STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Place at Maryville	2648 Sevierville Rd Maryville, TN 37804

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35198 Based on review of facility policy, medical record review, observation and interview, the facility failed to maintain dignity by not providing timely assistance with toileting for 1 resident (#89) and not providing incontinence care for 1 resident (#80) of 52 residents sampled. This failure resulted in psychosocial harm to Resident #89 and Resident #80. The findings include: Review of the facility Dignity Policy dated 1/1/17 revealed .Each resident shall be cared for in a manner that promote and enhances quality of life, dignity, respect and individuality .1. Residents shall be treated with dignity and respect at all times .11. Demeaning practices and standards of care that compromise dignity are prohibited . Medical record review revealed Resident #89 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Muscle Weakness. Medical record review of the Minimum Data Set (MDS) 14 day assessment dated [DATE] revealed Resident #89 had an indwelling catheter and was frequently incontinent of bowel. Medical record review of the unscheduled MDS assessment dated [DATE] revealed the Resident's Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. Continued review of the MDS revealed the resident required extensive 2 person assist for bed mobility, transfers, and toileting. Interview with Resident #89 on 8/14/18 at 9:47 AM in the resident's room, confirmed .They are real short on day shift. I have called out because I need the bed pan and they did not get to me for a while and I had an accident on myself. It made me feel shamed . Interview with the Director of Nursing (DON) on 8/20/18 at 3:11 PM in the conference room, confirmed .she [Resident #89] was not treated with respect and dignity . Medical record review revealed Resident #80 was admitted to the facility on [DATE] with diagnoses including Osteoarthritis, Malaise, Dysphagia, Contracture of Left and Right Knee, Muscle Weakness and Unspecified Abnormalities of Gait and Mobility. (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Medical record review of the significant change MDS dated [DATE] revealed the resident scored a 0 on the BIMS indicating the resident was severely cognitively impaired. Continued review revealed Resident #80 required 1 person assist for bed mobility, locomotion on unit, eating, toileting, dressing and hygiene. Continued review revealed the resident was always incontinent of urine and bowel and was not managed on a bowel and bladder incontinence program. Medical record review of the quarterly care plan, undated, revealed the resident was always incontinent . nursing to check every 2 hours and change if wet/soiled and clean skin with mild soap and water .apply moisture barrier . Continued review revealed Bowel Continence: incontinent of bowel movement .check for incontinence .every 2 hours .clean and dry skin if wet or soiled . Further review revealed Resident #80 required extensive assistance with bathing, hygiene, dressing and grooming with goal .will be odor free . Medical record review of the ADL (Activities of Daily Living) Verification Worksheet revealed Resident #80 was provided incontinence care on 8/13/18 at 12:54 AM with the next incontinence care documented on 8/13/18 at 6:40 PM at time lapse of 17 hours and 46 minutes. Observation of Resident #80 on 8/13/18 at 10:48 AM, in the 2 South dining room, revealed the resident with front of pants and perineal area wet. Observation of Resident #80 on 8/13/18 at 11:59 AM, in the dining room, revealed the resident with front of pants and perineal area wet and had a strong urine odor. Observation of Resident #80 on 8/13/18 at 4:03 PM, in the resident's room, revealed the resident sitting in a wheelchair in his room. Continued observation revealed Resident #80's pants and the bottom front of his shirt were wet and soiled with a brown and dark yellow ring at the bottom of the shirt and had a strong urine odor. Interview with Licensed Practical Nurse (LPN) #1 on 8/13/18 at 4:06 PM, in the resident's room, confirmed the resident's pants and shirt were wet with urine and he was in need of incontinence care. Continued interview revealed the last time resident had been provided incontinence care or toileted was unknown. Further interview confirmed the resident had a strong odor of urine. Interview with the DON on 8/15/18 at 3:50 PM, in the conference room, confirmed a resident wet with urine and with a strong odor of urine, sitting in the dining room area, could be offensive to other residents and could result in feelings of embarrassment for the resident. 39794

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39794 Based on review of facility policy, review of a facility statement, medical record review, observation, and interview, the facility failed to complete an interdisciplinary team (IDT) assessment for self-administration of medications by 1 resident (#131) of 8 residents reviewed during initial pool process, of 52 residents sampled. The findings include: Review of the facility Administering Medication Policy Statement, revised 12/12, revealed .25. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely . Review of facility policy Self-Administration of Medication dated 10/18/17 revealed .1. A resident will not self-administer his or her medications until a determination has been made by the interdisciplinary team that the resident can safely perform this task .2. The household Clinical Mentor, [nurseUnit Manager] at the request of the resident, will assess the resident to determine the resident's ability to self-administer his or her medications .findings of the assessment will be documented in the resident's clinical record . Review of a facility statement signed by the Administrator and dated 8/15/18, revealed There is no resident who self-administers medications. Medical record review revealed Resident #131 was admitted to the facility on [DATE] with diagnoses of Hypertension, Transient Cerebral Ischemic Attacks, and Anemia. Medical record review of the resident's care plan dated 5/15/18, revealed the resident was at risk for unstable blood pressure related to Hypertension, .Administer B/P [blood pressure] meds [medications] as ordered .at risk for altered tissue perfusion related to anticoagulant [blood thinner] therapy .Administer meds [Aspirin] at same time daily . Medical record review of a current physician's order dated 7/31/18, revealed the resident had orders for Aspirin 81mg (milligrams) daily, lactobacillus acidophilus (a probiotic) daily, Prilosec (for gastric reflux) 20 mg daily, and Sam-E (an over the counter supplement for arthritis) 400 mg daily. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #131 required 2 person assistance with bed mobility and 1 person assistance for transfers, dressing, toileting and personal hygiene. Continued review revealed a Brief Interview for Mental Status (BIMS) Score of 3, indicating severe cognitive impairment. Observation and interview with Resident #131 on 8/13/18 at 9:36 AM, in the resident's room, revealed a cup of pills sitting on the resident's over bed table. Interview with the resident revealed the resident requested to have the medications after breakfast. Further interview revealed the resident had not participated in a care plan meeting to determine if self-administration of medication was appropriate. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #1 on 8/13/18 at 9:47 AM, on the 2 South hall, confirmed LPN #1 left the medications on the over bed table .because resident likes to take her medication after she eats . Continued interview confirmed the medication was Prilosec, SamE, a baby aspirin, and a probiotic. Observation of the resident on 8/14/18 at 8:29 AM, in the resident's room, revealed a cup of pills sitting on the resident's over bed table. Interview with LPN #1 on 8/14/18 at 8:41 AM, on 2 South, revealed the resident had requested to take the medications after breakfast. Continued interview revealed LPN #1 was unaware if self-administration of medication was care planned for the resident, or if there was written documentation of an IDT assessment for the resident to self-administer medications. Interview with the Director of Nursing (DON) on 8/15/18 at 3:50 PM, in the conference room, confirmed no residents in the facility had been assessed for self-administration of medications. Continued interview confirmed medications were not to be left with residents for self-administration.

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F 0656 Level of Harm - Minimal harm or potential for 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** 35198 35200 39794 Based on medical record review, observation and interview, the facility failed to develop and implement a person-centered care plan to address the resident's need for assistive devices during meal times for 1 resident (#54) of 52 sampled residents. The findings include: Medical record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Dysphagia, Dementia, and Generalized Anxiety. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident required 1 person assistance with dressing and personal hygiene, and 2 person assistance with transfers and set up help for eating. Continued review revealed the resident was on a mechanically altered diet, had an identified weight loss, and had no oral or dental issues. Continued review revealed the resident scored 14 on the Brief Interview For Mental Status (BIMS), indicating he was cognitively intact. Medical record review of the quarterly Care Plan, undated, revealed .potential for weight loss .tremors of hands decrease his ability to self feed, dysphagia, swallowing difficulty .Staff to assist .when tremors are increased .Complete set-up and provide assistance with .eating . Continued review revealed at risk for Aspiration/Choking due to Dysphagia/Cough with intervention to .Assist .no straws .plate guard and weighted utensils with all meals . Medical record review of a clinical nurse's note dated 4/4/18 revealed .resident stated at lunch he couldn't feed himself, requested for staff to feed him . Observation of Resident #54 on 8/13/18 at 10:06 AM, in the resident's room, revealed the resident was eating a pureed breakfast provided in divided plate with no plate guard, had hand tremors and was noted to have food on clothing. Further observation revealed no weighted utensils in use. Observation of Resident #54 on 8/14/18 at 9:23 AM, in the resident's room, revealed the resident lying in bed, with the pureed breakfast meal provided in a divided plate with no plate guard, and regular eating utensils present. Continued observation revealed the resident had difficulty feeding himself due to the shakiness/tremors of the hands related to the disease process of Parkinson's. Observation of Resident #54 on 8/15/18 at 8:35 AM, in the resident's room, revealed his pureed breakfast was served in a regular plate, with regular eating utensils, and a bowl. Continued observation revealed the resident had obvious tremors of the upper extremities bilaterally. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #54 on 8/18/18 at 9:20 AM, in the resident's room, revealed the resident had breakfast food of pureed consistency on a regular plate with regular eating utensils, and nectar thick liquids. Continued observation revealed no plate guard and weighted utensils had been provided. Observation of Resident #54 on 8/20/18 at 9:15 AM, in the resident's room, revealed the resident had breakfast food pureed consistency in a divided plate and nectar thick liquids. Further observation revealed no plate guard or weighted utensils had been provided. Interview and observation with Resident #54 on 8/18/18 at 10:00 AM, in the resident's room, revealed the resident had never used weighted silverware and did not want to utilize. Continued interview revealed had used a plate guard and it made eating easier. Observation of resident revealed resident had a regular plate without a plate guard. Interview on 8/18/18 at 10:15 AM during the resident observation with Licensed Practical Nurse (LPN) #1 confirmed the facility had failed to provide Resident #54 with a divided plate, a plate guard, and weighted utensils to promote self-feeding at meal time.

