STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445112	A. BUILDING _____ B. WING _____	**03/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TREVECCA CENTER FOR REHABILITATION AND HEALING LLC	**329 MURFREESBORO RD NASHVILLE, TN 37210**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview the facility failed to have a call light in reach for 2 (Resident #1 and Resident #6) of 7 residents observed. The findings include: Medical record review revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. Observation on 3/17/2020 at 1:30 PM and 1:56 PM revealed Resident #1's call light lying on the bed while Resident #1 was seated in a wheelchair. The call light was not in reach for Resident #1. Medical record review revealed Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Annual MDS dated [DATE] revealed Resident #6 had a BIMS score of 11 which indicated moderate cognitive impairment. Observation on 3/19/2020 at 1:23 PM revealed Resident #6's call light was wrapped around the left sided hand rail not in reach for the resident who was seated in the chair. During an observation and interview on 3/17/2020 at 2:02 PM with Licensed Practical Nurse (LPN) #1, confirmed Resident #1's call not in reach. Continued interview confirmed the call light should be closer to the resident to use. During an observation and interview on 3/19/2020 at 1:25 PM with the Unit Manager she confirmed the call light was not in reach and stated no ma'am it is not. During an interview on 3/19/2020 at 2:17 PM with the Director of Nursing (DON) stated the call light should be accessible to residents in their rooms at all times.
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 facility policy review, medical record review, facility investigation and interview the facility failed to protect 1 resident from physical abuse (Resident #5) of 7 residents reviewed for abuse. The findings include: Review of the facility policy Abuse, Neglect and Exploitation of Residents revealed .All personnel (including volunteers) in all departments will be alert to indicators of suspected or actual abuse, neglect and exploitation resident is assisted to safety and is protected against (further) harm, and if abuse is suspected, personnel will report their observations to their supervisor immediately and without delay. All individuals will be encouraged to report any signs of suspected abuse, neglect, and exploitation .The Abuse Prohibition Coordinator will coordinate all investigations while ensuring the residents safety, and will report findings to the regulatory agencies as required .It is the responsibility of all staff to identify inappropriate behaviors towards residents, which may include but is not limited to: use of derogatory language; rough handling or residents; ignoring residents while giving care; directing residents who need toileting assistance to urinate/defecate in their clothing, etc . Medical record review revealed Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum (MDS) data set [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated no cognitive impairment. Medical record review revealed Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Quarterly MDS dated [DATE] revealed Resident #5 had a BIMS score of 10 which indicated moderate cognitive deficit with impaired understanding and reasoning related to dementia. Medical record review of the care plan dated 9/2/2011 revealed Resident #5 was care planned for alteration in thought process, cognitive deficit and impaired understanding. Medical record review of the progress note dated 3/10/2020 revealed .Patient (Resident #4) had a belt in his hand, admitted to hitting roommate with belt. Roommate removed from room and Supervisor and Administrator notified immediately . Record review of the facility investigation dated 3/16/2020 confirmed Resident #5 was hit with a belt on [DATE]20 by Resident #4 in the room they shared together. Continued review revealed the facility moved Resident #4 to a different floor. Review of facility investigation of a written statement by CNA #1 dated [DATE]20 revealed .I was notified by my Charge Nurse that an incident had just occurred in room [ROOM NUMBER] as I was giving care in another resident's room. I had previously been in room [ROOM NUMBER] and took patient in B bed (named Resident #5) to the shower. Patient enjoyed the shower and thanked me for his care. I had also given the patient in A bed (named Resident #4) incontinent care and repositioned him approx (approximately) 30 minutes prior to incident . Review of facility investigation of a written statement from Registered Nurse (RN) #3 dated [DATE]20 revealed .At approximately 9:40 PM this writer was standing outside of room [ROOM NUMBER] and overheard resident in A bed (Resident #5) yelling stop after several loud snap noises. This write immediately went into room and saw resident in B bed (Resident #4) sitting on the side of his bed facing A bed with a belt doubled in his hand. This writer asked resident in B bed if he had hit or struck resident in A bed with his belt in hand and he replied Yes, I did. Resident in A bed verbalized that B bed resident had hit him with his belt but could not tell me where he had hit him or why. This writer immediately removed resident in A bed from the room and placed in hallway. Nursing Supervisor notified and Administrator notified. Nursing supervisor removed the belt from the room. No visible marks noted on resident that was allegedly struck. Resident is at baseline cognition. Resident denies any pain at this time. this writer was in room approximately 15 minutes prior to incident administering medications to both residents in A and B beds without incident . Review of facility investigation of a written note dated 3.10.2020 from the Director of Nursing (DON) revealed Resident (named resident #4) was counseled regarding notifying staff if there are any issues or concerns with his roommate at any time. Also physical contact such as hitting of other residents is prohibited in the facility. (named Resident #4) expressed understanding . During an interview on 3/19/2020 at 10:35 AM with Resident #4 confirmed Resident #5 called him a punk and had said it several times prior to him hitting Resident #5 with his belt. During an interview on 3/19/2020 at 10:43 AM with Certified Nurse Aide (CNA) #1 indicated on [DATE]20 she had given Resident #5 a bed bath and then left the room Resident #4 and Resident # 5 shared. Then 15 minutes later someone had told her Resident #4 hit Resident #5 with a belt. Continued interview revealed the staff had placed Resident #5 in the hall for protection. During interview with RN #2 on 3/19/2020 at 10:17 AM confirmed Resident #4 admitted to striking Resident #5 with a belt and that would be considered abuse. During interview with the Administrator on 3/19/2020 at 7:40 AM he stated what he gave the surveyor was the full investigation except for staff inservices. Continued interview he stated They did a poor job of documenting inservices on that floor.

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