STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445276	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CUMBERLAND VILLAGE CARE	136 DAVIS LANE LAFOLLETTE, TN 37766

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 0600 **Level of harm** - Minimal harm or potential for 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** Based on review of the facility policy, medical record review, facility documentation review, and interview the facility failed to prevent abuse for 2 residents (#4 and #2) of 6 residents reviewed. The findings included: Review of the Facility policy titled, Abuse Prohibition, last revised 7/1/2019, showed, . (Name of facility) prohibit abuse .for all residents .Physical Abuse includes hitting, slapping .The Center Executive Director, or designee, is responsible for operating policies and procedures that prohibit abuse .Actions to prevent abuse .identifying, correcting, and intervening in situations in which abuse .is more likely to occur .The Center is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation . Review of the medical record showed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Care Plan dated 11/8/2018 (active) showed Resident #1 was care planned for the potential to exhibit physical behaviors related to ineffective coping skills, poor anger management, and poor impulse control. Interventions included divert the resident by giving alternative objects or activities initiated on 11/8/2018. Review of the Care Plan dated 5/27/2019 (active) showed Resident #1 was care planned for psychosocial distress with own well-being and/or social relationships related to frequent conflict with other residents and staff. Interventions included to assess the resident to process feelings and find positive outcomes initiated on 2/24/2020. Other interventions included evaluate the need for Psychatric/Behavioral Health consult, and encourage the resident's participation in activity preferences. These interventions were initiated on 5/27/2019 and revised on 4/14/2020 Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #1 had a Brief Interview of Mental Status score (BIMS) of 9 which indicated the resident was moderately cognitively impaired. Resident #1 exhibited physical behavioral symptoms directed toward others daily and required supervision and assistance with ambulation. Review of Resident #1's Progress Note dated 7/17/2020 showed, .res (resident) having behaviors this shift, yelling and cursing at staff and other residents, res has been pacing and talking to himself, res being very aggressive making the other residents and staff concerned for their safety, nurse instructed res to go to room . Review of the medical record showed Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Care Plan dated 8/17/2017 (active) showed Resident #4 was care planned for the potential to exhibit physical behaviors related to cognitive loss and Dementia. Interventions included to monitor conditions that may contribute to physical behaviors initiated on 8/17/2017. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] showed Resident #4 had a BIMS of 3 which indicated the resident was severely cognitively impaired. There were no concerns related to the resident's mood. Resident #4 had [MEDICAL CONDITION] and exhibited delusions. The resident required total assistance with activities of daily living, and the resident used a wheelchair for mobility. Review of facility documentation dated 4/24/2020 showed, Resident (Resident #1) in wheelchair in front of nurse's desk behind a female resident (Resident #4) in wheelchair .(Resident #1) rolled his wheelchair up to the back of the female resident (Resident #4) and hit her . Review of Resident #4's Progress Note dated 4/24/2020 showed, .A change in condition has been noted .Injury to head resident to resident altercation .in the morning .Orders obtained include .Neurochecks per protocol . Review of the medical record showed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Care Plan dated 12/1/2017 (active) showed, Resident #2 was care planned for exhibits, or has the potential to exhibit physical behaviors related to Cognition Loss/Dementia. Interventions in place included observe for non-verbal signs of physical aggression and provide a calm, quiet, well-lit environment which were initiated on 12/1/2017 and revised on 4/30/2020. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #2 had severely impaired cognitive skills for daily decision making. The resident exhibited physical behavioral symptoms directed towards others daily. No mood concerns were noted. Resident #2 required extensive assistance for activities of daily living and used a wheelchair for mobility. Review of facility documentation dated 7/16/2020 showed, Resident (Resident #1) was sitting at a table after breakfast & (and) got up mumbling to himself .When he was passing (Resident #2) he hit him in the side of the face . Review of Resident #2's Progress Note dated 7/16/2020 showed, .(Resident #2) was hit by another resident (Resident #1) this am (morning), resulting in red area @(at) corner of rt (right) eye . During a telephone interview on 7/27/2020 at 10:06 AM, License Practical Nurse (LPN) #1 confirmed she witnessed the physical abuse between Resident #1 and Resident #4 on 4/24/2020 in the secure unit. LPN #1 stated .(Resident #1) was in wheelchair came up behind (Resident #4) and hit her with his hand 3 times in the back of her head .(Resident #1) stated he didn't hit her she was a witch . During a telephone interview on 7/27/2020 at 10:34 AM, Certified Nursing Assistant (CNA) #1 stated she witnessed the physical abuse between Resident #1 and Resident #2 on 7/16/2020. CNA #1 stated .I walked behind the nursing desk (in the secure unit) he (Resident #1) was behind him (Resident #2) and hit him in the head .we monitor him and have eyes on him for monitoring .We just try to .keep him away from others he has problem with . During an interview on 7/27/2020 at 11:40 AM, LPN #3 confirmed .I was told about this man (Resident #1) so I keep Resident #1 and Resident #2 separated .(Resident #1) makes the residents (residents located on the secure unit) scared of him with yelling and cursing at them .we have someone there to watch resident to prevent the resident from physically hitting other residents . During an interview on 7/27/2020 at 3:53 PM, the Director of Nursing (DON) stated .If someone agitated or seeking someone out we put them on 1:1 .We were aware (Resident #1) hit other residents .We can't predict behavior .We only do 1:1 action if at risk for harming others or someone else or themselves . Continued interview confirmed the facility failed to protect Resident #2 and Resident #4 from abuse. During an interview on 7/27/2020 at 4:52 PM, the Administrator confirmed the facility failed to protect Resident #2 and Resident #4 from abuse by Resident #1.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility documentation review, and interview the facility failed to ensure allegations involving abuse was reported immediately, but not later than 2 hours after the allegation is made to the State Survey Agency for 3 residents (#1, #4, and #2) of 8 residents reviewed for abuse. The findings included: Review of the Facility policy titled, Abuse Prohibition, last revised 7/1/2019, showed . (name of facility) prohibit abuse .for all residents .Upon receiving information concerning a report of suspected or alleged abuse .the CED (Chief Executive Director) or designee will perform the following .Report allegations involving abuse .physical .not later than two hours after the allegation is made .Notify .other agencies as required . Review of the medical record showed Resident #1 was admitted to

