he admitted to the facility on [DATE], fell on [DATE] and staff were unaware he had fallen until they were notified by police officers who responded to a call for a welfare check. Resident #1 was unable to reach facility staff and called a friend to ask for help. The friend notified law enforcement after he called the facility 10-12 times with no answer. The facility failed to review and revise the Care Plan and implement an intervention following the fall on 2/17/2024. On 2/27/2024, 10 days later, Resident #1 fell again and sustained a hip fracture. The facility's failure placed Resident #1 in an Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more conditions of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to resident) when he fell on [DATE] and sustained a hip fracture. The Facility Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional [NAME] President were notified of the IJ on 4/2/2024 at 8:00 PM, in the conference room. The facility was cited Immediate Jeopardy at F-689 at a scope and severity of J which is substandard quality of care. The IJ began on 2/17/2024 and continued through 4/3/2024. The IJ ended on 4/4/2024 and was removed on site. An acceptable Removal Plan which removed the immediacy was provided by the facility 4/4/2024. Noncompliance continues at F-689 at a scope and severity of D. The corrective actions were validated on site by the surveyor on 4/5/2024 for F-689 . The facility is required to submit a Plan of Correction (POC). The findings include: Review of the facility's undated policy titled Fall Prevention Program, showed .When any resident experiences a fall, the facility will .assess the resident .complete an incident report .review the resident's care plan and update as indicated . Review of the facility policy titled, Falls, revised 11/8/2022, revealed .The intent of this requirement is to ensure the facility provides .supervision .to each resident to prevent avoidable accidents . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Medical record review showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Pain in Thoracic Spine, Difficulty Walking, Severe Malnutrition, Chronic Obstructive Pulmonary Disease, Dementia, with Behavioral Disturbances, Atrial Fibrillation, Long Term Use of Anticoagulants, and Acute and Chronic Respiratory Failure with Hypoxia. Review of the admission fall risk assessment dated [DATE] showed Resident #1 was considered at a high risk for falls. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #1 had a Brief Interview for Mental Status Score (BIMS) of 7 out of 15 which indicated Resident #1 had severe cognitive impairment. Resident #1 required substantial to maximum assistance of 1 or 2 staff members for all activities of daily living. Review of the facility incident logs dated 1/1/2024 to 3/27/2024, showed the facility documented Resident #1 fell on [DATE], 1/29/2024, 2/14/2024, 2/16/2024, and 2/27/224. Continued review showed a fall which occurred on 2/17/2024 had not been documented on the incident log. Review of the care plan for Resident #1 dated 1/22/2024, showed .Fall Prevention Care Plan .Resident has had actual falls including with injury .at risk for additional falls related to weakness, poor safety awareness and impaired cognition . Continued review of the care plan showed the facility implemented the interventions after falls as follows: 1/23/2024 (no injury noted) .Keep frequently used items in reach . 1/29/2024 (skin tear left elbow, reddened area to chin, treatment administered) .offer rest period between lunch and dinner as resident will accept . 2/15/2024 (no injury noted) .offer toileting before dinner as resident will accept . 2/16/2024 (dislodged indwelling urinary catheter, skin tear to right thumb/hand, skin tears to right shin, transferred to hospital) . fall mats at bedside . 2/17/2024 No documentation a fall occurred; no new fall interventions were implemented. 2/27/2024 Resident #1 had a fall sustaining a right hip fracture and was transported to the hospital. 3/5/2024 .Have resident in high traffic areas while up in wheelchair . Review of the nursing notes for 2/16/2024, showed .[Resident #1] observed in the floor of the hallway yelling for help .blood noted on ground from his RLL [right lower leg] and right hand .Resident laying with head against the door to his room and legs out in the hallway .catheter bag [indwelling urinary catheter] still attached to bed .Resident stated I fell and I don't know what happened .cleaned and bandaged skin tears . [indwelling urinary catheter] reattached to catheter bag called EMS to transport to ER [emergency room] for evaluation due to head injury on blood thinners [anticoagulants] . (continued on next page)

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	445382	A. Building B. Wing	04/05/2024

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the EMS records for Resident #1 dated 2/16/2024, showed .Injury to hand [primary] .falls . 2/16/2024 .dispatched to scene .on arrival received report from nurse .patient found on floor .concerned for head injury .patient on blood thinners .pulled out [indwelling urinary catheter] at some point today .but they [facility staff] reinserted one .pt [patient] found in bed on arrival .has skin tear to LT [left shin] .thumb . bleeding controlled .placed on cot via [by way of] draw sheet .transported [to the hospital emergency room] . Review of the hospital records dated 2/16/2024 showed Resident #1 was treated in the ER for skin tears to the thumb and shins. Resident #1 underwent neuroimaging [Computed tomography or CT Scan] which revealed no evidence of acute head injury or spinal injuries. Resident #1 was diagnosed with a severe Urinary Tract Infection (UTI) and fall related injuries. The indwelling urinary catheter was replaced in the emergency room . The resident returned to the nursing home with diagnoses of Fall from Standing, Multiple Skin Tears, a Complicated UTI with orders for antibiotics to treat the UTI, fall prevention instructions and wound care instructions. Review of the care plan revised 2/16/2024, showed Resident #1 had a new fall intervention for a floor fall mat at the bedside. Review of the Police Department Preliminary Investigative Report dated 2/17/2024, showed at 7:23 PM, a friend of Resident #1 called 911 and asked for a welfare check on Resident #1. The 911 caller stated Resident #1 had called him from the facility and informed the caller he had fallen to the floor, was on his back, and his calls for help [of the facility staff] had gone unanswered. Police officers arrived to the facility at 7:25 PM.Upon arrival officers made contact with [Resident #1] [at 7:30 PM] in room [Resident #1's room] in his bed .[Resident #1] stated he had not seen a nurse in over an hour and a half and that he did fall a while before officers got there .pushed his emergency button but no one came to help him .while officers were on the scene we did not see any nurses throughout the rehab .[Resident #1] was bleeding all over both of his arms, his legs, and possibly his back .There was blood in his bed, on the floor from his bed to the heating and air unit, all over the heating and air unit itself, across the floor to the doorway and on the wall and door . [Resident #1] requested an ambulance and wanted to go to the hospital .he was transported .by . [ambulance] to [hospital] .Just before the ambulance arrive to the rehab, a couple of nurses finally arrived and stated they did not know anything about [Resident #1] falling or bleeding everywhere. The nurses wanted to clean up [Resident #1's] wounds and the room before the ambulance arrived, and .