STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445504	A. Building B. Wing	06/08/2021

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405 Based on medical record review and interview, the facility failed to ensure 1 resident (Resident #1) of 4 residents reviewed were referred to the appropriate designated authority for Level 2 PASARR (Pre-Admission Screening and Annual Resident Review) evaluation and determination after a newly evident medical diagnosis. The findings include: Resident #1 was admitted to the facility on [DATE], with diagnoses including Acute Hematuria, Dysphagia, Major Depressive Disorder and Dementia. Medical record review showed the resident had the diagnosis of Psychosis added on 11/19/2019. Interview with the Health Information Manager on 6/7/2021 at 1:29 PM, showed she was responsible for submission request of PASARR Level II to the appropriate designated authority when needed. Continued interview confirmed the Health Information Manager failed to notify the designated authority of the newly diagnosed Psychosis for resident #1.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18784 Based on facility policy review, medical record review and interview, the facility failed to follow the Comprehensive Care Plan for 1 resident (Resident #259) of 4 residents to ensure a safe transfer with a mechanical lift. The facility's failure resulted in a fracture of the resident's proximal left tibia (upper part of the shin bone) and Harm for Resident #259. The findings include: Review of the facility policy titled Comprehensive Care Plan revised May 2021, showed .The plan must address the resident's individual needs, strengths, and preferences .The Comprehensive Care Plan planning process includes: .Incorporation of the resident's personal .preferences .The care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs .At a minimum, the care plan is updated with each comprehensive and quarterly assessment . Medical record review showed Resident #259 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Anxiety Disorder, Edema, Epilepsy, Chronic Pain, Major Depressive Disorder, and Chronic Kidney Disease. Medical record review of Resident #259's Comprehensive Care Plan, dated 6/15/2017, showed the resident had a self-care deficit related to impaired mobility with a linked intervention TRANSFER: The resident requires total assistance by (2) staff to move between surfaces. Continued review showed there was a second Focus [problem] revised on 12/04/2019, .assistance with transfers r/t [related to] impaired mobility . with the linked intervention .Mechanical lift with 2 staff members assistance with transfers with red sling . Medical record review of the quarterly Minimum Data Set (MDS) assessment, dated 8/10/2020, showed Resident #259 was cognitively intact, totally dependent with 2 persons assist for transfers, did not walk, and had range of motion impairments to both legs. Medical record review of an SBAR (Situation, Background, Assessment, and Recommendation) Communication Form, dated 10/10/2020, showed Resident #259 had complained of pain to the left lower leg. The area below the left knee was red, swollen, and painful. A Physician's Assistant (PA) was notified with a new order for an x-ray obtained. Review of a radiology report, dated 10/11/2020, showed .KNEE EXAM .LEFT .non-displaced fracture of the proximal tibia . (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Interview with Certified Nursing Assistant (CNA) #1, on 6/7/2021 at 3:20 PM, showed she had worked the day shift on 10/9/2020. Interview showed she had gone into Resident #259's room and he was insisting she get him up into the wheelchair. CNA #1 stated the staff often transferred the resident with 2 assist, not using the lift. CNA #1 stated she had not transferred him by herself before 10/9/2020. She stated she assisted him to a seated position on the side of the bed and he put his arms around her neck. She stated the resident was unable to put weight on his legs, so she positioned the bed higher than the wheelchair, and slid him into the wheelchair. She stated once he was seated in the wheelchair, he said his leg was hurting and his right leg was behind the left leg. CNA #1 confirmed the resident was care planned for the use of a mechanical lift for transfers. Interview with the PA on 