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 35198 35200 38390 Based on review of facility policy, medical record review, review of facility documentation, observation, and interview, the facility failed to revise 7 residents' (#119, #28, #34, #39, #40, #47, and #80) care plans after falls with effective interventions to prevent further falls of 52 sampled residents, placing residents #119, #28, #34, #39, #40, #47, and #80 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The facility's failure is likely to place any resident at risk for falls in Immediate Jeopardy. The Administrator and the Director of Nursing (DON) were informed of the IJ in the conference room on 8/18/18 at 8:10 PM. The IJ was effective 11/10/17, and is ongoing. The findings include: Review of the facility policy Care Planning-Interdisciplinary Team dated 1/1/17 revealed .Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .which includes, but is not limited to the following personnel: a. The resident's Attending Physician; b. The Registered Nurse who has responsibility for the resident; c. The Dietary Manager/Dietician; d. The Social Services Worker responsible for the resident; e. The Activity Coordinator; f. Therapists (speech, occupational, recreational, etc.), as applicable; g. Consultants (as appropriate); h. The Director of Nursing (as applicable); i. The Charge Nurse responsible for resident care; j. Nursing Assistants responsible for the resident's care; and k. Others as appropriate or necessary to meet the needs of the resident .The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan .The mechanics of how the Interdisciplinary Team meets its responsibilities in the development of the interdisciplinary care plan .is at the discretion of the Care Planning Committee . Medical record review revealed Resident #119 was admitted to the facility on [DATE] with diagnoses including History of Falling, Dementia, Anxiety, Muscle Weakness, Abnormalities of Gait and Mobility, and Lack of Coordination. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of Resident #119's ongoing care plan revealed the resident was at risk for falls and interventions implemented included on 12/24/15: non-slick footwear that fits and assist with transfers as needed; instruct on safety measures to reduce the risk of falls (posture, changing positions, use of handrails); keep areas free of obstructions; keep personal items within easy reach; bed to be in lowest position with wheels locked; call light within reach when in room; invite/escort to activities of choice; instruct/remind to call for assist with mobility/transfers; use of proper assistive device wheelchair/walker. On 1/8/16 a sensor alarm in chair was added; on 2/5/16 a bed sensor was added; on 4/15/16 floor mat due to resident transfers self to from wheel chair was added; on 5/9/16 posey grip in wheelchair due to increased falls was added; 10/14/16 toileting as needed and Call Before You Fall signs was added; and on 5/30/17 anti-tip bars and anti-lock brakes to wheelchair was added. Medical record review revealed Resident #119 had 9 falls from 7/1/17 - 7/10/18 with dates of falls 7/1/17, 8/20/17 (resulting in a laceration to the forehead requiring sutures), 10/15/17, 11/10/17 (resulting in a bone fracture of the lower leg), 11/16/17, 11/19/17, 4/13/18 (resulting in a femur fracture), 6/27/18, and 7/10/18. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #119 required extensive assistance with bed mobility, transfers, dressing, personal hygiene, and was dependent for toileting. Continued review revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating severe cognitive impairment. Medical record review of the Care Plan dated 12/24/15 and revised 7/10/18 revealed the care plan was not revised with the interventions indicated by falls investigations including to toilet every 2 hours (10/15/17 fall), toilet more frequently and utilize bean bag (11/16/17 fall), and for Velcro noodles to mattress rail (7/10/18 fall). Interview with Nurse Mentor (nurse Unit Manager) #1 on 8/18/18 at 9:25 AM in the Mentor's office, confirmed .All of us are responsible to make sure the intervention is to be implemented [revised] on the care plan . Ultimately the mentor is responsible . Interview with the Director of Nursing (DON) on 8/18/18 at 10:36 AM in the conference room, confirmed the care plan had not been revised to include new interventions for toileting interventions (10/15/17 fall and 11/16/17 fall) and Velcro noodles to the mattress (7/10/18 fall) . Medical record review revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Dementia, Heart Disease, Previous Myocardial Infarction, Osteoporosis, Anemia, and Osteoarthritis. Medical record review of the quarterly MDS dated [DATE] revealed Resident #28 required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. Continued review revealed a BIMS score of 3, indicating severe cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of Resident #28's current care plan, not dated revealed, [Resident #28] is at risk for falls d/t [due to]: Decreased mobility, LT [left] hip fracture s/p [status post] ORIF [Open Reduction Internal Fixation], dementia . Actual Falls: 5/19/17, 6/17/17, 2/15/18 with FX [fracture] L [left] distal femur (resolve) Interventions: Assist [Resident #28] to wear non-slick footwear that fits. Attempt to engage [Resident #28] in ADL's [Activities of Daily Living] that improve strength, balance and posture. Instruct [Resident #28] on safety measures to reduce the risk of falls (posture, changing positions, use of handrails.) Keep areas free of obstructions to reduce the risk of falls or injury. Keep nurse call light within reach, Instruct [Resident #28] to use call bell or call out of assistance. Keep personal items within easy reach; bed to be in lowest position with wheels locked. Review of an Incident/Accident Report revealed Resident #28 had a fall on 2/15/18 at 9:45 AM, in the resident's room with injury. Continued review revealed, .Additional comments and/or steps taken to prevent recurrence: Ensure w/c [wheelchair] is within reach while in bed . Medical record review revealed the resident's care plan was not revised to include the intervention to keep the wheelchair within reach while the resident was in bed. Review of an Incident/Accident Report revealed Resident#28 had a fall on 6/7/18 at 2:00 PM in the dining room, CNA [Certified Nurse's Assistant] observed res. [resident] topple forward from her w/c to the floor. Res. remained alert. Skin tear noted to left forearm. Res. did hit her head on right forehead. No bruising @[at] this time . Additional comments and/or steps taken to prevent recurrence: Res. cautioned re: leaning forward in w/c . Medical record review of the resident's care plan revealed the resident's care plan was not revised to reflect the resident's fall on 6/7/18. Interview with Licensed Practical Nurse (LPN) #4 on 8/17/18 at 4:36 PM, in the secure unit, revealed the Household Nurse Mentor for each unit was responsible for updating a resident's care plan after a fall. Interview with Household Nurse Mentor #1 on 8/17/18 at 5:05 PM, in the secure unit nurse's office, revealed the Mentor was responsible for updating Resident #28's care plan with new fall interventions. Continued interview and review of the resident's care plan with the Nurse Mentor confirmed the resident's care plan had not been revised after the resident's fall on 2/15/18 to keep the resident's wheelchair within reach, and confirmed the facility failed to update the resident's care plan after the resident's fall on 6/7/18. Medical record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Major Depressive Disorder, Presence of Left Artificial Hip, Lumbago with Sciatica, Scoliosis, and Chronic Kidney Disease. Medical record review of the quarterly MDS dated [DATE] revealed Resident #34 required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. Continued review revealed a BIMS score of 3, indicating severe cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of Resident #34's current care plan, not dated, revealed, [Resident #34] is at risk for falls related to Decreased Mobility, Scoliosis, Narcotic and Psychotropic Medication Use . Continued review revealed the following interventions: .Assist with toileting as needed. Attempt to engage [Resident #34] in ADL's that improve strength, balance and posture. Fall risk assessment as indicated. Keep call light within reach and remind how to use as needed. Keep room free from clutter, walkways clear. Keep frequently used items within reach. Monitor medications for changes that may effect falls. Footwear will fit properly and have non-skid soles. Instruct [Resident #34 on safety measures to reduce the risk of falls (posture, changing positions, use of handrails) .Goals: Resident #34 will have no falls this review period . Review of an Incident/Accident Report revealed Resident #34 had a fall on 2/25/18 at 4:30 AM in the resident's room .Heard someone crying and found pt [patient] on the floor in her room. She states she was going to BR [bathroom] and fell . C/O [complain of] lt [left] hip pain. Skin tear to Lt elbow . Continued review revealed, Additional comments and/or steps taken to prevent recurrence: Call before you fall posted . Medical record review of the resident's care plan revealed Resident #34's care plan was not revised to reflect the resident's fall on 2/25/18 or the new intervention to post the call before you fall sign. Review of an Incident/Accident Report revealed the resident had a fall on 6/16/18 at 9:55 PM in the resident's room .I was told by CNA [Certified Nurse Assistant] that resident was on the floor in her room, went to assess resident, she had skin tear to lt. hand, bump on left side of head and was c/o lt hip pain . Further review revealed, .Additional comments and/or steps taken to prevent recurrence .Call before you fall, posey grip [rubberized mat for resident to sit on while in wheelchair to prevent sliding from chair] . Medical record review of Resident #34's care plan revealed the care plan was not revised to reflect the fall the resident had on 6/16/18 or the new intervention to add the posey grip to the wheelchair. Review of an Incident/Accident Report revealed the resident had a fall on 7/14/18 at 7:05 PM in the resident's room .Resident's roommate was calling for help [staff] and I went to the room and resident was on the floor in front of the sink and blood was pooled around her head . Further review revealed, .Additional comments and/or steps taken to prevent recurrence: Call before you fall. Encourage out of room more . Medical record review of Resident #34's care plan revealed the care plan was not revised to reflect the fall on 7/14/18 or the intervention to .encourage out of room more . Interview and review of the resident's care plan on 8/18/18 at 12:08 PM with the DON, in the conference room, revealed the Household Nurse Mentors on the units were responsible for ensuring revisions to the care plan were completed after a fall. Continued interview confirmed Resident #34's care plan had not been revised to reflect any of the resident's falls, and did not accurately reflect the fall interventions. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review revealed Resident #39 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction with Hemiplegia and Hemiparesis Left side, Contracture of Lower Extremity, Atrial Fibrillation, Dementia, and Pressure Ulcer. Medical record review of the quarterly MDS dated [DATE] revealed Resident #39 required extensive assistance with bed mobility and 1 person assistance for transfers, dressing, toileting and personal hygiene. Continued review revealed a BIMS score of 7, indicating severe cognitive impairment. Medical record review of Resident #39's care plan with a goal date of 6/10/18, revealed the resident was .at risk of falls d/t [due to] weakness, Left sided weakness s/p [status post] CVA [Cerebrovascular Accident], Dementia . Review of the facility documentation revealed the resident had a total of 9 falls between 4/3/18 and 8/11/18. Medical record review revealed Resident #39's care plan was updated to reflect 5 dates the resident had falls: 4/3/18, 4/15/18, 6/7/18, 6/27/18 (fall was actually 6/26/18 according to Icident/Accident Report) and 6/30/18. Continued review revealed the only times the resident's care plan was revised to reflect a new intervention after a fall were 6/7/17 - Call before you fall sign; 6/27/18 (for the 6/26/18 fall) - Pool noodles to bed; 6/30/18 - Frequent rounds; and 7/2/18 - Scoop mattress ordered. Interview with Household Nurse Mentor #2 on 8/15/18 at 7:40 AM, on the 400 unit confirmed the resident's care plan was not revised to reflect new or effective interventions to address Resident #39's continued falls. Interview with the DON on 8/16/18 at 9:30 AM, in the conference room confirmed the facility failed to revise the resident's care plan and failed to implement new or effective interventions to address the resident's continued falls. In summary, Resident #39 had 9 falls between 4/3/18-8/11/18. Interventions on the falls investigation were not consistently placed on the care plan. There were 6 falls with no intervention added to the care plan. Medical record review revealed Resident #40 was admitted to the facility on [DATE], with diagnoses including Dementia, Chronic Kidney Disease, Hypertension and a History of Falls. Medical record review of the admission MDS dated [DATE] revealed Resident #40 required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. Continued review revealed a BIMS score of 3, indicating severe cognitive impairment. Medical record review of Resident #40's care plan dated 5/23/18, revealed Resident #40 is at risk of falls due to weakness, History of Falls, Dementia and Hypertension. Interventions including wear non-slick footwear that fits; instruct the resident on safety measures to reduce risk of falls; attempt to engage in activities of daily living (ADL's) that improve strength; balance and posture, and keep areas free of obstacles to reduce the risk of falls or injury (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of facility documentation revealed the resident had a total of 4 falls between 6/27/18 and 8/2/18. Medical record review of Resident #40's care plan dated 8/6/18 revealed the care plan was not updated to reflect the resident had falls on the following dates: 6/27/18, 7/16/18, 7/30/18 and 8/2/18. Continued review revealed the resident's care plan was not revised to reflect new or effective interventions to address the resident's continued falls resulting in the resident sustaining a head injury. Observation and interview with LPN Nurse Mentor #2 on 8/17/18 at 10:00 AM, in the resident's room, confirmed the resident was in bed with the head of the bed up, fall mats to both sides of the bed were without alarms, and the call light was out of reach of the resident. Further observation revealed the Nurse Mentor took the Call Before You Fall sign off the closet door and asked the resident to read the sign. Continued observation revealed Resident #40 held the sign in her hand, smiled, and stated nice. The resident was not able to read the Call Before You Fall sign. Further interview confirmed .She doesn't use the call bell, she hollers for us . Continued interview confirmed the Call Before You Fall sign was not an appropriate intervention for Resident #40 and re-education on the use of a call light for a severely cognitively impaired resident was not an appropriate fall prevention intervention. Interview with the DON on 8/20/18 at 11:15 AM, in the conference room confirmed the resident had multiple falls without appropriate interventions put in place. In summary, Resident #40 had 4 falls between 6/27/18 and 8/2/18. Interventions on the falls investigation were not placed on the care plan. There were no new interventions added to the care plan after each fall. Medical record review revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including Dementia, Cerebral Vascular Accident, Schizoaffective Disorder, and Bipolar Disorder. Medical record review of the admission MDS dated [DATE] revealed Resident #47 required extensive assistance of I person with bed mobility, transfers, dressing, toileting and personal hygiene. Continued review revealed a BIMS score of 3, indicating severe cognitive impairment. Medical record review of Resident #47's comprehensive care plan with an effective date of 4/5/18 revealed, . at risk for falls d/t weakness, RT [related to] acetabular fracture [a break in the socket portion of the hip joint] s/p [status/post] fall, vision impairment, encephalopathy, dementia, anxiety, schizoaffective disorder, myasthenia gravis and psychotropic med use . Continued review of the care plan revealed, .Actual falls 4/9/18, 4/10/18, 4/11/18, 4/14/18, 4/23/18, 4/25/18, 4/26/18, 4/27/18, 5/6/18 .Goals .will maintain current level of mobility with no increase in the incidence of falls/injuries .Interventions .Assist .to wear non-slick footwear that fits .attempt to engage .in ADLs that improve strength, balance, and posture .instruct .on safety measures to reduce the risk of falls (posture, changing positions, use of handrails) .keep areas free of obstructions to reduce the risk of falls or injury .keep nurse call light within easy reach .Instruct .to use call bell or call out for assistance .keep personal items within easy reach; bed to be in lowest position with wheels locked .bean bag provided to reduce the risk of falls .self-releasing lap buddy to reduce the risk for falls with injury . Continued review revealed none of the interventions documented on the care plan had been dated to illustrate when the interventions were initiated and implemented. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an Incident/Accident Report dated 4/5/18 and timed 7:30 PM revealed Resident #47 .crawled from his room into [another room]. Multiple skin tears on bilateral elbows and L [left] knee bruise . Continued review revealed .Additional comments and/or steps taken to prevent recurrence: call before you fall, bed in low position Medical record review of Resident #47's care plan revealed the resident's care plan was not revised to reflect the resident's fall on 4/5/18 or the intervention to post call before you fall sign. Review of an Incident/Accident Report dated 4/9/18 and timed 10:30 PM revealed the resident had a fall in the resident's room without injury .called to resident room. CNA report that resident had been on floor mat by bed on knees . Further review revealed, .Additional comments and/or steps taken to prevent recurrence: call before you fall, increased rounds . Medical record review of Resident #47's care plan revealed the resident's care plan was not revised to reflect the new intervention of increased rounds. Review of an Incident/Accident Report dated 4/11/18 and timed 2:45 PM revealed, .sitting in wheelchair in day room with spouse. Leaned forward and slid out of chair. Landed on buttock . Continued review revealed, . Additional comments and/or steps to prevent recurrence: Informed spouse of need for full time sitter . Medical record review of Resident #47's care plan revealed no revision to the care plan to reflect the recommendation for the family to hire a sitter. Medical record review of a nurse note dated 4/25/18 revealed, .resident was transferred to floor [to another unit] .he has been getting out of his w/c since he arrived to floor, causing his personal alarm to go off, staff has been able to prevent resident from falling or scooting on the floor up to this point, he has wandered in the area between staff bathroom and med room and scooted himself out of his chair and onto the floor . transferred back to his chair after assessment for injury . Medical record review of the resident's care plan revealed the use of a personal emergency alarm for the resident was not included on the resident's care plan. Review of an Incident/Accident Report dated 4/25/18 and timed 11:30 PM revealed, .CNA notified this nurse that resident was lying in floor beside bed . Review of a Fall Investigation Tool dated 4/25/18 revealed, .intervention .fall mats . Medical record review of Resident #47's care plan revealed no revision to the care plan to reflect the use of fall mats for the resident. Review of an Incident/Accident Report dated 6/13/18 and timed 11:50 AM revealed, .called to room by PT [physical therapy] staff. Pt [patient] was already back in bed but was asleep on mat beside bed when physical therapy found him .he says 'I did not fall or get hurt' . Continued review revealed, .Additional comments and/or steps taken to prevent recurrence: offer rest periods, know whereabouts . (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of Resident #47's care plan revealed the care plan was not revised to reflect the fall on 6/13/18 and was not revised to reflect the interventions of offering rest periods and .know whereabouts . Observation and interview on 8/18/18 at 3:50 PM, in the resident's room, with CNA #17 revealed no call before you fall sign posted. Interview with CNA #17 confirmed fall mats were located on each side of the resident's bed (not on the resident's care plan). Continued interview revealed the CNA had never known the resident to have had any alarms or seatbelts since the time the resident was moved to the secure unit (approximately 2 months ago). Continued observation in the resident's room also revealed no bean bag chair was in the resident's room as documented on the resident's care plan. Interview and review of Resident #47's care plan with the DON on 8/20/18 at 3:45 PM, in the conference room, revealed the Household Nurse Mentor was responsible for ensuring revisions to the resident's care plan after a fall. Continued interview and review of Resident #47's care plan confirmed the resident's care plan was not revised to reflect the fall on 6/13/18 or the interventions of offering rest periods and .know whereabouts . Continued interview confirmed the resident's current plan of care did not accurately reflect the actual interventions which were observed to be in place at this time. Medical record review revealed Resident #80 was admitted on [DATE] with diagnoses including Dysphagia, Contracture of Left and Right Knee, Muscle Weakness and Unspecified Abnormalities of Gait and Mobility. Medical record review of the significant change MDS dated [DATE] revealed Resident #80 required extensive assistance with bed mobility and personal hygiene, and was totally dependent upon staff for dressing, eating and personal hygiene. Continued review revealed a BIMS score of 3, indicating severe cognitive impairment. Medical record review of the quarterly care plan undated revealed Resident #80 was at risk for falls. Further review revealed Resident #80's care plan was not updated with effective interventions after falls on 3/1/18, 4/20/18 and 6/19/18 nor after a fall with serious injury on 7/2/18. Medical record review of the clinical notes dated 7/2/18 revealed .returned from [hospital] .C1[cervical]-C2 Fx [Fracture] and Aspen [Rigid neck brace] collar placed around residents neck, collar is to stay in place for 3 months .laceration to forehead with stitches .will continue to monitor . Interview with MDS Coordinator #3 on 8/17/18 at 7:55 AM, in the MDS office, revealed the MDS coordinators updated the care plans quarterly with the MDS assessments. Continued interview revealed the care plans were updated all other times by the nurses on the floor. Interview with LPN #1 on 8/18/18 at 3:00 PM, on 2 South Hallway, revealed interventions were to be placed on the care plan and updated by the .care plan manager . Refer to F689 39794 40640 (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	40639 40606