[Officer #1 and Officer #2] .both told the nurses to leave things the way they were so paramedics could see the injuries . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of police body cam footage of the incident, time stamped and dated 2/17/2024, showed both police officers who responded to the 911 call activated body cams immediately upon entering the facility lobby at 7:30 PM (the police officers had knowledge of the key access code of the locked keyless entry pad to the front lobby doors). Body cam footage from both officers showed no staff members were visible anywhere in the facility as they walked to Resident #1's room from the front lobby and made initial contact with the resident at 7:30 PM. Resident #1 was observed in his bed which was at normal height (approximately between thigh and hip high and not lowered as documented in the nursing notes) when the police officers arrived. Resident #1 was observed on the camera stating to the officers he had fallen and wished to be taken to a hospital. EMS was summoned by radio by the police officers at 7:34 PM. Officer #1 left Resident #1's room at 7:35 PM, walked back to the lobby to await the ambulance and no facility staff were visible anywhere in the facility. Officer #1's footage showed she awaited the ambulance in the front lobby and was not approached by any staff members. At 7:50 PM (approximately 20 minutes after arrival to the facility) Registered Nurse (RN #1) made contact with Officer #1, and asked if she could help the officer, and the officer explained why she was there, and that Resident #1 had fallen and an ambulance had been called for the resident. Review of body cam footage from Police Officer #2, showed at 7:30 PM, Resident #1 informed the police officers he called his friend to request an ambulance after he had fallen and felt shaky and was itching. The footage showed at 7:32 PM, Resident #1 again informed the police officers he had fallen. Officer #2 remained with Resident #1 continuously throughout the incident [without staff knowledge]. Further review showed Resident #1 stated he had been in the floor and had not spoken to anyone [facility staff] since he fell . Resident #1 described to Officer #2 how he pulled himself from the floor onto his knees grabbing onto the AC unit adjacent to his bed. Officer #2's body cam footage showed the police officer inspected the entire room and observed dried blood on the HVAC (AC) unit, dried blood spatter noted on the fall mat beside the bed adjacent to the HVAC unit, dried blood smear on the door trim beside the door at the entrance to Resident #1's room, dried blood spatter on the back of Resident #1's room door, and dried blood spatter on the flooring between the doorway and Resident #1's bed. Officer #2's body cam footage showed Resident #1 had a large skin tear on the left elbow with bright red blood. Close up footage of Resident #1's skin injuries showed the skin tear on the left elbow had rolled up skin on the upper aspect of the wound. No dressing was visible on the left arm. Bright red blood was visible on the back of Resident #1's right elbow with another large skin tear. No dressing was visible on the wounds. Bright red blood was also noted on Resident #1's clothing near Resident #1's waist on the right side and was also visible on the resident's bedding. The officer questioned Resident #1 about the observation of blood on his pants and Resident #1 stated he had pain in his back and felt he had injured his back. Continued review of Officer #2's body cam footage showed as staff entered the room with Officer #1 (approximately 20 minutes after the police officers arrived at the facility), both officer's informed them Resident #1 had stated a fall, showed staff evidence of his injuries and the blood spatter throughout the room. Officer #1 was observed pointing out to staff members they were standing in dried blood on the floor. Staff stated to police they were unaware Resident #1 had fallen. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Officer #1's body cam footage showed at 7:54 PM staff members approached the officer in the hallway outside Resident #1's door and requested permission to clean [Resident #1] up before transport to the hospital. The officers advised staff an ambulance was in route and not to clean Resident #1's wounds, as EMT's needed to see the resident's injuries and the condition of the room as it was found by the police. Further review of Officer #2's body cam footage showed EMS personnel arrived at the resident's room at 7:55 PM and immediately greeted Resident #1 by his first name. EMS asked the resident if he wanted to go the hospital. Resident #1 stated he did and explained he had fallen and had been injured. Review of Nursing Notes dated 2/17/2024 at 10:04 PM, showed .[Resident #1] in bed in low position with blood noted to left elbow area, alert no complaints of pain, will send to emergency room for evaluation, family members aware . Review of the Police Department Preliminary Investigative Report for Resident #1 dated 2/17/2024, the detective notes revealed .On 2/18/2024, I [Detective] reviewed the officers body camera from this incident . [Officer #1] arrived and for the time the camera was on there was no nurses observed in the hallways . [Resident #1] was in the bed at normal height [and not in a low bed as indicated by the nurse's notes] in his room .[Resident #1] asked if she was the police and began telling her what happened .there was fresh blood on his shirt in the left elbow area, bed sheet, blanket and spatter on the AC .[Officer #1] asked how he [Resident #1] got back in bed and [Resident #1] stated he managed .later told officer that he [Resident #1] used the AC unit to get himself back up which is why it had blood on it .[Officer #1] asked if he [Resident #1] wanted an ambulance and he explicitly said yes .officer asked for his name and birthdate which he gave and spelled without issue .Officer .then went to the front door to await an ambulance .[Officer #1] waited at the front door approximately 15 minutes for the ambulance .went back toward the room and encountered two nurses in the hallway near [Resident #1's] room .One of the nurses asked if she could help her .She explained why she was there, which the nurses appeared to not be aware of .The nurses then entered the room and ask [Resident #1] what happened .one of the nurses said [Resident #1] fell yesterday also and had blood everywhere . Continued review showed .Another nurse returned and asked about going in the room and changing [Resident #1] .[Officer #1] told her not to, because an ambulance was enroute and they needed to see the state he was in . Review of the EMS documents dated 2/17/2024, showed .dispatched to pt [patient] [Resident #1] evaluation request by PD [police department] at [facility] .Upon arrival were led by law enforcement .pt was alert and oriented .stated he had fallen while trying to get to the bathroom .stated he had fallen approximately 1.5 hours ago and was eventually able to get himself back in bed .stated he wanted to go to the hospital .findings of an approximately 6 cm [centimeter] skin tear on left elbow and a 4 cm skin tear on right elbow. Review of the hospital emergency room records dated 2/17/2024, showed Resident #1 underwent laboratory studies, neuroimaging studies and treatment for additional skin tears at the hospital. Review of the triage notes showed, .This RN [Registered Nurse] spoke to the patient family friend [the 911 caller] .