STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445390	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PICKETT CARE AND REHABILITATION CENTER	**129 HILLCREST DRIVE BYRDSTOWN, TN 38549**

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F 0655 **Level of harm -** Actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility fall investigation review, and interview, the facility failed to develop a baseline care plan for fall risk for a resident at high risk for falls resulting in a fall with a laceration which required staples to the back of the head (harm) for 1 resident (Resident #7) of 7 residents reviewed for falls. The findings include: Review of the facility's policy, Falls dated 11/6/2019, revealed, .All residents will have a comprehensive fall risk assessment on admission/readmission .Appropriate care plan interventions will be implemented and evaluated as indicated by assessment .Care Plan will be implemented based on fall risk evaluation score with individual goal and interventions specific to each patient . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged to the hospital on [DATE]. Review of the Fall Risk Assessment Tool dated 6/9/2020, showed a score of 15, indicating Resident #7 was at high risk for falls. Review of the 5 day Minimum Data Set (MDS) assessment dated [DATE], showed Resident #7 had moderately impaired cognitive status. The resident required extensive assist of 1 staff with transfers, ambulation, and toileting, and the resident had a fall with a fracture in the month prior to admission to the facility. Medical record review revealed the facility did not develop a baseline care plan to address the resident's high risk for falls and previous history of falls. Review of the facility fall investigation dated 6/15/2020, showed Resident #7 had a fall at 3:00 PM and sustained a laceration to the back of the head. The resident had been in bed prior to the fall, no fall interventions were in place at the time of the fall, and the resident was transferred to the emergency room for evaluation. The laceration required 4 staples to close the wound. During an interview on 6/30/2020 at 11:16 AM, the MDS Coordinator confirmed Resident #7 had a fall risk assessment dated [DATE] with a score of 15 on the assessment, indicating Resident #7 was at high risk for falls. The MDS Coordinator confirmed the facility did not develop a baseline care plan to address Resident #7's fall risk prior to the fall that occurred on 6/15/2020. During an interview on 6/30/2020 at 11:20 AM, Licensed Practical Nurse (LPN) #1 stated Certified Nursing Assistant (CNA #3) had just left the resident's room where Resident #7 was lying on the bed, and when she came back to Resident #7's room, she found the resident on the floor. The resident stated he was trying to go to the bathroom and the resident had a laceration to the back of the head. LPN #1 was unable to remember if any fall interventions were in place at the time of the fall. During an interview on 7/1/2020 at 11:15 AM, the Administrator confirmed Resident #7 had a fall on 6/15/2020 which resulted in a laceration requiring 4 staples to the back of the resident's head. She confirmed the facility had not developed a baseline care plan with interventions to prevent falls prior to the fall on 6/15/2020. The Administrator stated if the resident had a fall risk care plan with fall interventions in place, he would have been less likely to fall. The Administrator confirmed the facility had not followed their policy for the development of a fall risk care plan for a resident who scored high risk for falls on the admission Fall Risk Assessment Tool. Refer to F-689
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** Based on facility policy review, medical record review, facility fall investigation review, and interviews, the facility failed to implement the care plan for 1 resident (Resident #4) of 7 residents reviewed for falls. The facility's failure to implement the care plan resulted in Resident #4 sustaining a shoulder fracture (Harm) from a fall while transferring to the chair. The findings include: Review of the facility policy titled, Comprehensive Care Plans, dated 7/19/2018, revealed, .will include how the facility will assist the resident to meet their needs, goals and preferences .interventions are implemented after consideration of .problem areas and their causes .will reflect action, treatment, or procedure to meet the objectives toward achieving .goals .Care plans are ongoing and revised as information about .condition change . Review of the facility policy titled, Falls dated 11/6/2019, revealed, .2. A Comprehensive Care Plan will be implemented based on fall risk evaluation score with individual goal and interventions specific to each patient . Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's comprehensive care plan dated 11/20/2019, revealed Resident #4 had an intervention for assistance which stated .Elder to have shoes on for transfers .Transfer with assist of 2 staff . Review of Resident #4's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact and required extensive assistance of 2 staff members for transfers. Review of a facility fall investigation dated 11/25/2019, revealed .CNA (Certified Nursing Assistant) was assisting (Resident #4) with transfer CNA care plan not followed (assist of 2 staff for transfers) .Elder did not have on appropriate footwear . Review of a radiology report dated 11/25/2019, revealed Resident #4 sustained a shoulder fracture. During an interview on 6/30/2020 at 10:30 AM, the Administrator confirmed Resident #4's care planned fall interventions were not implemented, resulting in a fall with Harm to Resident #4. Refer to F-689