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F 0677 Level of Harm - 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** 39794 Based on medical record review, observation and interview, the facility failed to provide assistance with activities of daily living for dependent residents by failure to provide bathing assistance for 1 resident (#53), and failure to provide timely incontinence care and toileting for 2 residents (#80 and #89) of 52 residents sampled. This failure resulted in Harm for Resident #80 and Resident #89. The findings include: Medical record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses including Acute Kidney Failure, Chronic Pain Syndrome, Generalized Anxiety Disorder, Atrial Fibrillation, and Diabetes. Review of the quarterly care plan updated on 5/30/18 revealed self-care deficit .Extensive assistance required with bathing .Scheduled shower days: Tuesday and Friday AM .2 Times Weekly Starting 06/23/2016 .Staff to ask [Resident #53] Every other day if she would like a bath .Active (Current) . Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Continued review revealed the resident required 2 person assistance with bed mobility and toileting and 1 person assistance with dressing, hygiene, and bathing. Medical record review of the Activities of Daily Living (ADL) Verification Worksheet revealed from 7/10/18 through 7/18/18, revealed Resident #53 received 1 shower. Interview with Resident #53 on 8/13/18 at 11:08 AM, in the resident's room, revealed the resident did not receive a shower .last week at all not Tuesday or Friday they told me they were short staffed .it has happened before .not enough of them . Continued interview revealed .I was supposed to get a shower twice a week . Interview with Certified Nursing Assistant (CNA) #3 on 8/15/18 at 9:25 AM, in the 2 South Dining room, revealed the facility did not always have enough help to take care of the residents. Further interview revealed there have been times residents have not received showers and missed a shower day that resulted in the residents receiving only 1 shower per week .Our Kiosk that we document in does not differentiate in partial showers, bed baths, showers or whatever it just says bathing and we mark that no matter what we do but that does not mean that a .shower is done .but it looks like it . Interview with Household CNA Coordinator #1 (a CNA also) on 8/15/18 at 9:40 AM, in the 2 south dining room revealed there are .call offs and have lost some employees and do not always have enough staff to take care of the residents about 2-3 days out of the week . Further interview revealed there had been times the residents had not received showers because of staffing . Interview with CNA #4 on 8/15/18 at 9:56 AM, in the 2 south dining room, confirmed .not always enough staff to meet the needs of the residents .it upsets me .we are understaffed, I can't do my job the way I would like . Continued interview revealed .It's that way almost every day just 2 of us . (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Interview with LPN #2 on 8/15/18 at 10:05 AM, in the 2 south den area, revealed there was not always enough staff to meet the needs of the residents .like today the person I was working with put her notice in so there is only 1 nurse, the weekends there are not enough CNA's, last Sunday there was only 1 nurse and 2 CNA's .there have been times the residents have not received a shower due to staffing . Interview with LPN #1 on 8/18/18 at 9:12 AM, on the 2 south hallway, confirmed there .is never enough staff . recently had a set back with a CNA getting fired, a nurse quit, a CNA quit .they haven't been replaced .I have reported to the Director of Nursing (DON) and the Administrator . Medical record review revealed Resident #89 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Muscle Weakness. Medical record review of the MDS 14 day assessment dated [DATE] revealed Resident #89 had an indwelling catheter and was frequently incontinent of bowel. Medical record review of the unscheduled MDS assessment dated [DATE] revealed the Resident # 89's BIMS score was 15, indicating the resident was cognitively intact. Continued review of the MDS revealed the resident was extensive 2 person assist for bed mobility, transfers, and toileting. Interview with Resident #89 on 8/14/18 at 9:47 AM in the resident's room, confirmed .They are real short on day shift. I have called out because I need the bed pan and they did not get to me for a while and I had an accident on myself. It made me feel shamed . Interview with the DON on 8/20/18 at 3:11 PM in the conference room, confirmed .she [Resident #89] was not treated with respect and dignity . Medical record review revealed Resident #80 was admitted to the facility on [DATE] with diagnoses including Osteoarthritis, Malaise, Dysphagia, Contracture of Left and Right Knee, Muscle Weakness and Unspecified Abnormalities of Gait and Mobility. Medical record review of the significant change MDS dated [DATE] revealed the resident was moderately cognitively impaired. Continued review revealed Resident #80 required 1 person assist for bed mobility, locomotion on unit, eating, toileting, dressing and hygiene. Continued review revealed Resident #80 was always incontinent of urine and bowel and was not managed on a bowel and bladder incontinence program. Medical record review of the quarterly care plan, undated, revealed the resident was always incontinent . nursing to check every 2 hours and change if wet/soiled and clean skin with mild soap and water .apply moisture barrier . Continued review revealed Bowel Continence: incontinent of bowel movement .check for incontinence .every 2 hours .clean and dry skin if wet or soiled . Further review revealed a self-care deficit with extensive assistance required with bathing, hygiene, dressing and grooming with goal .will be odor free . Medical record review of the ADL (Activities of Daily Living) Verification Worksheet revealed Resident #80 was provided incontinence care on 8/13/18 at 12:54 AM with the next incontinence care documented on 8/13/18 at 6:40 PM at time lapse of 17 hours and 46 minutes. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Observation of Resident #80 on 8/13/18 at 10:48 AM, in the 2 South dining room, revealed the resident with front of pants and around perineal area wet. Observation of Resident #80 on 8/13/18 at 11:59 AM, in the dining room, revealed the resident with front of pants and around perineal area wet and had a strong urine odor. Observation of Resident #80 on 8/13/18 at 4:03 PM, in the resident's room, revealed the resident sitting in a wheelchair in his room. Continued observation revealed Resident #80's pants and the bottom front of his shirt were wet and soiled with a brown and dark yellow ring at the bottom of the shirt and had a strong urine odor. Interview with LPN #1 on 8/13/18 at 4:06 PM, in the resident's room, confirmed the resident's pants and shirt were wet with urine and he was in need of incontinence care. Continued interview revealed the last time resident had been provided incontinence care or toileted was unknown. Further interview confirmed the resident had a strong odor of urine. Interview with the DON on 8/15/18 at 3:50 PM, in the conference room, confirmed a resident wet with urine and with a strong odor of urine, sitting in the dining room area, could be offensive to other residents and could result in feelings of embarrassment for the resident.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35198 35200 38390 Based on facility policy review, medical record review, observation and interview, the facility failed to prevent the development of a pressure ulcer for 1 resident (#80) wearing a medical device of 5 residents reviewed for pressure ulcers and failed to practice proper infection control prevention through hand hygiene during a dressing change for 1 resident (#119) of 2 persons observed for dressing changes of 52 residents sampled. The facility's failure resulted in the development of a pressure ulcer and Harm for Resident #80. The findings include: Review of the facility policy, Pressure Ulcers dated 5/1/11 revealed .To provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care .All wounds, regardless of cause will be evaluated with documentation at each dressing change. A thorough wound evaluation will be completed at least weekly .Documentation will contain information regarding: Location and Staging .Size .Exudate .Pain . Wound bed .Description of wound edges .All pressure ulcers must be monitored daily .For pressure ulcers that do not have daily .dressing change ordered, the TAR [treatment record] should reflect daily monitoring . An interdisciplinary team will perform weekly wound rounds to observe and measure all pressure ulcers in the facility. Documentation of findings will be kept on the Weekly Pressure Ulcer Record .Skin/Wound Care Protocols .Relieve pressure in and out of bed . Review of the facility policy, Pressure Ulcer Prevention dated 6/2013 revealed .To assure that no pressure ulcers develop within the facility unless it is unavoidable . Review of the facility Skin Assessments/Checks Policy revised 7/24/18, revealed .A skin assessment will be conducted by the nurse on a weekly basis. Documentation will include any and all skin issues noted .Skin assessments will be done by nursing assistants on bath/shower days. Any skin issues noted will be reported to the resident's nurse . Review of the facility policy, Pressure Ulcer Treatment, revised 7/18, revealed .If a resident is noted to have a pressure ulcer the nurse in charge of the resident's care should be notified. The nurse should notify the Wound Nurse and Physician .Follow standing orders for pressure ulcers including writing the order as 'per treatment guidelines' .these guidelines have been approved by the Medical Director .The Wound Nurse will evaluate the initial treatment based off the standing orders on their next working day to determine if any changes need to be made based on the condition of the ulcer . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy, Infection Control: Handwashing dated 1/1/17 revealed .All personnel will follow the handwashing procedure to prevent the spread of infection and disease .Employees will perform appropriate handwashing procedures using antimicrobial or non-antimicrobial soap and water under the following conditions .Before, during and after performance of normal duties such as handling dressings . Whenever doubt of contamination .Using gloves does not replace handwashing/hand hygiene . Medical record review revealed Resident #80 was admitted to the facility on [DATE] with diagnoses including Dysphagia, Contracture of Left and Right Knee, and Muscle Weakness. Medical record review of the Significant Change MDS dated [DATE] revealed the resident had moderate impaired cognitive skills for daily decision making. Continued review revealed the resident required assistance of 1 person for bed mobility, locomotion on unit, eating, toileting, dressing, hygiene, and 2 person assistance for transfers. Medical record review of the Clinical Note dated 7/2/18, at 10:19 AM, revealed the resident suffered a fall from the bed at approximately 9:10 AM, and was sent to the emergency room for evaluation. Medical record review of the Clinical Note dated 7/2/18 at 8:30 PM, revealed the resident returned from the emergency room at 8:10 PM, with the diagnosis of Cervical (C)1-C2 fracture and Aspen collar (a medical device to stabilize the neck/cervical region) placed around the resident's neck. Continued review revealed the collar was to stay in place for 3 months then have a follow-up with x-rays to monitor progress. Continued review revealed the resident was also sent with a collar for bathing. Medical record review of the Weekly Skin Assessment Form dated 7/27/18 revealed .Open area to Rt. [right] Clavicle. Medical record review of the Clinical Note dated 7/28/18 at 8:24 AM, revealed on 7/27/18 at 9:21 PM, an open area described as a skin tear was discovered on the resident's right clavicle measuring 3 centimeters (cm) in length by 0.8 cm in width. Medical record review of the Physician's Order and progress notes dated 7/30/18 revealed .Consult wound care team for evaluation and treatment of skin around/beneath C-Collar . Medical record review of the Clinical Note dated 8/2/18 at 7:29 AM, revealed the resident was evaluated by the Wound Nurse Practitioner (NP). Continued review revealed the wound to the resident's right clavicle measured 3.2 cm by 2.6 cm by 0.2 cm. Continued review revealed the NP described the wound as unstageable at this time and facility acquired pressure ulcer, medical device related injury. Medical record review of the Physician's Order and progress notes dated 8/2/18 revealed .refer to [neuro surgeon] for cervical fracture follow up .Please D/C [discontinue] Hard C-collar .Place patient in soft cervical collar .D/C current wound treatment .Hydrofera Blue .R [right] cervical wound .change every 3 days and PRN [as needed] . Medical record review of the Clinical Note dated 8/7/18, revealed the wound to the right clavicle was evaluated by the NP and measured 2.3 cm by 1.1 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan undated, conducted on 8/14/18 revealed no documentation or update that included C1-C2 fractures, care and use of the cervical collar, pressure ulcer development and specific treatment or interventions. Observation of the resident on 8/14/18 at 5:17 PM, in the resident's room, revealed the resident received wound care to unstageable right clavicle wound provided by Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1. Continued observation revealed the soiled dressing to right clavicle was removed and contained a moderate amount of yellowish-brown drainage on the dressing, and the wound bed was covered with slough which indicated an unstageable wound. Interview with the Director of Nursing (DON) on 8/16/18 at 9:05 AM, in the conference room, confirmed the expectation was a daily skin assessment to be conducted on residents who wore a splint, or a Cervical Collar. Interview with Licensed Practical Nurse (LPN) #2 on 8/16/18 at 9:30 AM, on 2 South Hallway, revealed skin assessments were conducted by nursing staff weekly. Continued interview revealed the CNAs (Certified Nursing Assistant) reported skin issues that were observed during bathing or care. Further interview revealed residents who wore splints or cervical collars should have had skin checked weekly and when bathed. Interview with CNA #4 on 8/16/18 at 2:21 PM, in the 2 South living room area, revealed CNAs were not allowed to remove the C-Collar. Continued interview revealed the nurse changed the soft collar out with one used on bath days. Further interview revealed the C-collar had not been removed except for bath days. Interview with CNA Household Coordinator #1 on 8/16/18 at 2:23 PM, in the 2 South living area, revealed CNAs did not remove cervical collars. Continued interview revealed the nurse changed the cervical collar for shower days. Interview with CNA #3 on 8/16/18 at 2:42 PM, in the 2 South living room area, revealed the C-collars were exchanged for showers and that was the only time the C-collar was removed. Interview with the wound NP on 8/17/18 at 5:10 PM, in the conference room, revealed the wound to right clavicle was a preventable, avoidable, medical device induced pressure ulcer. Medical record review revealed Resident #119 was admitted to the facility on [DATE] with diagnoses including History of Falling, Dementia, Anxiety, Muscle Weakness, Abnormalities of Gait and Mobility, and Lack of Coordination. Observation with the Wound Care Nurse on 8/15/18 at 8:14 AM, in Resident #119's room, revealed the Wound Care Nurse prepared for wound care for 2 pressure ulcers and 1 lesion: *Stage 2 pressure ulcer located on the right heel *Lesion on the left foot *Stage 2 pressure ulcer located on the L ischial (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Continued observation revealed the Wound Care Nurse washed her hands, applied clean gloves, removed sock from the right heel, applied wound cleanser and applied betadine to pressure ulcer. Continued observation revealed she reapplied sock to the right foot and removed sock from left and applied wound cleaner to the left foot lesion with her contaminated glove. Further observation revealed she placed her gloved contaminated fifth digit of her hand in triad cream and placed it on the left foot lesion. Continued observation revealed the Wound Care Nurse reapplied the resident's left sock and repositioned the resident's pants to reveal the left ischium pressure ulcer. Further observation revealed she removed the dressing with her contaminated gloved hands then removed the contaminated gloves. Continued observation revealed she applied clean gloves to her uncleaned hands. Further observation revealed she measured the left ischium pressure ulcer with her contaminated gloves, applied wound cleanser to the pressure ulcer, placed the Hydrofera Blue directly on the wound, and applied a new dressing with unclean hands. Continued observation revealed she placed the contaminated items in the bag, removed her contaminated gloves and washed her hands. Interview with the Wound Care Nurse on 8/15/18 at 8:25 AM in the conference room, confirmed, .I failed to remove my gloves and wash hands during the dressing change .I applied treatment with dirty gloves . Interview with the Director of Nursing (DON) on 8/16/18 at 9:52 AM in the conference room confirmed .She failed to wash her hands and apply clean gloves during the dressing change. She [Wound Care Nurse] did not follow infection control practices and did not follow our policy . 39794

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 35198 Based on facility policy review, medical record review, interview, facility investigation review, and observation, the facility failed to implement an effective fall prevention program for 7 residents (#119, #40, #39, #80, #28, #34, #47) of 7 residents reviewed for falls with injuries, of 40 residents in the facility with falls. The facility's failure to implement new interventions and have an effective falls prevention program resulted in injuries for 6 Residents (#119, #40, #80, #28, #34, and #47) and placed Residents (#119, #40, #39, #80, #28, #34, #47) in Immediate Jeopardy (a situation in which the provider's noncompliance has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator and the Director of Nursing (DON) were informed of the Immediate Jeopardy on 8/18/18 at 8:20 PM, in the conference room. The Immediate Jeopardy (IJ) was effective 11/10/17 and is ongoing. The facility was cited F689 at a scope and severity of K, which constitutes Substandard Quality of Care (SQC). The findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility policy Falls-Clinical Protocol-Assessment and Recognition, last revised 9/12, revealed .5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observation of the events, etc. 6. Falls should be categorized as: a. Those that occur while trying to rise from a sitting or lying to an upright position; b. Those that occur while upright and attempting to ambulate; and c. Other circumstances such as sliding out of a chair or rolling from a low bed to the floor. 7. Falls should also be identified as witnessed or unwitnessed events. Cause Identification- 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. a. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke. b. Often, factors in varying degrees contribute to a falling problem . Treatment/Management - 1.Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance) .The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. b. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented. 3. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention (for example, dizziness or musculoskeletal pain) has resolved. 4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will reevaluate the continued relevance of current interventions. 5. As needed, the physician will document the presence of uncorrectable risk factors, including reasons why any additional search for causes is unlikely to be helpful . Review of facility policy, Accident and Incident Report-Resident, dated 1/1/17 revealed .When an accident or incident involving a resident occurs, any person witnessing the incident will call for appropriate assistance . To assure appropriate follow-through on all accidents and incidents. To study the cause of accident and incidents and to give guidance for corrective/preventive action .Do not move the resident until a licensed nurse evaluates the condition . Medical record review revealed resident #119 was admitted to the facility on [DATE] with diagnoses including History of Falling, Dementia, Anxiety, Muscle Weakness, Abnormalities of Gait and Mobility, and Lack of Coordination. Medical record review of a Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #119's Brief Interview for Mental Status (BIMS) score was 0, indicating the resident had severe cognitive impairment. Continued review of the MDS revealed the resident was extensive 2 person assist for bed mobility, transfers, and toilet use and was frequently incontinent of urine. Review of facility documentation revealed Resident #119 had 9 falls between 7/9/17 to 7/10/18 and 2 falls resulted in traumatic injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of Resident #119's ongoing care plan revealed the resident was at risk for falls and interventions implemented included on 12/24/15: non-slick footwear that fits and assist with transfers as needed; instruct on safety measures to reduce the risk of falls (posture, changing positions, use of handrails); keep areas free of obstructions; keep personal items within easy reach; bed to be in lowest position with wheels locked; call light within reach when in room; invite/escort to activities of choice; instruct/remind to call for assist with mobility/transfers; use of proper assistive device wheelchair/walker. On 1/8/16 a sensor alarm in chair was added; on 2/5/16 a bed sensor was added; on 4/15/16 floor mat due to resident transfers self to from wheel chair was added; on 5/9/16 posey grip in wheelchair due to increased falls was added; 10/14/16 toileting as needed and Call Before You Fall signs was added; and on 5/30/17 anti-tip bars and anti-lock brakes to wheelchair was added. Medical record review of a Clinical Notes Report dated 7/1/17 at 10:16 PM, revealed, .res [resident] alarm heard sounding at same time of a loud crash .res in bathroom, on the floor, wheelchair by sink. Brakes on wheelchair not on .no injuries .Will continue to monitor closely and respond to alarms . Interview with the DON on 8/17/18 at 10:25 AM, in the conference room, confirmed an investigation was not conducted for the fall on 7/1/17 in order to determine the cause of the fall and to implement interventions to prevent further falls. Medical record review of a Falls Risk assessment dated [DATE] revealed Resident #119 scored a 22 (high risk for potential falls). Review of a facility Incident/Accident Report dated 8/20/17 revealed on 8/20/17 at 5:00 PM the resident had a fall. Further review revealed .Resident observed lying in hallway in front of her w/c [wheelchair]. Lying with face down and toward right side. Laceration to right forehead, scratch on right cheek .Additional comments and/or steps taken to prevent recurrence: Will ask PT [physical therapy] eval [evaluation] for cushion . Review of a Written Statement for the accident on 8/20/17 revealed, I just sat [Resident #119] back in her chair, she had been leaning forward. I sat down at kiosk by kitchen to chart my vitals. I also noticed before incident she was dragging rt [right] foot under chair. I told her several times from 3 - 4:30 pm to slow down and sit back in her chair so she wouldn't fall [Resident #119 had severe cognitive impairment]. As I started charting .another CNA [Certified Nursing Assistant] said oh no, I turned to see [Resident #119] w/c rolling over her, she was on the floor, the w/c flipped . Review of a Written Statement for the accident on 8/20/17 revealed, This nurse was notified that resident had fallen out of her w/c in hallway. Observed lying on the floor in front of her w/c [wheelchair] .Was lying with face down on floor and toward her right side large amt [amount] of blood from laceration on right forehead . Medical record review of a physician's order dated 8/20/17 at 5:15 PM revealed an order to send Resident #119 to the emergency room (ER) for evaluation. Medical record review of a Clinical Notes Report dated 8/20/17 at 11:13 PM, revealed, .Resident has stitches in right forehead . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Interdisciplinary Team Review for the accident on 8/20/17, revealed, Interventions implemented was not completed and Probable Cause was leaning forward in w/c. Request eval for cushion . Interview with the Clinical Therapy Manager on 8/17/18 at 3:55 PM, in the therapy room, confirmed .She [Resident #119] was not evaluated for wheelchair seating and positioning after 8/20/17 .No recommendations were done, there was no eval . Medical record review of a Significant Change in Status MDS assessment dated [DATE] revealed the resident's BIMS was 0 and was occasionally incontinent of urine. Medical record review of a Falls Risk assessment dated [DATE] revealed Resident #119 scored a 23 (high risk for falls). Medical record review of a Clinical Notes Report dated 10/15/17 at 11:16 PM revealed, This nurse was informed that resident was sitting in the floor in the bathroom .Resident sitting beside commode trying to get self up. States that she slid off the commode after she went to the bathroom. No injuries found .Resident reminded by staff and family to please ask for assist when needing to go to the bathroom [Resident had severe cognitive impairment] . Review of an Incident/Accident Report dated 10/15/17 revealed the actual time of the fall was 5:15 PM. Review of the CNA's Written Statement revealed I was getting [another resident] up for supper. I heard [Resident #119] calling HELP ME. I found her on floor in .bathroom. She was trying to get in her w/c and slid into floor . Further review revealed, .steps taken to prevent recurrence: try to keep resident in sight of staff to help her go to BR [bathroom] . Review of the Interdisciplinary Team Review for the fall on 10/15/17 revealed Interventions implemented was to toilet the resident at least every 2 hours (an expected nursing intervention) and the Probable Cause was Toileting self et [and] fell . Medical record review of a Clinical Notes Report dated 11/10/17 at 8:53 AM revealed, 0805 [8:05 AM] Notified by CNA that chair alarm was activated and she entered room and observed resident sitting in the floor in the bathroom. Resident was attempting to pull herself up from a sitting position. CNA assisted resident into w/c and then notified this nurse. This nurse observed resident and noted to have deformity to right lower extremity . Further review revealed at 1:35 PM, .diagnosis of right tibia/fibula [lower leg bones] fracture . Review of the Incident/Accident Report for the accident on 11/10/17 revealed the steps taken to prevent recurrence was not completed. Continued review of a Written Statement by the CNA revealed The alarm was going off on the chair in [Resident #119] room and she was in the bathroom trying to get up hanging on the rail and on the floor and her right leg was around bottom of the toilet between the wall. She was hanging so help transfer her to the wheelchair and let the nurse know . Medical record review of ER (Emergency) Trauma Worksheet dated 11/10/17 revealed .unwitnessed fall .fell this morning out of her wheelchair while attempting to stand .Granddaughter states this happens quite frequently at patients nursing home and has resulted in several injuries in the past .Patient complains of right lower leg pain . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Investigation Tool for the accident on 11/10/17 revealed for the Interdisciplinary Team Review, Interventions implemented was not completed and Probable Cause: Res transferring self. No safety awareness. Medical record review of the acute care Hospital Discharge Summary dated 11/14/17 revealed .Right tib-fib [tibia-fibula] fracture following a fall .suffered a fall at [facility] and sustained a right tib-fib fracture .cast was applied . Interview with Licensed Practical Nurse (LPN) #3 on 8/16/18 at 3:00 PM, in the 1 North nurses station, revealed .[on 11/10/17] CNA assisted her to the wheelchair .then came to get me .when I went in there observed a clear deformity to right lower leg .the CNA was not supposed to move her . Interview with the DON on 8/16/18 at 9:52 AM, in the conference room confirmed it did not appear an intervention to prevent falls was put in place after the fall on 11/10/17. Medical record review of a Clinical Notes Report dated 11/16/17 at 10:30 AM revealed, CNAs report that chair alarm was activated and staff went to investigate alarm and observed [Resident #119] sitting in the bathroom .This nurse entered room and observed resident sitting in the floor beside the toilet with both legs stretched out in front of her. No apparent injuries .Resident had an incontinence episode of stool and was assisted on toilet. Resident transferred to sunroom and seated in bean bag chair . Review of an Incident/Accident Report dated 11/16/17 revealed the steps taken to prevent recurrence: Res had just been toileted @ [at] 9:30 [fall occurred at 10:30]. Will ask res more freq [frequently] if toilet needs. Bean bag utilized as well . Review of a CNA's Written Statement for the accident on 11/16/17 revealed, Chair alarm was going off . [Resident #119] was trying to get on the toilet alone . Review of the Interdisciplinary Team Review for the accident on 11/16/17 revealed, Interventions implemented: Toilet more freq. Utilize bean bag. Probable Cause: apparently attempting to toilet self. Medical record review of a Clinical Note Entry dated 11/19/17 at 12:45 PM revealed, .Observed resident sitting in the floor next to the bed with bilateral legs outstretched in front of her. W/C was also next to the bed and alarm had activated. When resident was asked what she was doing, she places her hands on her hand and states 'I don't know' .no apparent injuries .Daughter states that during a visit this week her mother told her she needed to go to the bathroom, and before she could get help, her mother was attempting to go to the bathroom unassisted . Review of a CNA's Written Statement for the accident on 11/19/17 revealed, Light was going off in [Resident #119] room and when I went in she was on the floor beside her bed. Review of the Incident/Accident Report for the accident on 11/19/17 revealed .steps taken to prevent recurrence .therapy picked her up . Review of the Interdisciplinary Team Review for the accident on 11/19/17 revealed no documentation a review was conducted, no interventions were implemented, and a probable cause was not indicated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of Resident #119's ongoing care plan revealed an intervention on 11/24/17 of self-releasing safety belt in the wheelchair. Medical record review of a quarterly MDS assessment dated [DATE] revealed Resident #119's BIMS was 0 and the resident was frequently incontinent of urine. Medical record review of a Clinical Notes Report dated 4/13/18 at 2:36 PM revealed 1400 [2:00 PM] Called to sunroom by CNA. CNA reports walking into dining room and observing resident laying in the floor in the sunroom. Reports that resident was previously sitting at the dining room table for meal. Upon assessment, observed resident laying on her left side in front of her w/c which was left in the sunroom during meal . Resident crying and yelling out in pain .resident does grab at her left hip and leg . Review of a Clinical Notes Report dated 4/13/18 at 11:42 PM revealed, .resident was admitted to [hospital] with a Lt. [left] femur fx. Medical record review of an acute care hospital Surgical Consultation Note dated 4/13/18 revealed .female who has profound dementia fell today injuring her left hip. X-rays in the emergency room reveal comminuted angulated intertrochanteric fracture of the left hip . Review of the Incident/Accident Report for the accident on 4/13/18 revealed the .steps taken to prevent recurrence was not completed. Review of the Investigation Tool revealed under Devices .Ordered sensor, alarm in place it was written N/A (not applicable). Under Interventions, (indicating interventions that were to be in place at the time of the fall) was a self-releasing seat belt, mats, pressure sensor alarm, nonskid socks, low bed, and night light. Review of the Interdisciplinary Team Review for the accident on 4/13/18 revealed no documentation a review was conducted, no interventions were implemented, and a probable cause was not indicated. Medical record review of the acute care hospital Discharge Summary dated 4/16/18 revealed .Left proximal femur fracture postop [postoperative] 4/15 [4/15/18] ORIF [open reduction internal fixation] . Interview with LPN #3 on 8/16/18 at 3:08 PM, in the 1 north nurses station, revealed .[on 4/16/18] After lunch saw her sitting at one of the dining room tables .was in a regular chair .wheelchair was in the sunroom .was attempting to ambulate to her wheelchair .I assessed her .Complain of pain left hip area .Was grabbing and grimacing Left hip/leg area . Medical record review of Resident #119's ongoing care plan revealed an intervention on 4/19/18 of Lap Buddy (cushion placed across the lap and hooks under arms of wheel chair) while in wheel chair and on 4/21/18 sensor alarm to wheel chair (an intervention that was to be in place since 1/8/16). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of a Clinical Notes Report dated 4/19/18 at 6:00 PM revealed, Interdisciplinary Meeting held this day, in attendance: [3 family members], Administrator, Medical Director, DON, Therapy Manager, Clinical Mentor, and Social Worker. Resident family concerned regarding resident numerous falls . remain concerned with number of falls that have occurred. Family understands that resident has a dx [diagnosis] of Dementia, which is advancing. Resident has no safety awareness due to her cognitive deficits. Current interventions reviewed and will remain, with the addition of a lap buddy to apply to w/c, unfortunately the current armrests on resident w/c will not accommodate this lap buddy. Therapy to order new arm rests for w/c, then we will apply further Velcro to add another layer of protection and another step for resident to attempt to self transfer or remove these intervention devices. We will continue with current lap buddy until these new arm rests arrive. Hipsters provided to staff and instructed on use and to also leave resident in her w/c for meals . Review of an undated letter addressed to the family of Resident #119 and written by the facility Administrator revealed, .Thank you for taking time to meet regarding [Resident #119]'s care plan. More specifically, we discussed your concerns regarding the potential for [Resident #119] to suffer an injury by falling .it is important you clearly understand that [the nursing facility] cannot eliminate the potential for falls to occur .as we discussed, we will not have a staff member consistently within close proximity of [Resident #119], nor are we required to do so. Even with a staff member nearby, a resident still may accidentally fall. It is simply an unavoidable risk .you may consider hiring a private duty aide to remain with [Resident #119] . Medical record review of a Significant Change in Status MDS assessment dated [DATE] revealed Resident #119's BIMS was 0 and the resident was frequently incontinent of urine. Medical record review of a Clinical Notes Report dated 6/27/18 at 8:09 PM revealed, Residents bed sensor alarm sounded and noted that resident was partly off bed onto bedside matt. Bed was in lowest position and resident had legs and bottom on matt and upper torso on bed hanging onto side rails. Noted that resident had a skin tear on back and left arm . Review of an Incident/Accident Report dated 6/27/18 revealed .steps taken to prevent recurrence: Pool noodles . Review of the Interdisciplinary Team Review for the accident on 6/27/18 revealed, .Interventions implemented: Pool noodles. Probable Cause: Climbing out of bed, side rails are padded, has low air loss mattress w/ [with] sensor alarm, mats et low bed. Medical record review of a Clinical Notes Report dated 7/10/18 at 3:10 AM revealed, Pt [patient] alarm going off when CNA went to room, found pt half in bed and half out of bed. Head and upper body in bed and legs and feet on floor. Pt. has abrasion in middle of forehead . Review of an Incident/Accident Report dated 7/10/18 revealed .steps taken to prevent recurrence: Velcro noodles to mattress rail . Review of the Interdisciplinary Team Review for the accident on 7/10/18 revealed, Interventions implemented: Velcro noodle to mattress. Probable Cause: Unknown due to cognition. Res could not explain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Registered Nurse (RN) #2 on 8/15/18 at 7:03 AM, in the 1 north nurse's station, revealed .She [Resident #119] has fallen on numerous shifts .when up has to be in wheelchair and has a belt .she knows how to unhook .she is like a Houdini . Interview with the DON on 8/16/18 at 9:05 AM, in the conference room, confirmed . She [Resident #119] has had frequent falls. She continues to fall with all the interventions she has. We even told family they might want to consider hiring a 24 hour sitter. We have a few frequent fallers . Interview with CNA #16 on 8/16/18 at 2:42 PM, in the 1 north hallway, revealed .We don't have enough supervision for her [Resident #119] . Observation and interview with the Director of Nursing (DON) on 8/17/18 at 7:33 AM, in Resident #119's room, revealed the resident was in bed lying on her left side. Further observation revealed Velcro pads were hanging downward, on the outer upper end of the bed rails, and the pool noodles were up against the wall. Interview with the DON confirmed .the Velcro noodles are not attached to the bed correctly and the pool noodles are not in the resident's bed . Interview with Licensed Practical Nurse (LPN) House Mentor #1 on 8/17/18 at 8:10 AM, in the 1 North dining room, revealed .If she is sitting in a regular chair a staff member has to be with her. No intervention to address resident supervision .she continues to try to transfer herself and fall. She has no safety awareness . The lap buddy I just an extra measure to free herself. It is to slow her down. The lap buddy is working to certain extent. Gives us more time to get to her . Further interview confirmed no interventions were put in place to prevent further falls after Resident #119's fall on 11/10/17. Interview with House Mentor #1 on 8/18/18 at 9:25 AM, in the Mentor's office, confirmed staff were not documenting toileting. Further interview confirmed Resident #119 needed more frequent toileting than every 2 hours. The Mentor stated . All of us are responsible to make sure intervention is to be implemented . Further interview revealed when a fall occurred, .Nurse Fills out incident report .IDT [Interdisciplinary Team] comes up with new intervention . Further interview confirmed a root cause analysis was not done for the falls on 11/19/17 or 4/13/18 to determine the probable cause of the falls in order to implement interventions to prevent further falls. Further interview revealed, .