[911 caller] stated he called the nursing home approximately 10 to 15 times and ' .never got a response' .states when he could not get ahold of anyone he called the sheriffs office to do a welfare check .Wound care completed on patient's bilateral elbow skin tears and an upper back skin tear . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital ER physician notes dated 2/17/2024, showed the physician had documented, . reportedly called family members and stated he had fallen .family .called police .police went to the facility . police then called EMS .patient [Resident #1] was seen here earlier this morning [late night of 2/16/2024 into early morning of 2/17/2024] and had a fall, was discharged to the facility on antibiotics .patient without acute traumatic findings on imaging .noted to have pulmonary infiltrate [Pneumonia] .spoke with patient's facility . they were strongly advised to closely monitor patient over the next few days given his increased fall risk .will discharge Fall prevention literature was included in discharge orders sent back to the facility. Review of the witness statement for RN #1 dated 2/17/2024, showed .Saw police officer outside door [Resident #1's room doorway] .stated he [Resident #1] had fallen and crawled to the door and been there for hours .Stated Resident called family and told them, family called police .[Resident #1] .lying in bed, noted blood to the left arm area .noted blood on air conditioner, minimal amount there and also on mat to the left side of the bed .noted small dried drops at the doorway and about a foot into hall .officer stated you are standing in the blood .From prior night fall [2/16/2024] reported to me by nurses that had him [provided care on the night of 2/16/2024] he had a dressing on left upper (arm) .and steri-strips to right thumb .rt [right] chin had steri strips applied .reported he had crawled to door that night .Nurse stated when he was in emergency room he stated he fell down some stairs . Review of Resident #1's medical record and care plan showed no new intervention had been implemented for the fall or after the resident returned from the hospital on 2/17/2024. Review of the facility document titled, Final Investigation, dated 2/21/2024, signed by the former Administrator showed .Background of the event .911 call placed by friend of [Resident #1] 2/17 [2/17/2024] approximately 7:30 PM .Resident told friend he had fallen and needed help and could not reach anyone [staff at the facility] .Injuries .No known injuries from this alleged event .this resident .with a history of falls and did have previous fall on 2/16/2024 .resulting in trip to the ER [emergency room] due to fall being unwitnessed . he did have skin injuries to the RLL [right lower limb] and right hand with skin tears to right elbow .Initial Report Summary .Facility nurse notified the Director of Nurses on 2/17 at approximately 8:00 PM that a 911 call had been made by the resident's friend alleging that he [Resident #1] had fallen and could not get help [from the facility staff] .They [Resident #1's family/friend] were concerned . Investigative Activity .Staff on that unit were interviewed regarding the alleged incident .It was determined the resident was in bed at the time of arrival of the EMS/police .There was no indication that he had fallen in that immediate time frame .they [the facility staff] had been in and out of the room throughout this shift to include delivery of meals .Investigative Activity: .Staff interviews made and statements gathered indicate no indication of a fall on this date [2/17/2024] . Based on record review and witness statements there was no fall on this date [2/17/2024] .The residents conversation with friend was most likely describing events of his previous fall [2/16/2024] .It is highly likely due to his unclear speech and dementia with a BIMs of 07 [severe cognitive impairment on scale of 7 out of 15] that the time frames and occurrences were not accurate .Conclusion .The facility camera system recorded events of that .time frame were conducted with [former DON] .[local detective] .and [TBI] [Tennessee Bureau of Investigations] [special agent] .that revealed there was no indication that the resident had fallen .The tape confirmed events surrounding care to include delivery of the evening meal .Based on the above mentioned information I [former Administrator] cannot substantiate that there was a fall, no wrong doing on behalf of the staff .on date of this alleged occurrence [2/17/2024] . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility ATTESTATION document dated 2/21/2024, signed by the former DON showed .Please accept this document as my attestation and is being submitted as evidentiary material related to the investigation being conducted for [Resident #1] related to 911 call on 2/17/2024 .This event was reported to me on 2/17/2024 via [by way of] telephone call at 7:55 PM by [Registered Nurse, RN #1] .[RN #1] notified me that there were officers here that said they had been called to check on [Resident #1] because he had told his friend that he was in the floor and didn't have help .Resident was in the bed resting when officers responded .I [former DON] asked [RN #1] when the last time he [Resident #1] was seen by staff and she [RN #1] stated he was seen when staff were picking up trays after the dinner time meal and he was resting in bed .and there was no concerns at that time .[RN #1] stated . to me [former DON] that she was told by police that they were waiting on EMS to take the resident to the ER to get checked out .Police told [RN #1] not to touch [Resident #1] that they wanted to send him [to the hospital] how he was .[RN #1] let me know that EMS had come and were picking him up within minutes of notifying me that the police had arrived .Continued review of the attestation document revealed .On 2/20/2023 TBI agent and local detective came to the facility in regard to the 2/17 [2/17/2024] 911 call .They asked me [former DON] what I knew about the event .I stated the above account and stated I had the statements in a folder in my desk .They asked for copies of the statements .Detective asked about cameras in the hallway outside [Resident #1's room] .I let her [Local Detective] know they [the camera footage] go back 3 days roughly 72 hours .we go review the footage from that time period police responded .SSD [Social Services Director] able to pull up camera footage from the area and time frame requested .when reviewing footage .it is seen that [Certified Nursing Assistant] [CNA #2] went to [Resident #1] room and picked up the dinner tray .