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** Based on facility policy review, facility fall investigation review, medical record review, and interview, the facility failed to ensure a safe transfer procedure for 1 resident (Resident #4), resulting in a shoulder fracture, and failed to prevent a fall with injury for 1 resident (Resident #7) who sustained a laceration with 4 staples placed to the back of the head. The facility failed to ensure the safety of 2 residents (#4, #7) of 7 residents reviewed for falls, resulting in Harm to Residents #4 and #7. The findings include: Review of the facility policy, Gait Belt dated 1/4/2019, revealed, .Each stakeholder who provides direct patient care shall use a gait belt during the ambulation, transfer or movement of residents .Each stakeholder .is required to have a gait belt on their person .should be worn around their waist . Review of the facility policy, Falls dated 11/6/2019, revealed, .It is the intent of this facility to provide residents with assistance and supervision in an effort to minimize the risk of falls and fall related injuries . Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Fall Risk assessment dated [DATE], revealed Resident #4 was a high risk for falls. Review of Resident #4's comprehensive care plan dated 11/20/2019, revealed an intervention for assistance .Elder to have shoes on for transfers .Transfer with assist of 2 staff . Review of Resident #4's admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was cognitively

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) intact and required extensive assistance of 2 staff members for transfers. Review of a Progress Note dated 11/25/2019 at 12:50 PM, revealed Resident #4 was transferred to a local hospital via ambulance. Review of a X-Ray report dated 11/25/2019, revealed Resident #4 had a spiral [MEDICAL CONDITION] humeral diaphysis (shoulder fracture). Review of a facility fall investigation dated 11/25/2019, revealed .CNA (Certified Nursing Assistant) was assisting (Resident #4) with transfer CNA care plan not followed (assist of 2 staff for transfers) .Elder did not have on appropriate footwear .gait belt not used for transfer (per policy) . During an interview on 6/30/2020 at 3:35 PM, Licensed Practical Nurse (LPN) #3 stated on 11/25/2019, at the time of the fall, CNA #2 stepped out into the hallway and said she needed help. LPN #3 went into the room and saw Resident #4 on the floor, sitting up against the dresser. Resident #4 told LPN #3 he lost his balance. After assessing the resident, LPN #3 observed CNA #2 not wearing a gait belt around her waist, which was required to transfer the resident. LPN #3 stated CNA #2 had transferred the resident without the assistance of a second staff person. LPN #3 stated 2 staff members were present outside the resident's room at the time of the fall and were available to assist CNA #2, but the CNA had not requested assistance. During an interview on 7/1/2020 at 9:15 AM, Resident #4 stated CNA #2 came into the room to assist the resident with transferring from the bed to the chair. Resident #4 stated, .I am supposed to wear special shoes when I transfer .but I had on non-skid socks which did not work for me .(CNA #2) did not use good transfer skills, did not use a gait belt, and she was the only one in here. It takes 2 people to transfer me .I heard my arm break as I went down to the floor . During an interview on 7/1/2020 at 11:15 AM, the Administrator confirmed Resident #4 had a fall on 11/25/2019 when CNA #2 did not use a gait belt and assistance of 2 staff members to transfer Resident #4. This fall resulted in Harm for Resident #4 when he sustained a shoulder fracture. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged to the hospital on [DATE]. Review of the Fall Risk Assessment Tool dated 6/9/2020, showed a score of 15, indicating the resident was at high risk for falls. Review of the 5 day MDS assessment dated [DATE], showed Resident #7 had moderately impaired cognitive status. The resident required extensive assist of 1 staff with transfers, ambulation, and toileting, and the resident had a fall with a fracture in the month prior to admission to the facility. Review of the C.N.A. Care Report, undated, and the resident's baseline care plan in effect on 6/15/2020, revealed no documentation of interventions to prevent falls. Review of the facility fall investigation dated 6/15/2020, showed Resident #7 had a fall at 3:00 PM and sustained a laceration to the back of the head. The resident had been in bed prior to the fall, no fall interventions were in place at the time of the fall, and the resident was transferred to the emergency room for evaluation. Review of the emergency room documentation dated 6/15/2020, showed Resident #7 was transferred to the emergency room from the facility with a 3 centimeter laceration to the back of the head and a skin tear to the left elbow. The laceration on the back of the head required closure with 4 staples. Review of a Resident Progress Note dated 6/15/2020, showed Resident #7 returned to the facility with 4 staples intact to the back of the head. During an interview on 6/30/2020 at 11:14 AM, the Administrator confirmed Resident #7 had a fall on 6/15/2020, the resident was at high risk for falls based on the fall risk assessment dated [DATE], and interventions to prevent falls should have been developed and implemented prior to the fall on 6/15/2020. During an interview on 6/30/2020 at 11:16 AM, the MDS Coordinator confirmed Resident #7 had a fall risk assessment dated [DATE] with a score of 15, indicating the resident was at high risk for falls. The MDS Coordinator confirmed the resident did not have interventions to prevent accidents prior to the fall that occurred on 6/15/2020. During an interview on 6/30/2020 at 11:20 AM, LPN #1 stated she was assigned to Resident #7 on 6/15/2020, when the resident fell . LPN #1 stated CNA #3 had just left the resident's room where Resident #7 was lying on the bed. CNA #3 went to check on another resident, and when she came back to Resident #7's room, she noticed he was not in the bed and found him on the floor. The resident stated he was trying to go to the bathroom and the resident had a laceration to the back of the head. During an interview on 7/1/2020 at 11:15 AM, the Administrator confirmed Resident #7 had a fall on 6/15/2020 which resulted in a laceration requiring 4 staples to the back of the resident's head. She confirmed the facility had not developed interventions to prevent falls prior to the fall on 6/15/2020. The Administrator stated if the resident had interventions in place, the resident would have been less likely to fall.