[Resident #119] needs supervision within eye sight .She wanders all over unit . Further interview revealed the interventions implemented of toileting more frequently and toileting as needed were not different and not specific. Interview with the DON on 8/18/18 at 10:36 AM, in the conference room, revealed .I don't know what Velcro noodles would be exactly, maybe pool noodles . Interview with the DON on 8/18/18 at 12:39 PM, in the conference room, revealed .I've not seen a bean bag chair since I've been here .The lap buddy slows her down. We have recommended to family they do the 24 hour sitter .A lap buddy wouldn't prevent falls .You can't really prevent falls . Telephone interview with CNA #23 on 8/18/18 at 1:00 PM revealed the CNA had never seen any pool noodles with Velcro and did not know what Velcro noodles (intervention that was to be put in place after the fall on 7/10/18) were. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with CNA #5 on 8/18/18 at 8:59 PM, revealed the CNA did not know what Velcro pool noodles were. 35200 Medical record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Dementia, Chronic Kidney Disease, Hypertension, and a History of Falls. Medical record of Resident #40's care plan dated 5/23/18 revealed the resident was at risk for falls due to weakness, history of falls, Dementia, and Hypertension. Continued review revealed interventions included wear non-slick footwear, instruct the resident on safety measures to reduce risk of falls, attempt to engage in Activities of Daily Living (ADL's) that improve strength, balance, and posture, and keep areas free of obstacles to reduce the risk of falls or injury. Medical record review of the Admission MDS dated [DATE], revealed Resident #40 had a BIMS score of 3, indicating the resident was severely cognitively impaired, and required extensive assistance of 1 for mobility, toileting, and transfers. Review of a facility Incident/Accident report dated 6/27/18, revealed Resident #40 was found on her knees in her room with 2 skin tears to the left wrist. Continued review revealed steps taken to prevent recurrence included .Call before you fall signs - visual cueing . Review of the Interdisciplinary Team Review for the accident on 6/27/18 revealed no documentation a review had been completed, no documentation of interventions implemented to prevent further falls, and no documentation of the probable cause of the fall. Medical record review of a Nursing Note dated 7/6/18, revealed .Ambulates w[with] walker w/one assist, however she frequently forgets to ask for assist and attempts to get out of chair and ambulate to/from room by herself. Frequent reminders given to call for assist. Gait is unequal and unsteady . Medical record review of a Nurses note dated 7/30/18, revealed Resident #40 was in her recliner, attempted to pick up a cup that had fallen on the floor, and slid out onto the floor. Further review revealed the resident had non slip socks on. Continued review revealed the resident was instructed to always use the call light. Review of a facility Incident/Accident report dated 7/30/18 revealed Resident #40 had a fall in her room with no injuries noted. Continued review revealed steps taken to prevent recurrence .Reinstructed & [and] demo [demonstrate] call light use . Review of the Interdisciplinary Team Review for the accident on 7/30/18 revealed no documentation a review had been completed, no documentation of interventions implemented to prevent further falls, and no documentation of the probable cause of the fall. Review of a falls assessment dated [DATE] revealed Resident #40 scored 11 (at risk for falls). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an Incident/Accident report dated 8/2/18 revealed Resident #40 was found lying on her back in her bathroom with her walker on top of her. Continued review revealed .Two knots were found on the back of her head with a laceration on one of them .It was determined to send her out for evaluation . Review revealed interventions in place at the time of the fall were mats and non-skid socks. Further review revealed steps taken to prevent recurrence .Reiterate use of call light .Removal of hosiery and use slipper socks . Review of CNA #15 Written Statement revealed, [CNA #14] and I were in [another resident's room] with another resident, and heard someone yelling. Ran out to see what happened next door. Went into [Resident #40] room and found her lying on bathroom floor . Review CNA #14 Written statement revealed, [CNA #15] & [and] I were in [another resident room] and heard some one yelling and went to check in each room & it was [Resident #40] laying in bathroom floor . Review of the Interdisciplinary Team Review for the accident on 8/2/18 revealed no documentation a review had been completed, no documentation of interventions implemented to prevent further falls, and no documentation of the probable cause of the fall. Further review revealed no signature from the Medical Director, Administrator or DON to indicate the fall was reviewed. Review of a falls assessment dated [DATE] revealed Resident #40 scored a 14 (at risk for falls). Medical record review revealed the resident was admitted to an acute care hospital on 8/2/18 for .Mechanical fall .Subdural hematoma .Vascular Dementia .Patient was admitted after falling backwards in bathroom at [facility] . Medical record review of a Computed Tomography (CT) of the Head radiology report dated 8/2/18 revealed the resident had an acute subdural hematoma (SDH). Medical record review of a Nursing Note dated 8/6/18 revealed .Resident arrived back from [named hospital] 8/6/18 .Family at bedside .daughter states she is alert at times and does not recognize her. She has severe bruising to back of head and neck, w/a [with a] small scab to back of L [left] side of head. Bruising to R [right] arm, R index finger swollen and red. Small skin tears to bilateral arms. L lower arm skin tear . Medical record review of Resident #40's care plan dated 8/6/18, revealed the resident was at risk for falls related to weakness, History of Falls, Dementia, psychotropic medication use and status post SDH with interventions to keep areas free of obstructions to reduce the risk of falls or injury, place call bell/light within easy reach, remind resident to call for assistance before moving from bed to chair and from chair to bed, respond promptly to calls for assist to the toilet, footwear will fit properly and have non-skid soles, and provide reminders to use ambulation and transfer devices. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Medical record review of a Nursing Note dated 8/12/18 revealed the nurse heard Resident #40 yelling out, the nurse entered the room, and found the resident lying in the corner of her room with her back against the wall. Further review revealed the resident was found to have a large bruise to the left hip and a skin tear to the right arm. Continued review of the note revealed earlier the same day, the resident was found standing in the resident's room, going to the bathroom, and other staff reported she gets up without calling for assistance. Further review revealed the resident's call light was in reach at the time of the fall and staff re-educated the resident on the use of the call light. Review of a facility Incident/Accident Report dated 8/12/18, revealed the resident was found in the corner of her room between the bed and the bathroom and the resident stated she slipped. Continued review revealed under steps taken to prevent recurrence there were no interventions implemented. Review of the Investigation Tool for the accident on 8/12/18 revealed, under the section Interventions, which indicated the interventions in place at the time of the fall, none of the interventions were marked, and handwritten in the section was Re-Educate. Review of the Interdisciplinary Team Review for the accident on 8/12/18 revealed no documentation a review had been completed, no documentation of interventions implemented to prevent further falls, and no documentation of the probable cause of the fall. Further review revealed no signature of the Medical Director, Administrator or DON to indicate they had reviewed the accident. Medical record review of a falls assessment dated [DATE] revealed the falls assessment was incomplete and no score was documented. Medical record review of a Physician's Order dated 8/16/18 at 4:00 PM revealed .Please get floor mat that alarms @ nurses station & place beside bed . Interview with RN #3 and medical rec [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36450 Based on facility policy review, medical record review, and interview the facility failed to provide catheter care for 1 resident (#89) of 4 residents reviewed with catheters, of 52 sampled residents. The findings include: Review of facility policy Catheter Care-Indwelling Catheter, dated 1/1/17, revealed .PURPOSE: to prevent infection and provide daily hygiene . Medical record review revealed Resident #89 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, Chronic Kidney Disease, and Urinary Tract Infection. Medical record review of a 14 Day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status Score of 15, indicating the resident was cognitively intact. Continued review revealed the resident required extensive assistance with 1 staff member for bed mobility and toileting and required total assistance with 2 staff members for transfers and bathing. Further review revealed the resident required a wheelchair for mobility and was assessed as having an indwelling catheter. Medical record review of admission orders dated 6/13/18, revealed, .FC[Foley Catheter][indwelling urinary catheter] .chg [change] monthly .cath [catheter] care . Medical record review of readmission orders dated 7/10/18 revealed Resident #89's catheter had been changed on 6/6/18. Medical record review of a Clinical Nurse Note dated 8/11/18 revealed .catheter replaced with #18 [size] catheter with 20cc [cubic centimeter] balloon [balloon to hold catheter in place] . Medical record review of a Physician Order Sheet dated 8/18/18 revealed .Urinary Catheter Care q [every] shift .Starting 8/18/18 .Insert indwelling catheter .Every One Month Starting 8/18/18 . Interview with Resident #89 on 8/18/18 at 11:45 AM, in the resident's room, revealed .my catheter was changed just the other day .that was the first time they [facility] changed it .the nurse said she had to change the catheter because I had it since June .they don't do catheter care everyday .they only do it on Tuesday and Thursday when I have my bath . Interview with LPN Nurse Mentor #5 on 8/18/18 at 3:56 PM, in the nursing station, confirmed when the resident was admitted to the facility the physician order for catheter care had not been initiated. Continued interview confirmed the facility failed to provide catheter care for Resident #89. (continued on next page)

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	445017	A. Building B. Wing	08/20/2018