[Resident #1] was never seen in the hallway or the doorway of his room from the time trays were given out at dinner to the time police responded .TBI agent and detective seemed to have no concerns . Review of the facility incident logs dated 1/1/2024 to 3/27/2024 showed the incident of 2/17/2024 had not been documented. Review of the nursing notes showed on 2/27/2024, Resident #1 had a witnessed fall from his wheelchair while seated in the hallway near the nursing station. Resident #1 complained of right hip pain and staff summoned EMS to the facility. Resident #1 was transferred back to the hospital by EMS for the third time in 10 days related to falls . Review of the EMS records dated 2/27/2024, showed EMS was dispatched to the facility due to a reported fall. On arrival they found Resident #1 in the hallway floor surrounded by staff. Resident #1 complained of right hip pain rated as 10/10. Resident #1 was examined by EMTs and transported to the hospital by ambulance. Review of the hospital records dated 2/27/2024, showed in the emergency room Resident #1 underwent Computer Assisted Tomography (CAT SCAN) which showed .on the right is an acute appearing intertrochanteric fracture with varus angulation and surrounding soft tissue swelling [a displaced fracture of the upper femur, hip fracture] . Resident #1 was admitted to the hospital and underwent surgical repair of his fractured hip on 2/29/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 3/27/2024 at 6:05 PM, showed Resident #1 lying in his bed at a regular height (between thigh and waist high). A single fall mat was on the left side of the bed between the bed and air conditioning unit. Resident #1 was confused but recalled falling several times at the facility. Resident #1 recalled one incident where he crawled to the doorway and was bleeding, and stated he had fallen into the wall and an ambulance came and transported him to the hospital. The resident stated one time he called his friend (the 911 caller) and showed the surveyor the cellular phone he used .I used this to call .because nobody [facility staff] comes . when you call for assistance. Resident #1 stated, .now I have fallen again, I broke my hip, I can't walk anymore, it's hopeless for me now . During an interview on 3/28/2024, the Interim Director of Nursing (DON) stated he became aware on 3/28/2024, the state and local law enforcement agents and Adult Protective Service Investigators had visited the facility and investigated the incident of 2/17/2024 for Resident #1. The DON reported he had reviewed facility files related to the matter with emails dated 2/21/2024 on the morning of 3/28/2024, and that was when he became aware the police had concerns about the incident. The DON reported the former DON and former Administrator had investigated the incident and determined there was no evidence Resident #1 fell on [DATE]. The Interim DON stated the incident occurred before his, the newly hired Assistant DON's, and the Interim Administrator's start of employment at the facility and they had not been informed of the allegations or specific facility findings related to the incident until the State Survey Agency had begun it's investigation on 3/27/2024. During a telephone interview on 4/1/2024 at 1:00 PM, the 911 caller of 2/17/2024, stated he was a friend of Resident #1 who along with his father had assumed surrogacy roles for Resident #1 because Resident #1 had no children of his own, or relatives in the United States. The 911 caller stated Resident #1 called him on the evening of 2/17/2024 (didn't recall exact time) but knew it was in the late afternoon or early evening hours and reported he had fallen from his bed, was on his back, had called out for help repeatedly and the facility staff had not responded to his calls for help. The 911 caller stated Resident #1 informed him he had been in the floor .over an hour . The 911 caller stated he then immediately attempted to call the facility on the main line, then called both wings in attempts to reach staff, between 10 and 12 times, and each time he called, the phone rang but went unanswered. At that point, he dialed 911 and requested police go to the facility for a welfare check on Resident #1 and the facility. During an interview on 4/1/2024 at 1:15 PM, Certified Nurse Aide (CNA) #3 stated on the night of the incident (2/17/2024), a majority of the patients on the wing were situated on the far end of the unit away from Resident #1's room and staff were on that end of the unit most of the shift. CNA #3 stated around the time of the incident, all 3 staff stationed on the unit were engaged with a family member of another resident. CNA #3 stated CNA #2 had collected Resident #1's meal tray around 6:15 to 6:30 PM that night and at that time the resident was in bed. CNA #2 confirmed she was not aware of the police officer on the unit until around 8:05 PM. (Police Officers entered Resident #1's room at 7:30 PM and left the unit with EMS at 8:03 PM per the body cam footage). CNA #3 stated she had not entered the resident's room during the incident or encountered Officer #2. CNA #3 stated after the incident she cleaned the resident's room and noted blood on the AC unit and floor mat beside the bed. CNA #3 described blood spatter on the AC [air conditioner] vent as appearing like a feather had painted it on the vents. CNA #3 confirmed staff were not aware police officer had entered the building or of Resident #1's fall until they were notified by the police officers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/1/2024 at 2:10 PM, CNA #2 stated she had seen Resident #1 in his bed around 6:15 to 6:30 PM when she picked up his dinner tray. CNA #2 stated she lowered Resident #1's bed to the lowest setting (indicating lowered to the floor) after removing his tray as she was aware of his fall on 2/16/2024 (this is conflicting as to what was reflected on the police camera footage and police investigative report which stated the bed was at a regular height at approximately thigh to waist high). CNA #2 stated at that time Resident #1 was awake, in bed, and had an intact dressing on his left elbow (the police officer body camera footage showed no dressing or bandage on the resident's left elbow). CNA #2 confirmed she was unaware police had entered the unit until she went to answer a call light in a resident room next door to Resident #1 sometime between 7:00 and 7:30 PM (couldn't recall exact time). CNA #2 confirmed the nurse on duty was also not aware the police officers had entered the facility. CNA #2 stated she had not been in the resident's room or observed the resident after approximately 6:30 PM that evening and was not aware Resident #1 had fallen until the staff had been notified by the police officers. During an interview on 4/1/2024 at 2:45 PM, RN #1 stated she was the nurse on duty at the time of the incident on 2/17/2024. RN #1 corroborated CNA #2 and #3's account of issues with a family member on the far end of the unit at the time the incident with Resident #1 had arisen. RN #1 stated only 2 residents were situated on the rear hallway (Resident #1 and his neighbor in the next room) the rest of the unit's residents were on the front hall. RN #1 was unable to recall the census on the unit on 2/17/2024 but knew it was at least 20 residents. RN #1 stated she had not heard the unit telephone ring that evening but added the only phone was located at the nursing station and could not be heard from the hallways or clinical spaces. RN #1 stated she observed police officers sometime between 6:30 and 7:00 PM but could not recall the exact time (Police entered the unit at 7:30 PM). RN #1 stated after she became aware the police officers had found Resident #1, she