F 0867 **Level of harm -** Actual harm **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, review of Re-Certification and Revisit survey findings, review of Quality Assurance Performance Improvement (QAPI) documents, medical record review, and interview, the facility's QAPI committee failed to audit, monitor, and maintain compliance with the Plan of Correction (POC) dated 11/19/2019, resulting in 2 residents (Residents #4 and #7) of 7 residents reviewed for falls sustaining falls with injuries (Harm). The findings include: Review of the facility's policy titled, Quality Assurance/Performance Improvement (QAPI) Program, dated 10/2/2019, revealed .the intent of this facility .QAPI .designed to systematically monitor evaluate and improve the quality and appropriateness of resident care .[MEDICATION NAME] both outcomes and processes .with the objective of improving the organization's overall performance . Review of the annual Re-Certification survey completed on 8/14/2019, revealed the facility was cited for failure to implement care plans and failure to provide supervision to prevent accidents, resulting in Harm to 1 resident. The facility failed to implement a care plan fall intervention for the assistance of 2 staff members for repositioning of the resident. A Certified Nursing Assistant (CNA) attempted to reposition the resident without assistance from another staff member, which resulted in a fall with a nasal fracture. Review of the facility's Plan of Correction (POC) dated 9/15/2019 for the deficiencies cited on the 8/14/2019 Re-Certification survey, revealed the CNA care plans were to be placed in a binder and kept at the nurses stations. The CNAs were to review and initial the care plans at the beginning of their shifts. During the monthly QAPI meeting, the committee would review and identify any concerns. The Director of Nursing (DON)/Unit Manager would audit the CNA care plans to ensure the CNAs had reviewed and initialed the care plans. Review of a revisit survey completed 10/1/2019, revealed the facility failed to implement the POC and the facility was recited deficient practice for failure to develop/implement comprehensive care plans and failure to provide supervision to prevent accidents/falls. Review of the facility's POC dated 11/19/2019, revealed the CNA care plans were to be reviewed for accuracy on all new admissions/re-admissions. The CNAs were to initial daily that the resident care plans were reviewed. The DON/Unit Manager/Administrator would audit the CNA care plan books to ensure the CNAs had initialed the care plans. Incidents would be reviewed in the monthly QAPI meeting. Documentation of audits would be reviewed monthly during the QAPI meeting and any concerns identified would be addressed immediately. Review of a Performance Improvement Plan (PIP) titled Quality Performance/Peer Review Facility Plan of Action/Continuous Quality Improvement dated 11/27/2019, revealed a PIP had been developed after Resident #4 sustained a fall with injury on 11/25/2019. Resident #4's care plan indicated the resident was to have 2 staff members to assist the resident with transfers. The facility policy Gait Belt dated 1/4/2019, indicated staff were to use a gait belt when transferring or moving residents. On 11/25/2019, CNA #2 transferred Resident #4 without a gait belt and without the assistance of 2 staff. The facility had identified in the investigation .policy not followed .care plan not followed . The facility PIP included to conduct ongoing audits of comprehensive care plans and CNA care plans, audits of signatures on CNA care plans, and incidents would be discussed in morning meetings with the monthly QAPI committee reviewing and recommending any further follow up. The PIP interventions were the same interventions on the submitted POCs that were to be implemented to sustain compliance. During a complaint survey conducted from 6/29/2020 - 7/1/2020, deficient practice was identified for the facility's failure to develop and implement care plans and failure to prevent avoidable accidents. Resident #4 sustained a shoulder fracture when CNA #2 transferred the resident from bed to a chair without use of a gait belt and without 2 person assistance, and Resident #7 receivied a laceration to the back of the head requiring 4 staples when the facility did not implement interventions to prevent avoidable accidents for a resident who was a high risk for falls. During an interview and review of residents' falls for the last 6 months on 6/30/2020 at 10:30 AM, the Administrator confirmed the QAPI committee met monthly. The Administrator confirmed the QAPI committee reviewed all care plans and accidents. The Administrator confirmed the 11/27/2019 PIP was not effective and a new PIP was not put in place. During an interview on 7/1/2020 at 11:15 AM, the Administrator confirmed the facility had experienced staff turnover and the QAPI plan needed to be reassessed. The Administrator stated falls had continued to increase and the QAPI plan for implementation of care plans to prevent accidents had not been effective. She stated the facility had planned to focus on nursing documentation and do a .deep dive . on falls. The facility had developed a PIP, but it had not been

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F 0867 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) implemented. The facility was in the process of hiring hospitality aides, although she acknowledged they would not be allowed to assist in direct patient care. Refer to F-655, F-656, and F-689