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.

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #1 had a Brief Interview of Mental Status score (BIMS) of 9 which indicated the resident was moderately cognitively impaired. Resident #1 exhibited physical behavioral symptoms directed toward others daily. Resident #1 required supervision and assistance with ambulation. Review of the medical record showed Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] showed Resident #4 had a BIMS of 3 which indicated the resident was severely cognitively impaired. Resident #4 had [MEDICAL CONDITION] and exhibited Delusions. The resident required total assistance with activities of daily living. The resident used a wheelchair for mobility. Review of facility documentation dated 4/24/2020 showed, Resident (#1) in wheelchair in front of nurse's desk behind a female resident (Resident #4) in wheelchair .(Resident #1) rolled his wheelchair up to the back of the female resident (Resident #4) and hit her . Review of Resident #4's Progress Note dated 4/24/2020 showed, A change in condition has been noted .Injury to head resident to resident altercation .in the morning .Orders obtained include .Neurochecks per protocol . Review of the medical record showed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly MDS assessment dated [DATE], showed Resident #2 had severely impaired cognitive skills for daily decision making. The resident exhibited physical behavioral symptoms directed towards others daily. Resident #2 required extensive assistance for activities of daily living and used a wheelchair for mobility. Review of facility documentation dated 7/16/2020 showed, Resident (#1) was sitting at a table after breakfast & (and) got up mumbling to himself .When he was passing (Resident #2) he hit him in the side of the face . Review of Resident #2's Progress Note dated 7/16/2020 showed, .(Resident #2) was hit by another resident (Resident #1) this am (morning), resulting in red area @ (at) corner of rt (right) eye . During an interview on 7/27/2020 at 10:06 AM, by telephone, Licensed Practical Nurse (LPN)#1 stated she reported the physical abuse of Resident #1 hitting Resident #4 in the head to the Director of Nursing (DON) on 4/24/2020 within 20 minutes of the incident. During an interview on 7/27/2020 at 3:31 PM, LPN #2 stated she notified the DON of the physical abuse of Resident #1 hitting Resident #2 on the side of the face near the resident's eye on 7/16/2020. During an interview on 7/27/2020 at 3:53 PM, the DON stated she notified the Administrator (Abuse Coordinator) of the physical abuse between Resident #1 and Resident #2 on 7/16/2020 immediately after being informed of the incident by LPN #2. Continued interview showed the DON also notified the Administrator of the physical abuse between Resident #1 and Resident #4 on 4/24/2020 after being notified of the incident by LPN #1. During an interview on 7/27/2020 at 4:52 PM, the Administrator stated the facility failed to report the 2 allegations of abuse which occurred on 4/24/2020 and 7/16/2020 to the State Survey Agency. The Administrator stated .I forgot missed it .