immediately telephoned the former Director of Nursing (DON) and informed her of the nature of the situation while police were still on the premises. RN #1 stated she informed the DON that Resident #1 had fallen again and appeared to be injured. RN #1 stated she was aware CNA #2 had last seen the resident around 6:15 PM to 6:30 PM (approximately 1 - 1 hour and 15 minutes before the fall) that evening and the resident had been in bed. RN #1 stated she believed Resident #1 had fallen, and confirmed the fall went undetected by the facility staff until the police arrived. During an interview on 4/1/2024 at 3:50 PM, the Interim DON confirmed the facility Resident #1 had suffered a fall with related injuries on 2/16/2024 and 2/17/2024. The DON confirmed the facility failed to review, revise, and update the care plan to implement interventions in response to Resident #1's fall on 2/17/2024 and the resident had received a serious injury (fractured hip) from the fall on 2/27/2024. The DON confirmed the facility failed to protect Resident #1 from a serious injury related to falls. The DON further confirmed the facility investigation performed on 2/21/2024 by the former [NAME] and former Administrator appeared incomplete and the facility incident log did not include the unwitnessed fall. During an observation and interview on 4/1/2024 at 5:45 PM, showed Resident #1 was on 1 to 1 staff supervision. The DON stated new interventions and enhanced supervision of Resident #1 had been implemented on 3/28/2024, after the corporate office had reviewed the incident which had occurred on 2/17/2024 and due to signs of agitation and increased confusion, Resident #1's room had been moved closer to the nursing station, the bed was lowered to its maximum low setting, a scoop mattress (specialty mattress with raised borders) was added and bilateral fall mats were noted beside the bed. The interventions were implemented 1 month after the fall on 2/27/2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Refer to F-657 and F-725. Allegation of Compliance (AOC) Removal Plan for F-689 The facility's corrective actions for the removal plan were issued to

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on facility policy review, medical record review, incident logs, review of census and staffing data review, time punch reports review, police reports and police officer body camera (cam) video footage review, and interviews, the facility failed to maintain sufficient nurse staffing levels on 1 of 2 units on the night of 2/17/2024. The facility's failure to maintain sufficient nurse staffing levels to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of residents on 1 of units (The Mountain Unit) on 2/17/2024 of 60 days reviewed which resulted in facility staff not detecting a fall for Resident #1 for an unspecified amount of time. The facility's failure to maintain safe staffing levels placed Resident #1 in an Immediate Jeopardy (IJ) situation, (A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to result in serious injury, harm, impairment, or death to a resident, and must be immediately corrected). The facility's failure to maintain safe staffing levels had the potential to impact all 78 residents of the facility. The Facility Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Regional [NAME] President were notified of the IJ on 4/2/2024 at 8:00 PM, in the conference room. The facility was cited Immediate Jeopardy at F-725 at a scope and severity of J. The IJ began on 2/17/2024 and continued through 4/3/2024. The IJ ended on 4/4/2024 and was removed on site. An acceptable Removal Plan which removed the immediacy was provided by the facility on 4/4/2024 for F-725. The corrective actions were validated on site by the surveyor on 4/5/2024 for F-725. The facility is required to submit a Plan of Correction (POC). The findings include: Review of the facility's undated policy titled, Nursing Services and Sufficient Staff, showed .It is the policy of this facility to provide sufficient staff to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident .The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis .Licensed Nurses .Other nursing personnel including .nurse aides .Providing care includes .responding to resident needs . Review of the medical record showed Resident #1 was admitted to the facility on [DATE], with diagnoses including Pain in Thoracic Spine, Difficulty Walking, Severe Malnutrition, Chronic Obstructive Pulmonary Disease, Dementia, with Other Behavioral Disturbances, Atrial Fibrillation, Long Term Use of Anticoagulants, and Acute and Chronic Respiratory Failure with Hypoxia. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #1 had a Brief Interview for Mental Status Score (BIMS) of 7 out of 15 which indicated Resident #1 had severe cognitive impairment. Resident #1 required substantial to maximum assistance of 1 or 2 staff members for all activities of daily living. Review of the facility nursing notes dated 2/16/2024, showed Resident #1 had been transported to a local hospital due to a fall with related injuries. Review of the care plan showed Resident #1 had a fall on 2/16/2024 and a new intervention of a fall mat to the bedside was implemented. Review of facility documentation dated 2/17/2024, showed the facility census on the unit in which Resident #1 resided was 27 with staffing of 1 Registered Nurse and 2 Certified Nurse Aides. Continued review showed the entire facility census was 75 with a total staffing pattern of 2 nurses and 5 Certified Nurse Aides. Review of the staffing data and resident census for Resident #1's unit (The Mountain Unit) dated 2/17/2024, showed on the night of the incident (2/17/2024), the unit was originally scheduled to have been staffed with 2 Licensed Practical Nurses (LPNs) and 2 Certified Nurse Aides (CNAs) for 27 residents. Review of the time punch reports for the Mountain Unit, dated 2/17/2024, showed an agency LPN had not reported for duty as scheduled. The unit was staffed with 1 Registered Nurse (RN #1) and 2 CNAs (CNAs #2 and #3) for 27 residents. The open position from the agency nurse went unfilled. Review of the Police Department Preliminary Investigative Report (police report) dated 2/17/2024 at 7:23 PM, showed a friend of Resident #1 called 911 and asked for a welfare check on Resident #1. The 911 caller stated Resident #1 had called him from the facility and stated he had fallen to the floor, was on his back, and his calls for help had not been answered by the staff. The 911 caller informed 911 he had repeatedly attempted to call the facility (10-15 times), but the phone went unanswered. Police arrived to the facility at 7:25 PM. Continued review of the police report showed, .Upon arrival officers made contact with [Resident #1] in room [Resident #1's room] in his bed .[Resident #1] stated he had not seen a nurse in over an hour and a half and that he did fall a while before officers got there .pushed his emergency button but no one came to help him .while officers were on the scene we did not see any nurses throughout the rehab . Resident #1 was bleeding all over both of his arms, his legs, and possibly his back. There was blood in the resident's bed, on the floor from his bed to the heating and air unit (AC unit), all over the heating and air unit itself, across the floor to the doorway and on the wall and the resident's room door. Resident #1 was transported by an ambulance to the hospital. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of police body cam footage of the incident, time stamped and dated 2/17/2024, showed both police officers who responded to the 911 call activated their body cameras immediately upon entering the facility lobby at 7:30 PM (Police Officer had knowledge of the pass code for the digital keyless entry for the front door of the facility) Body Cam footage from both officers showed no staff members were visible anywhere in the facility as they walked to Resident #1's room from the front lobby and made initial contact with the resident at 7:30 PM in his room. Resident #1 was observed in his bed which was at normal height (approximately between thigh and hip high) (not lowered as documented in the nursing notes) when officers arrived. EMS was summoned by police radio at 7:34 PM. Officer #1 left Resident #1's room at 7:35 PM, walked back to the lobby to await the ambulance and at no time were facility staff visible anywhere in the facility. 15 minutes later, at 7:50 PM (approximately 20 minutes after arrival to the facility), Registered Nurse (RN) #1 approached Officer #1, asked if she could help the officer, and the officer explained why she was there, and that Resident #1 had fallen. Continued review of body cam footage from Officer #2, showed at 7:30 PM, Resident #1 informed the police he had called his friend for help after he had fallen and felt shaky and was itching. The body cam footage showed Resident #1 stated he had fallen and . need to get out of here . Further review showed Resident #1 expressed he had fallen to Officer #2 again at 7:35 PM and stated he had been in the floor and had not spoken to anyone [facility staff] since he fell . Resident #1 then described to Officer #2 how he pulled himself from the floor onto his knees grabbing onto the AC unit adjacent to his bed. Officer #2's body cam footage showed Resident #1 had a large skin tear on the left elbow with bright red blood and a skin tear on the left elbow. Bright red blood was visible on the back of Resident #1's right elbow with another substantial skin tear. Continued review of Officer #2's body cam footage showed as staff entered the room with Officer #1, both officer's informed them Resident #1 reported a fall, showed staff evidence of his injuries and the blood spatter throughout the room. In the background of the police body cam footage, staff stated to police they were unaware Resident #1 had fallen. Staff were also heard to tell officers .there are only 3 of us [facility staff] here . Review of Officer #1's body cam footage showed at 7:54 PM staff members approached the officer in the hallway outside Resident #1's door and requested permission to clean up [Resident #1's] wounds and the room before transport to the hospital. The officer advised staff an ambulance was enroute and not to clean Resident #1, as EMT's needed to see the resident's injuries and the room as found by the police officers. Further review of Officer #2's body cam footage showed EMS personnel arrived at the room at 7:55 PM and transported the resident to the hospital. Review of the Police Department Preliminary Investigative Report showed the detective notes dated 2/18/2024, revealed . On 2/18/2024, I [local detective] reviewed the officers body camera from this incident . [Officer #1] arrived and for the time the camera was on there was no nurses observed in the hallways . [Resident #1] was in the bed at normal height in his room .officer asked for his [Resident #1's] name and birthdate which he gave and spelled without issue .[Officer #1] .then went to the front door to await an ambulance .[Officer #1] waited at the front door approximately 15 minutes for the ambulance which still had not arrived .went back toward the room and encountered two nurses in the hallway near [Resident #1's] room .One of the nurses asked if she could help her .She explained why she was there, which the nurses appeared to not be aware of .The nurses then entered the room and ask [Resident #1] what happened .In the background one of the nurses said [Resident #1] fell yesterday also and had blood everywhere . Continued review showed, .Another nurse returned and asked about going in the room and changing [Resident #1] .[Officer #1] told her not to, because an ambulance was enroute and they needed to see the state he was in . (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the detective notes on the Preliminary Investigation Report showed an entry dated 2/22/2024, which read, .Agent .and I went to [the facility] on 2/20/2024, and met with Administrator [the former Administrator] .She stated she was aware of an incident, but did not know all the details .then went to get the Director of Nursing [the former DON] .[former DON] .stated written statements were collected from the three nurses who were working [on the evening of 2/17/2024] .The statements indicated the nurses were on that floor and no officer ever came and sought them out .Also that they offered to treat [Resident #1] but the officer would not allow them to .I [local detective] asked about video since there is a camera just outside his [Resident #1] door .Originally I was told it only holds 3 days and the time was up .Later, I learned that it was still on the system .We watched the video which showed a nurse picking up his [Resident #1] tray at approximately 6:15 PM and there was not another nurse went into the room or was even in that hallway prior to the officers arrival at approximately 7:25 PM [approximately 1 hour and 10 minutes later] .This investigation remains ongoing . During an interview on 3/28/204 at 3:15 PM, the facility scheduler, Certified Nurse Aide (CNA) #1 stated the facility used agency staff frequently to fill open shifts. CNA #1 stated in her estimation, around 30 to 40 percent of the facility shifts were filled by contracted agency employees from 2 online staffing services. CNA #1 stated it was not uncommon for employees of the online agencies to accept shift assignments made a week in advance, then cancel their shift with little or no advance notice on the day they were to report for duty. CNA #1 stated she frequently utilized the facility's own employees to cover shifts when agency personnel gave no notice (no call no show) and failed to report to work as scheduled. CNA #1 stated the facility had filed complaints with both online nursing agencies related to this problem repeatedly, but it had little or no recourse other than placing agency employees who failed to come to work as scheduled on do not return list. CNA #1 stated the facility's normal staffing pattern was for 2 nurses and at least 2 CNAs on every unit on night shifts, and 2 nurses and at least 4 CNAs on day shifts. CNA #1 confirmed on the night of 2/17/2024, an agency nurse, had not reported for duty as scheduled with no advance notice. CNA #1 stated she attempted to fill the vacancy with both agency and facility personnel but was unsuccessful. CNA #1 stated on the evening of 2/17/2024, she informed the former DON, The Mountain Unit was staffed with only 1 nurse and 2 CNAs (didn't recall the exact time) and was short staffed, but the DON could not fill the vacancy either. CNA #1 stated no member of the former nursing leadership team came in to work to fill the vacancy when the DON failed to procure a replacement nurse. CNA #1 confirmed the facility had multiple nursing leadership personnel who could have come into work to fill the open slot in the schedule which included the DON, Assistant DON, an MDS Nurse, or the Infection Control Nurse. The scheduler confirmed on the night of 2/17/2024, The Mountain Unit was understaffed. During an interview on 3/28/2024 at 5:56 PM, CNA #4 stated it was not uncommon for agency staff to fail to report for duty as scheduled or to report for duty late. CNA #4 stated she had worked overtime to cover unplanned absences around twice per pay period due to being understaffed. CNA #4 stated the staff absences and understaffing had been reported to administration. During an interview on 3/28/2024 at 6:00 PM, LPN #2 stated she occasionally worked overtime to cover unplanned contract staff absences. LPN #2 stated when agency personnel failed to report for duty the units were understaffed. LPN #2 stated the staff absences and the understaffing had been reported to administration, repeatedly. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/28/2024 at 6:02 PM, CNA #7 stated she had complained several times to the former facility leadership including the former DON and the former Administrator about the issue with reliability of contracted employees and impacts on scheduling and the low staffing levels with the difficulty in providing timely care to all the residents when the facility went understaffed. During an interview on 4/1/2024 at 1:00 PM, the 911 caller reported he was a friend of Resident #1. The 911 caller stated Resident #1 had telephoned him that evening (2/17/2024) (didn't recall exact time) and told him he had fallen, was in the floor and his cries for help went unanswered by staff. The 911 caller stated he attempted to call the facility's main line, and both unit phone numbers at the facility 10 to 15 times over several minutes, in efforts to reach staff and the calls went unanswered. The 911 caller stated after that, he became more concerned for Resident #1 and the facility after Resident #1 failed to answer his phone on return call. The 911 caller immediately dialed 911 and asked for a welfare check on the resident. The 911 caller stated he visited Resident #1 occasionally but never attempted visits after 5:30 PM as the lobby was usually unattended, the front door was locked and staff frequently did not answer the door or the phone, and no staff were ever near the lobby to open the front door, which was kept locked by a digital keypad-controlled lock and the caller did not have knowledge of the pass code to enter the facility. The 911 caller stated he had stopped visiting in the evenings for that reason. The 911 caller stated he felt the facility was always understaffed and was concerned about the situation. During an interview on 4/1/2024 at 1:15 PM, CNA #3 (who was on duty on the night of the incident on The Mountain Unit) stated the unit was understaffed on the night of 2/17/2024. CNA #3 stated she recalled the incident and described the entire shift as apocalyptic due to issues on the unit further compounded by the short staffing. CNA #3 stated most of the Residents on the unit were situated near the front of the unit, while Resident #1 was located near the rear of the unit with only one other resident. CNA #3 stated she had left the unit for around 10 to 15 minutes sometime between 6:45 and 7:00 PM that evening to get fast food for another Resident after a family member had made the demand. During that time, only the nurse (RN #1) and 1 CNA (CNA #2) staffed the unit. CNA #3 stated she was aware her co-worker CNA #2, had collected Resident #1's dinner tray around 6:15 to 6:30 PM and the resident had been in bed at that time. CNA #3 estimated there were around 30 residents on the unit on 2/17/2024. CNA #3 stated she was unaware police had entered the facility due to she and CNA #2 being engaged with other residents, most of whom required 2 persons assistance and who resided on the other end of the unit. CNA #3 stated due to an agency nurse absence, both CNAs were responsible for between 15 to 17 residents each and there was only 1 nurse on the unit that night. CNA #3 stated the unscheduled absences and agency personnel not reporting to work as scheduled was a common occurrence. CNA #3 confirmed she was not aware of the exact time police arrived to the unit on 2/17/2024, and estimated it to be around 8:05 PM. CNA #3 stated she believed the understaffing contributed to staff's failure to notice police officers when they arrived or to detect Resident #1's fall. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/1/2024 at 2:15 PM, CNA #2 stated on 2/17/2024 she last saw Resident #1 between 6:15 and 6:30 PM when she picked up his dinner tray. CNA #2 stated she lowered Resident #1's bed to low setting at that time (this is inconsistent to police body cam footage and police investigative notes which indicated Resident #1's bed was at a normal height) (approximately between thigh and hip high). CNA#2 stated Resident #2 had a bandage on his left elbow when she last saw him. (This was inconsistent with body camera footage observed by the State Agency (SA) which showed no evidence of dressings on Resident #1's left elbow when police entered the room on the night of 2/17/2024). CNA #2 stated on the night of the incident there were around 30 residents on the unit, then stated many were sick and required 2 staff assistance. CNA #2 stated the staffing pattern on 2/17/2024 of only 1 nurse and 2 CNAs made it difficult for CNAs to complete all assigned duties or monitor the entire unit. CNA #2 stated it was common for scheduled agency personnel to not report for duty and give no notice of their pending absence. CNA #2 stated she and other facility CNAs had repeatedly complained to the scheduler, the former DON, and the former Administrator of their concerns with agency personnel and understaffing when agency personnel failed to report for duty. CNA #2 stated facility employees volunteered for overtime to fill uncovered staff absences but could not meet every need. CNA #2 stated on 2/17/2024 she had not checked on Resident #1 again after picking up his dinner tray around 6:15-6:30 PM on the night of the occurrence. CNA #2 then explained she and the other CNA were providing care to others on the front section of the unit and were unaware Resident #1 had fallen. CNA #2 stated she had not seen the police officers arrive to the unit but noted their presence sometime between 7:00 and 7:30 PM (the police officers arrived to the facility at 7:30 PM and went unnoticed by staff for 20 minutes). CNA #2 confirmed CNA #3 had left the unit around 6:00 PM, to obtain food in efforts to calm another resident's family member, and stated CNA #3 was gone around 20 minutes, which left only her and the nurse on the unit. During an interview on 4/1/2024 at 2:45 PM, RN #1 stated on 2/17/2024 at the time of the incident with Resident #1, she was on the front wing of the unit administering tube feedings and medications to a resident and did not see police enter the facility. RN #1 stated the majority of residents on the Mountain Unit were situated on the front wing of the unit. RN #1 stated Resident #1 and one other resident remained on the rear wing of the unit, confirmed she was the only nurse on duty, and estimated she was assigned .at