STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445509	A. BUILDING _____ B. WING _____	**04/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF OLD HICKORY VILLAGE	**1250 ROBINSON ROAD OLD HICKORY, TN 37138**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, facility documentation, medical record review, and interview the facility failed to revise a comprehensive care plan for 1 of 3 residents (Resident #1) reviewed for falls. The findings include: Review of the facility policy titled, Fall Management dated [DATE]5/2019 revealed, .The interdisciplinary team will review and revise the care plan.upon a fall event and as needed thereafter. Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the medical record, Quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BI[CONDITION]) score of 14 indicating no cognitive impairment. Review of facility fall documentation dated [DATE]20 revealed Resident #1 was found on the floor in front of her wheelchair by Certified Nursing Assistant #1. Review of the care plan dated 11/13/2019 revealed no new interventions for Resident #1 related to the fall on [DATE]20. During an interview conducted on [DATE]4/2020 at 12:03 PM, the MDS Coordinator confirmed the fall care plan for Resident #1 was not updated to reflect interventions for the fall on [DATE]20. During an interview conducted on [DATE]4/2020 at 12:30 PM, the Director of Nursing confirmed the fall care plan for Resident #1 was not updated to reflect new interventions for the fall on [DATE]20.

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

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.