STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445368	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARRIMAN CARE & REHAB CENTER	**240 HANNAH ROAD HARRIMAN, TN 37748**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, medical record review, and interview, the facility failed to provide showers in accordance with the care plan for 1 resident (Resident #3) of 3 Residents reviewed for Activities of Daily Living (ADLs). The findings included: Review of the facility's policy titled Comprehensive Care Plans, last revised on 7/19/2018, showed .Care plan interventions are implemented after consideration of the resident's problem areas .interventions will reflect action, treatment or procedure to meet objectives toward achieving the resident goals . Review of the medical record showed Resident #3 was admitted to the facility on [DATE] for short term with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] showed Resident #3 scored a 13 (cognitively intact) on the Brief Interview for Mental Status and was independent in decision making and required assistance of one person for bathing. Review of the admission care plan dated 5/5/2020 showed Resident #3 was to be showered twice weekly (Tuesday and Friday) and as needed. Review of the ADL/Bathing log dated 5/1/2020 - 5/31/2020 showed no documentation Resident #3 was bathed from 5/8/2020 to 5/19/2020 (11 consecutive days). During an interview on 6/16/2020 at 2:00 PM, the Director of Nursing (DON) stated the facility failed to ensure Resident #3 was bathed twice weekly in accordance with the care plan between the period of 5/8/2020 and 5/19/2020. During a telephone interview on 6/19/2020, Family Member #1 stated when Resident #3 was discharged from the facility he had body odor, his hair was unkempt and oily, and he had skin irritation in the abdominal folds and groin. The family member stated the resident told her he had not been bathed in more than a week.

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.