6/7/2021 at 3:30 PM, confirmed the CNA had transferred Resident #259 from the bed to the wheelchair without use of the mechanical lift and without assist from another staff member. The PA further stated she believed CNA #1's failure to follow the care planned intervention for a lift transfer on 10/9/2020 had caused Resident #259's leg fracture. Interview with CNA #2 on 6/8/2021 at 8:40 AM, confirmed she worked the evening shift on 10/9/2020. She stated she assisted CNA #3 to transfer Resident #259 from the wheelchair back to the bed. She stated they transferred the resident with a 2-person assist and a gait belt. CNA #2 confirmed the resident was care planned for the use of a mechanical lift for transfers. Interview with the LPN (Licensed Practical Nurse) MDS Coordinator on 6/8/2021 at 9:24 AM, confirmed Resident #259's risk for falls care plan showed an intervention for the use of a mechanical lift, initiated on 6/15/2017. She stated therapy had evaluated and recommended a mechanical lift as the safest method of transfer. She confirmed the CNA's had access to the care plans in the computerized charting. Interview with the Director of Nursing (DON) on 6/8/2021 at 12:56 PM, confirmed the care plan had not been followed during the transfer on 10/9/2021. Interview with the District Director of Clinical Services on 6/8/2021 at 1:18 PM, confirmed the facility had identified the Harm to Resident #259 and had taken actions to correct the non-compliance. A plan of correction was developed from 10/10/2020-10/14/2020 to address the deficient practice that resulted in Harm on 10/9/2020. The corrective actions were validated on-site by the surveyors on 6/7/2021-6/8/2021 through interviews and review of documents. The facility's Allegation of Compliance for the Prevention of Accidents, dated 10/14/2020, was presented to the survey team and documented the following corrective actions were implemented. On 10/12/2020, counseling by use of the Teachable Moment was given to the 3 CNA's identified as transferring the affected resident out of the bed and later back to bed without use of the lift. On 10/12/2020, interviews were conducted by the Activities Director and the DON with all interviewable residents related to their care received by the CNA involved in the incident and with their care in general to rule out neglect or care plans not being followed. On 10/13/2020-10/14/2020 the DON completed an audit of 100% of all residents' Kardex and care plans. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	On 10/13/2020-10/14/2020 the Therapy Director completed an audit of 100% of all residents' care plans and Kardex for the appropriateness of each resident's requirement needs for transfer. Care plans were updated as needed. On 10/14/2020, the facility's Quality Assurance/Performance Improvement committee met and determined the root causes of the incident, reviewed the corrective actions taken, and planned for ongoing assessment tasks to confirm continued compliance. On 10/14/2020, orientation for newly hired nursing staff included education to follow care planned transfer status for residents. On 10/13/2020, the 64 nursing department employees received education to address use of the Care Plan and Kardex instructions related to transfers. On 10/14/2020, the 64 nursing department employees received re-education to address abuse, resident rights verses resident and staff safety. Audits of the residents' Kardex and care plans were completed by the DON and ADON on 10/12/2020, 10/21/2020, 10/30/2020, 11/2/2020, and 12/3/2020, and confirmed there were no issues noted with inappropriate transfers. 1. Surveyors interviewed the DON on 6/8/2021 at 2:00 PM, in the conference room. Interview confirmed there had not been any further incidents involving resident transfers. 2. Interview and review of audits for evaluation of transfers with lifts, with the DON, showed the observational audits were completed for 4 consecutive weeks as planned from 10/14/2020-11/14/2020 and then monthly x 2 as planned through 1/4/2021. 3. Surveyors interviewed 9 CNA's and 4 LPN's for knowledge of the inservices provided in the corrective action plan, safe use of mechanical lifts and no knowledge deficits were identified. The harm was cited past noncompliance and the facility is not required to submit a plan of correction.