least 20 . residents. RN #1 corroborated CNA #2 and CNA #3's accounts of an angry family member monopolizing staff attention and CNA #3 had left the unit for around .10 to 15 minutes . to acquire chicken nuggets from a nearby fast-food restaurant in attempts to appease a resident's family member, which left only RN #1 and CNA #2 on the unit. RN #1 stated she estimated she first saw the police officers enter the unit around 7:30 PM as she rounded the nursing station that night on the way to Resident #1's room. (Body cam footage showed this occurred at 7:50 PM, approximately 20 minutes after police arrival to the facility) and asked the Officer if she could help her. Continued interview revealed RN #1 confirmed she did not hear the unit telephone ring that night and reported the phones could not be heard from the hallway and no mobile handsets were in use at the facility. RN #1 stated she had expressed concerns about that to the former DON and Administrator several times before 2/17/2024, to no avail. RN #1 stated problems with agency staffing at the facility were problematic due to frequent no call no shows. RN #1 stated when agency staff failed to report as scheduled the unit was understaffed. RN #1 confirmed on 2/17/2024 an agency nurse failed to report for duty as scheduled. RN #1 stated she had expressed concerns related to understaffing and the reliability of contracted employees to the former Administrator and DON several times before the 2/17/2024 incident and felt the understaffing may have attributed to the staff being unaware of Resident #1's fall. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/1/2024 at 3:50 PM, the DON stated the facility's leadership team in place on 2/17/2024 were no longer employed at the facility. The DON stated this included the former Administrator, DON, Assistant Director of Nursing (ADON), MDS Nurse, and Infection Control Nurse. The DON stated after additional quality assurance reviews of Resident #1's incident on 2/17/2024 were completed by the current leadership team on 3/28/2024 (1 day after the State Agency entered the facility and 40 days after the incident), the facility had reviewed the staffing models and data and had put measures in place to aid the staffing issues. The DON confirmed on 2/17/2024 the Mountain Unit was understaffed but was unable to verify if she felt it attributed to Resident #1's fall. Refer to F-657 and F-689. Allegation of Compliance (AOC) Removal Plan for F725 The facility's corrective actions for the removal plan were issued to the surveyor on 4/3/2024. The corrective action plan included the following: 1. The Chief Regulatory and Compliance Officer provided training to the Administrator, DON, and ADON about their responsibility to ensure sufficient staffing at all times to assure resident safety. 2. The facility leadership and members of the Governing Body reviewed the facility's recruitment and retention program. 3. On 4/2/2024, the Administrator, DON, ADON, members of the Governing Body and Corporate Staff reviewed the allegations (2/17/2024 incident with Resident #1), discussed immediate actions and removal plan. 4. Policies and procedures were reviewed by the DON, ADON, Administrator, VP of Clinical Service and VP of Regulator Compliance. No changes were made to the current policies and procedures. 5. To ensure compliance with staffing requirements the DON, ADON, Administrator, and staff Scheduler will review daily staffing to ensure sufficient staffing at all times. a. When there are nurse or Certified Nursing Assistant (CNA) call ins, facility employees are asked to work with incentives offered and/or request for agency staff. 6. Members of the Governing Body and Corporate team will conduct daily calls, Monday-Friday to review staffing and determine if recruitment efforts are effective. The Removal Plan was validated onsite by the surveyor on 4/4/2024-4/5/2024 and included the following: 1. Surveyor validated through interviews with the facility's administrative and corporate staff they were knowledgeable about their responsibility to ensure sufficient staffing was maintained at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445382	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Mountain Post-Acute and Rehabilitation Cente	415 Cole Drive Pigeon Forge, TN 37863

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. The Administrative staff including the Administrator, DON, ADON, and staff scheduler were interviewed and stated daily meetings were being conducted and the staff scheduled were reviewed to ensure sufficient staffing. The interviewed staff stated when there were call ins by nursing staff including CNA's, other facility staff were asked to work and were offered incentives, in addition staffing agencies were called and were requested to assist. As a last resort if and if needed the DON, ADON, Wound Nurse, MDS nurse would assist with covering shifts to ensure safe staffing coverage. Through interviews with 7 CNA's, 5 LPN's, 2 RN's, the Wound Care Nurse, the MDS Coordinator, DON, and ADON revealed they had been educated and in-serviced on call ins and filling in shift as needed to maintain adequate staffing. 2. Review of the Recruitment Plan showed the facility had implemented the following to attain and retain staff: a. Job posting on line, verified through review of Indeed Job Recruitment. b. Social Media platforms c. A free cell phone to full time employees. d. Flyers were posted at the entrance of the facility regarding job openings. e. A Walk In Wednesday for job interviews at the facility. 3. Staffing was observed on both shifts 4/3/2024 to 4/5/2024. No short staffing was observed. Daily monitoring documentation of personnel on floor versus (vs) posted staffing matched. Punch report and staffing snap shots were reviewed and cross referenced against other falls investigated for Residents #3-#7 with no evidence of short staffing on the units and dates those falls occurred. Daily RN staffing was confirmed with observations and punch report checks during the survey period. Final walk through and staff/census counts conducted immediately before exit on 4/5/2024 showed no concerns. 4. Observations and interviews with the DON, ADON and Admin showed they had also underwent additional in service training conducted by the Corporate Compliance Consultant as reported in the AOC. Review of the QAPI sign in sheets and daily staffing calls showed those were completed as reported in the AOC. Medical director participation in the AOC/POC process was verified by her Nurse Practitioner onsite on 4/4/2024 and 4/5/2024. Prior to the exit conference (both participated and signed the QA sheets). 5. Daily observations of the scheduling calendar showed 4 agency personnel called off duty during the survey. All 4 open shifts were covered with other agency personnel or facility staff. The ADON covered a single 4-hour stint on 4/4/2024 until agency alternates could arrive due to staff tardiness due to a family emergency which was called to the ADON 8 hours in advance of the shift. This slot was eventually filled by an agency employee. Review and observation of the facility's AOC/Removal Plan, staffing schedules, staff postings, observation of staff and residents, daily staff meeting, and interviews showed the facility had implemented all corrective actions and the immediacy was removed onsite.