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F 0689 Level of Harm - Actual harm 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** 40105 Based on facility policy review, medical record review and interview, the facility failed to prevent accidents for 1 resident (Resident #259) of 4 residents reviewed for accidents. The facility failed to transfer Resident #259 with the care planned intervention for transfer. The facility's failure resulted in a fracture of the resident's proximal left tibia (upper part of the shin bone) and Harm for Resident #259. The findings include: Review of the facility policy titled LIFT, TRANSFER, AND REPOSITIONING POLICY dated 2010, showed . The IDT [Interdisciplinary Team] will use the Company Lift and Transfer Guide .to develop care plan interventions that will continue to focus on ensuring the residents attain and maintain their highest level of physical functioning .Residents identified as partial weight-bearing or non-weight bearing and needing assistance with lifts and transfers shall be lifted using an appropriate mechanical lift .Direct care staff will be responsible for the following .Lifting and transferring residents in accordance with the residents' plans of care . Medical record review showed Resident #259 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Anxiety Disorder, Edema, Epilepsy, Chronic Pain, Major Depressive Disorder, Chronic Kidney Disease. Medical record review of Resident #259's comprehensive care plan, dated 6/15/2017, showed the resident had a self-care deficit related to impaired mobility. Further review showed the resident was at risk for falls related to impaired mobility, required a mechanical lift with 2 staff members assistance for transfers. A lift pad was to be left underneath him, while in the wheelchair. Medical record review of the quarterly Minimum Data Set (MDS) assessment, dated 8/10/2020, showed Resident #259 was cognitively intact, totally dependent with 2 persons assist for transfers, did not walk, and had range of motion impairments to both legs. Medical record review of an SBAR (Situation, Background, Assessment, and Recommendation) Communication Form, dated 10/10/2020, showed Resident #259 had complained of pain to the left lower leg. The area below the left knee was red, swollen, and painful. A Physician's Assistant (PA) was notified with a new order for an x-ray to be obtained. Review of a radiology report, dated 10/11/2020, showed .KNEE EXAM .LEFT .non-displaced fracture of the proximal tibia . Review of a Nursing Progress Note, dated 10/12/2020, showed .PA evaluated resident post [after] xray results, current history and med [medication] regimen, stated x-ray showed non-displaced fracture and demineralization on bone which could have predisposed condition for fracture .Pain regimen in place . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #259's pain level flowsheet, included in the Medication Administration Record (MAR), showed a pain level of 2 on the morning of 10/10/2020. Review showed the pain medication was administered on 10/11/2021- 10/15/2020 with a pain level of 1-5 and the resident's pain was relieved. Medical record review of a PA Progress Note, dated 10/12/2020, showed the follow-up after Resident #259's x-ray, .The patient was complaining of left leg pain .after the patient was transported from his bed to his wheelchair. X-rays were performed, and I am reviewing those results today .He has flaccid paralysis [loose and floppy] of bilateral [both] lower extremities [legs] . Interview with Certified Nursing Assistant (CNA) #1, on 6/7/2021 at 3:20 PM, showed she had worked the day shift on 10/9/2020. Interview showed she had gone into Resident #259's room and he was insisting she get him up into the wheelchair. She stated he did not like using the mechanical lift because he said it squeezed him. CNA #1 stated staff often transferred the resident with 2 assist, not using the lift. CNA #1 stated she had not transferred him by herself before 10/9/2020. She stated she assisted him to a seated position on the side of the bed and he put his arms around her neck. CNA #1 stated the resident was unable to put weight on his legs, so she positioned the bed higher than the wheelchair, and slid him into the wheelchair. She stated once he was seated in the wheelchair, he said his leg was hurting and his right leg was behind the left leg. CNA #1 stated he complained of hurting for about 20 minutes. She placed his feet on the footrests of the wheelchair, and he did not complain anymore of pain during the shift. CNA #1 stated she had not reported the transfer and the resident's subsequent complaint of pain to the nurse, because he had stopped complaining of pain. She stated she did not transfer the resident back to bed on her shift. CNA #1 confirmed the resident was care planned for the use of a mechanical lift for transfers and stated she was unsure if she had ever reported his refusals to use the lift to a nurse. Interview with the PA on 6/7/2021 at 3:30 PM, confirmed CNA #1 had transferred Resident #259 from the bed to the wheelchair without use of the mechanical lift and without assist from another staff member. The PA stated when the resident complained of pain, the morning of 10/10/2021, an x-ray had been obtained which showed a tibial plateau fracture (a break in the larger lower leg bone below the knee). The PA confirmed the resident was unable to bear weight on his legs, before and after the leg fracture. The PA further stated she believed CNA #1's failure to follow the care planned intervention for a lift transfer on 10/9/2020 had caused Resident #259's leg fracture. Interview with Licensed Practical Nurse (LPN) #4 on 6/8/2021 at 8:25 AM, confirmed she had worked the day shift on 10/10/2020 and assessed Resident #259 for a complaint of pain. She stated the resident told her he had gotten hurt the previous day, during a transfer to the wheelchair on 10/9/2020. She stated she notified the PA and obtained an x-ray. LPN #4 stated the resident required a mechanical lift for transfers. Interview with CNA #2 on 6/8/2021 at 8:40 AM, confirmed she worked the evening shift on 10/9/2020. She stated she assisted CNA #3 to transfer Resident #259 from the wheelchair back to the bed. She stated there wasn't a lift pad under the resident, so they were unable to use the mechanical lift to transfer. She stated they transferred the resident with a 2-person assist and a gait belt. CNA #2 confirmed the resident was care planned for the use of a mechanical lift for transfers. Interview with CNA #4 on 6/8/2021 at 8:54 AM, confirmed she had worked the night shift on 10/9/2020. She stated Resident #259 did not complain of pain during the night. CNA #4 confirmed the resident required the use of a mechanical lift for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with CNA #5 on 6/8/2021 at 9:01 AM, confirmed she had worked the day shift on 10/10/2020. She stated Resident #259 complained of pain in his lower left leg, in the shin area, while she was getting him ready to get up in the wheelchair. She stated she had rolled him in the bed to get him dressed, his left leg was swollen and red and she reported it to the nurse. She stated the resident had told her his leg got caught in the wheelchair the previous day (10/9/2020) when a staff member transferred him without assistance. CNA #5 confirmed the care plan stated the resident required a mechanical lift for transfers. Interview with the LPN MDS Coordinator on 6/8/2021 at 9:24 AM, confirmed Resident #259's risk for falls care plan showed an intervention for the use of a mechanical lift, initiated on 6/15/2017. She stated therapy had evaluated and recommended a mechanical lift as the safest method of transfer. She confirmed the CNAs had access to the care plans in the computerized charting system. During interview by telephone with Resident #259's Attending Physician on 6/8/2021 at 9:58 AM, the physician stated CNA #1 .should have followed the protocol . for the resident's transfers. He stated the injury did sound consistent with the reported incident. Interview with the Director of Nursing (DON) on 6/8/2021 at 12:56 PM, confirmed CNA #1 transferred Resident #259 on 10/9/2020 by herself, without the use of a mechanical lift. She further confirmed on 10/10/2020 the resident had began to complain of pain in his left lower leg, an x-ray had been obtained, and the resident had sustained a fracture of his left proximal tibia. The DON stated physical therapy had completed an evaluation and determined the mechanical lift was the safest method of transfer for the resident. The DON stated she did not believe the resident was able to bear weight on his legs during a transfer. The DON confirmed the improper transfer of Resident #259 on 10/9/2020 could have caused the fracture of the resident's proximal tibia. The DON confirmed the care plan had not been followed during the transfer on 10/9/2020 and confirmed the resident was at increased risk for fracture due to bone demineralization. Interview with the District Director of Clinical Services on 6/8/2021 at 1:18 PM, confirmed the facility had identified the Harm to Resident #259 and had taken actions to correct the non-compliance. A plan of correction was developed from 10/10/2020-10/14/2020 to address the deficient practice that resulted in Harm on 10/9/2020. The corrective actions were validated on-site by the surveyors on 6/7/2021-6/8/2021 through interviews and review of documents. The facility's Allegation of Compliance for the Prevention of Accidents, dated 10/14/2020, was presented to the survey team and documented the following corrective actions were implemented. On 10/12/2020, counseling by use of the Teachable Moment was given to the 3 CNA's identified as transferring the affected resident out of the bed and later back to bed without use of the lift. On 10/12/2020, interviews were conducted by the Activities Director and the DON with all interviewable residents related to their care received by the CNA involved in the incident and with their care in general to rule out neglect or care plans not being followed. On 10/13/2020-10/14/2020 the DON completed an audit of 100% of all residents' Kardex and care plans. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/13/2020-10/14/2020 the Therapy Director completed an audit of 100% of all residents' care plans and Kardex for the appropriateness of each resident's requirement needs for transfer. Care plans were updated as needed. On 10/14/2020, the facility's Quality Assurance/Performance Improvement committee met and determined the root causes of the incident, reviewed the corrective actions taken, and planned for ongoing assessment tasks to confirm continued compliance. On 10/14/2020, orientation for newly hired nursing staff included education to follow care planned transfer status for residents. On 10/13/2020, the 64 nursing department employees received education to address use of the Care Plan and Kardex instructions related to transfers. On 10/14/2020, the 64 nursing department employees received re-education to address abuse, resident rights verses resident and staff safety. Audits of the residents' Kardex and care plans were completed by the DON and ADON on 10/12/2020, 10/21/2020, 10/30/2020, 11/2/2020, and 12/3/2020, and confirmed there were no issues noted with inappropriate transfers. 1. Surveyors interviewed the DON on 6/8/2021 at 2:00 PM, in the conference room. Interview confirmed there had not been any further incidents involving resident transfers. 2. Interview and review of audits for evaluation of transfers with lifts, with the DON, showed the observational audits were completed for 4 consecutive weeks as planned from 10/14/2020-11/14/2020 and then monthly x 2 as planned through 1/4/2021. 3. Surveyors interviewed 9 CNA's and 4 LPN's for knowledge of the inservices provided in the corrective action plan, safe use of mechanical lifts and no knowledge deficits were identified. The harm was cited past noncompliance and the facility is not required to submit a plan of correction.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43265 Based on facility policy review, observation, and interview, the facility failed to maintain a sanitary environment in 1 of 1 kitchen, in 1 of 1 walk-in refrigerator, in 1 of 1 walk-in freezer, in 1 of 1 stand-alone refrigerator, and in 1 of 1 food and paper storage room observed, potentially affecting 61 of 65 residents in the facility. The findings include: Review of the facility policy Food Storage: Dry Goods, dated ,d+[DATE], showed .Dining Services Director or designee regularly inspects [food service areas] [for] contamination . Review of the facility policy Foods Storage, dated ,d+[DATE], showed .foods will be stored wrapped or in covered containers, labeled and dated . Review of the facility policy Food Safe Handling for Foods from Visitors, dated ,d+[DATE] showed .discard . any food items that have been stored for [equal to or greater than] 7 days . Observation and interview with the Lead Cook (LC) #1 on [DATE] at 9:36 AM, in the kitchen, showed 30 uncovered small bowls of stewed apple dessert on an uncovered rack and 2 cups of loose cornmeal in a pitcher, covered with plastic wrap dated ,d+[DATE], inside a confectioner sugar bin. Interview confirmed the facility failed to ensure the 30 uncovered small bowls of stewed apple dessert was labeled, and dated. Continued interview confirmed the facility failed to discard expired food items available for resident use. Observation and interview with LC #1 on [DATE] at 9:45 AM, in the walk-in refrigerator showed the following: 2 boiled eggs, unshelled, in yellow liquid in a sealed plastic bag, dated [DATE] 1 opened 45-ounce jar of spaghetti sauce containing 1 cup, undated 15 opened unwrapped blueberry muffins, loose in box, undated Interview with LC #1 confirmed the facility failed to ensure resident food was labeled and dated and failed to discard expired food items available for resident use. Observation and interview with LC #1 on [DATE] at 9:50 AM, in the walk-in fridge showed the following staff food items: One 16-ounce yogurt One 9-ounce frozen orange chicken dinner One 16-ounce salad dressing, ,d+[DATE] full (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	One 8-ounce frozen dinner, undated Interview with LC #1 confirmed the facility failed to store staff food items in a separate refrigerator from resident use. Observation and interview with LC #1 on [DATE] at 9:55 AM, in the walk-in freezer, showed 10 uncovered, undated frozen breadsticks. Interview confirmed the facility failed to ensure resident food was covered, labeled and dated. Observation and interview with LC #1 on [DATE] at 10:00 AM, in the kitchen at the stand-alone refrigerator showed the following: One opened employee 20-ounce bottle sports drink, undated One 46 fluid ounce thickened orange juice, approximately ,d+[DATE] remaining, undated One 32 fluid ounce thickened dairy drink, approximately 1 cup remaining, undated One 32 fluid ounce thickened dairy drink, approximately ,d+[DATE] cup remaining, undated One 32 fluid ounce thickened dairy drink, approximately ,d+[DATE] cup remaining, undated One 32 fluid ounce chicken broth, opened and undated 4 cups of tea remaining in covered pitcher, dated [DATE](expired 9 days) 4-ounce cup pineapple snack, undated 3 pre-made cheese sandwiches, undated Individually poured liquids uncovered: Three 8-ounce nectar thick milk Three 8-ounce nectar thick water Two 8-ounce nectar thick tea Two 8-ounce fruit punch Two 8-ounce cranberry juice Two 4-ounce cranberry juice Two 8-ounce apple juice One 8-ounce orange juice (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with LC #1 confirmed the facility failed to ensure resident food was labeled, covered, dated, and failed to discard expired food items available for resident use. Continued interview confirmed the facility failed to store an employee sports drink in a separate refrigerator. Observation and interview with LC #1 on [DATE] at 10:10 AM, in the food and paper storage room showed the following: One 128 fluid ounce pancake syrup, approximately ,d+[DATE] cup remaining, undated One 5-pound bag cornbread mix, 2.5 pounds remaining, undated 6 cups corn cereal opened in large zipped bag, undated 42 ounces oats, ,d+[DATE] cup remaining, undated One 5-pound bag cornbread mix, ,d+[DATE] mix remaining, undated 1.5 cups cake mix in box opened, undated Interview with LC #1 confirmed the facility failed to ensure resident food was labeled and dated. Observation with LC #1 on [DATE] at 10:21 AM, in the food and paper storage room showed, upon entry, two damaged areas in the left far corner ceiling of the room. Proximal damaged area, approximately eight inches in diameter, with actual break in ceiling tile. The distal damaged area was approximately four inches in diameter. Both areas were light brown in color, with a darker brown ring surrounding each perimeter. Continued observation showed two boxes situated directly underneath the discolorations on a food storage rack. Both boxes and contents were stained and misshapen. Continued observation showed black debris on 2 of 2 ceiling vent covers. Interview with LC #1 on [DATE] at 10:25 AM, in the food and paper storage room, confirmed she had not noticed or reported the damaged boxes in the corner on the food storage rack, or the damaged ceiling above the food storage rack. Continued interview confirmed the facility did not maintain a sanitary environment. Observation with LC #1 on [DATE] at 12:05 PM, in the kitchen, showed black debris on 6 of 6 ceiling vent covers. Interview with LC #1 on [DATE] at 12:15 PM, in the kitchen, confirmed black debris on 6 of 6 ceiling vent covers. Continued interview confirmed the facility had not maintain a sanitary environment in the kitchen. Observation with the District Manager (DM) and Director of Maintenance on [DATE] at 12:35 PM, in the food and paper storage room, confirmed the presence of two discolored and damaged areas in the left far corner ceiling of the room and black debris in 8 out of 8 ceiling vent covers in the storage room and kitchen area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445504	A. Building B. Wing	06/08/2021

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the DM and Director of Maintenance on [DATE] at 12:45 PM, confirmed the facility failed to maintain a sanitary environment. Continued interview showed he was responsible for all vent cover cleaning and he was not aware of the leaks in the ceiling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445504	A. Building B. Wing	06/08/2021

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 43265 Based on facility policy review, observation, pest control documentation review, and interview, the facility failed to maintain an effective pest control program in 1 of 1 paper storage rooms, potentially affecting 61 of 65 residents. The findings include: Review of facility policy, Pest Control [Infection Prevention] revised 4/2021, showed .emphasis on the pest control program in kitchens .monitoring environment will be done by the center's staff. Pest control problems will be reported promptly . Review of facility policy, Pest Control, revised 9/2017, showed .Dining Services Director coordinates with the Director of Maintenance to arrange pest control services on a monthly basis or as needed .all food preparation, service, and storage areas will be monitored regularly for any signs of pest/vermin . Review of (named) pest control company invoice, dated 5/15/2021, showed rodent services consisting of bait-trap (mouse and insect glue board, pre-baited to attract mice and insects) were placed at the facility in May 2021. Observation with the Lead Cook (LC) #1 on 6/6/2021 at 10:21 AM, in the food and paper storage room showed two boxes, with contents stained and misshapen, situated on the top of a food storage rack. Continued observation showed one box contained discolored labels and the second box contained a glue board rat tray with three dead mice affixed to the surface of the board and six boxes of toothpicks. Interview with LC #1 on 6/6/2021 at 10:25 AM, in the kitchen, confirmed .there was three mice on that board . Interview with the District Manager on 6/6/2021 at 12:40 PM, confirmed LC#1 had communicated the discovery of three mice on a glue board on a top food rack in the food and paper storage room on 6/6/2021. Continued interview confirmed food storage areas were to be checked regularly for any signs of pests by all staff and problems reported to the pest control company. Continued interview confirmed the facility failed to monitor for rodents and pests. Interview with the Director of Maintenance on 6/6/2021 at 12:45 PM, confirmed he was made aware of the three dead mice stuck on the glue board on 6/6/2021. Continued interview showed he was unaware of a rodent issue. Interview with the Director of Maintenance on 6/7/2021 at 10:45 AM, confirmed he was responsible for reporting issues promptly to the extermination company. Continued interview confirmed the facility failed to monitor for rodents and pests.