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on 8/18/18 at 5:00 PM, in the conference room, confirmed the catheter was to be replaced monthly and catheter care was to be reordered when the resident returned to the facility. Continued interview confirmed catheter care was to be completed daily unless ordered otherwise.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39794 Based on review of facility policy, medical record review, observation and interview, the facility failed to ensure interventions were implemented and monitored to prevent further weight loss for 2 residents (#34, #54) of 5 residents reviewed for nutrition, of 52 residents sampled. The findings include: Review of the Facility Weight Assessment and Intervention Policy revised 9/08 revealed 6 .threshold for significant unplanned weight and undesired loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight) / (usual weight) x 100]: a. 1 month- 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe .Continued review revealed . Individualized care plans shall address .identified causes of weight loss .Goals and benchmarks for improvement .Time frames and parameters for monitoring and reassessment . Medical record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Lumbago with Sciatica, Scoliosis, Chronic Kidney Disease (CKD), Hypertension (HTN), Dementia, Hyperlipidemia and Major Depressive Disorder. Medical record review of a Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident scored 3 on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired. Continued review revealed Resident #34 was independent with eating with assistance of set up only, and had no weight loss. Medical record review of the weight record from May 2018 through August 2018 revealed: 5/6/18 126.2 pounds 6/3/18 126 pounds 7/3/18 121.8 pounds 8/5/18 weight 111.2 pounds 8/12/18 weight 115.4 pounds Review of Nutrition Progress assessment dated [DATE] revealed Resident #34's current weight was 126 pounds, Nutrition Diagnosis of risk of weight loss, .Intervention: Liberalization of diet, Evaluation .monitor weights and intake . Review of a clinical notes report dated 8/10/18 at 1:45 PM entered by Dietitian #2 revealed a significant weight loss of 8.7 percent, 10.6 pounds from 7/3/18 through 8/5/18. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review of Physician's Order Sheet and Progress Notes dated 8/10/18 revealed an entry .RD [Registered Dietician] recommendation -Weekly wts [weights] x [for] 4 weeks r/t [related to] 8.7% wt loss x 1 month, Refer to Psychiatry [Psych] d/t [due to] wt loss . Review of Physicians Order Sheet and Progress Notes dated 8/15/18 revealed .recommendation per RD: 1) Boost Plus [nutritional supplement drink] TID [3 times per day] between meals . Review of Resident #34's care plan dated 8/16/18 revealed .therapeutic diet as ordered CCD [consistent carbohydrate diet] regular diet. Therapeutic restriction of choice .provide ques and encouragement. Feed [Resident #34] remaining food items .monitor food intake at each meal .Boost three times a day between meals . Interview with LPN #5 in nurse's office in secure unit on 8/18/18 at 3:10 PM revealed the nutritional supplement Boost was documented as given on the Medication Administration Record (MAR). Continued interview revealed review of the 8/2018 MAR revealed no documentation of percent [%] of intake of supplement. Review on 8/18/18 at 3:10 PM of the Psychiatry referral book in the Nurses office revealed Resident #34 was referred to Psychiatry on 8/10/18. Continued review revealed no documentation the referral had been addressed by Psychiatry. Interview with the DON on 8/18/18 at 4:55 in the conference room confirmed Resident #34 had not been seen by Psychiatry since the referral date of 8/10/18, . should have been since Psych is in the building 2 times a week . Interview on 8/20/18 at 10:19 AM with Dietary Manager and Registered Dietician #1 in the conference room confirmed the facility failed to ensure interventions were implemented to prevent further weight loss. Medical record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Dysphagia, Unspecified Lack of Coordination, Reduced Mobility, Muscle Weakness, Dementia, and Generalized Anxiety. Medical record review of the quarterly MDS dated [DATE] revealed no behaviors, required 1 person assistance with hygiene, 2 person assistance with transfers, and dressing, and set up help for eating. Continued review revealed Resident #54 was on a mechanically altered diet, weighed 219 pounds, and had no oral or dental issues. Continued review revealed a BIMS Score of 14 indicating the resident was cognitively intact. Medical record review of the quarterly MDS dated [DATE] revealed no behaviors, required 1 person assistance with dressing and hygiene, 2 person assistance with transfers, and set up help for eating. Continued review revealed Resident #54 was on a mechanically altered diet, had a weight loss of 20 pounds from the previous MDS assessment, with a current weight of 199 pounds, and had no oral or dental issues. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review of the quarterly care plan print date of 6/14/18 revealed .potential for weight loss . tremors of hands decrease his ability to self feed, dysphagia, swallowing difficulty .Staff to assist .when tremors are increased .Complete set-up and provide assistance with .eating . Continued review revealed at risk for Aspiration/Choking due to Dysphagia/Cough with intervention to .Assist .no straws .plate guard and weighted utensils with all meals . Further review revealed the facility failed to develop and implement an individualized care plan to address the identified weight loss of 20 ponds. Observation of Resident #54 on 8/13/18 at 10:06 AM, in the resident's room, revealed the resident was eating breakfast provided in a divided plate with no plate guard, had hand tremors and was noted to have food on clothing. Further observation revealed no weighted utensils in use. Observation of Resident #54 on 8/14/18 at 9:23 AM, in the resident's room, revealed breakfast was provided in a divided plate with no plate guard, and regular silverware. Continued observation revealed the resident had difficulty feeding self due to tremors of hands. Observation of Resident #54 on 8/15/18 at 8:35 AM, in the resident's room, revealed breakfast was served on a regular plate, with regular silverware and bowl. Interview with RD #1 on 8/15/18 at 2:50 PM, in the conference room, revealed RD #1 was unfamiliar with this resident and was not aware of the resident's weight loss or any interventions. Further interview revealed the RD was not able to determine the interventions that were previously initiated on the care plan and if the interventions of weighted utensils and plate guard were discontinued. Interview with MDS Coordinator #3 on 8/17/18 at 7:55 AM, in the MDS office, revealed the MDS Coordinators updated the care plans quarterly with the MDS assessments. Continued interview revealed the care plans were updated all other times by the nurses on the floor. Continued interview revealed no straws, and the plate guard were active on the care plan for Resident #54. Observation of Resident #54 on 8/18/18 at 9:20 AM, in the resident's room, revealed the resident had breakfast food pureed consistency, a regular plate and regular silverware. Continued observation revealed no plate guard or weighted utensils. Interview with LPN #1 on 8/18/18 at 10:15 AM, on the 2 South Hall way revealed the resident had a plate guard but it was discontinued. Continued interview revealed the resident used a divided plate with meals. Further interview, in the resident's room, confirmed resident did not have a plate guard, a divided plate or weighted utensils. Interview with LPN #1 on 8/18/18 at 3:00 PM, on 2 South Hall, revealed the interventions were to be placed on the care plan and updated by the .care plan manager . Continued interview revealed LPN #1was unaware of Resident #54's 20 pound weight loss or any weight loss interventions except a divided plate that had been used. Interview and observation with Resident #54 on 8/18/18 at 10:00 AM, in the resident's room, revealed the resident had never used weighted silverware and did not want to utilize. Continued interview revealed Resident #54 had used a plate guard when provided and it made eating easier. Continued observation revealed the resident had a regular plate without a plate guard. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	40606

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35200 Based on facility policy review, medical record review, observation, and interview the facility failed to assess and monitor the effectiveness of an individualized Pain Management Program for 1 resident (#236) of 3 residents reviewed for pain of 52 sampled residents. The facility's failure to effectively control Resident #236's pain resulted in actual Harm to the resident. The findings include: Review of the facility policy, Pain Management, undated, revealed .Pain is always subjective; pain is whatever the person says it is .Fear of dependence, tolerance and addiction does not justify withholding opioids analgesics in residents suffering with pain .Alert Communicative Resident .1. Resident identified with having pain will be asked degree of pain according to Numerical Pain Scale (0-10), with zero representing no pain and 10 representing the worst possible pain .4. Efficacy will be documented within one hour after administration of analgesic .9. Physician will be notified of ineffective analgesic .10. Physician will be notified immediately if pain suddenly becomes severe .18. Prevalent pain breakthrough should be reported to physician . Medical record review revealed Resident #236 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, End Stage Renal Disease, Pressure Ulcer, and Pain. Review of the 14 day Minimum Data Set assessment dated [DATE], revealed the resident had a score of 15 on the Brief Interview For Mental Status, indicating she was cognitively intact. Medical record review of a care plan, undated, revealed .Potential for altered level of comfort-chronic pain related to .recent pressure ulcer s/p [status post] surgical debridement, hip pain .Interventions .Notify MD [Medical Doctor] of unusual complaints of pain . Medical record review of a Nurse Practitioner's (NP) note dated 8/2/18 revealed .Discussion with patient regarding pain management had requested an increase in pain meds due to wound. Education provided re [regarding] pain management and good stewardship of use. Discussed times of administration important to better manage pain related to wound . Neurological .Patient is awake, alert and oriented x 3 . Medical record review of a nurse's note dated 8/6/18 at 3:29 PM revealed .Resident had c/o [complaints of] pain unrelieved by PRN [as needed] medication .NP notified. New orders to continue pain medication and new order for Ativan [medication to treat anxiety] PRN for anxiety . Medical record review of a Physicians Order dated 8/6/18 revealed Oxycodone-Acetaminophen [Percocet-narcotic pain medication] 10 milligrams [mg]-325 mg tablet PRN every 6 hours and Lorazepam [medication to treat anxiety] 0.5 mg tablet PRN every 12 hours. Resident went to dialysis this AM .Resident did not tolerate dressing changes well . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Medical record review of a nurse's note dated 8/6/18, revealed .Resident stated she did not need the Ativan at this moment .Wound care done on L [left] hip this AM. Resident is now refusing to have wound care done on R [right] hip d/t [due to] pain, wound care nurse made aware. Will continue to monitor for further changes . Medical record review of a Wound Nurse note dated 8/6/18 revealed .Talked a long time for importance of changing drsgs [dressings] twice a day with reasoning .Right buttock wound was surgically had debridement done. Measured 12.8 x 9.8 .Left buttock wound measured 14 x 14 .There is another small wound noticed just below it measures 3 x 1.5 . Medical record review of a nurse's note dated 8/7/18 revealed .Resident complained of pain that is unrelieved by PRN pain medication . Wound care completed. Resident did not tolerate dressing changes well . Medical record review of a nurses note dated 8/8/18 at 4:06 PM revealed .Also discussed about the importance of accepting and managing the wound care as ordered .Ensured that pain management prior to the dressing change for the best outcome . Medical record review of a Physicians Order dated 8/9/18 revealed .medicate for pain prior dressing change . Medical record review of the Medication Administration Record dated 8/1/18 to 8/15/18 revealed no documentation of a pain score for the administration of Percocet [narcotic pain medication] 10 mg-325 mg from 8/2/18 at 6:23 AM to 8/15/18 at 6:39 AM, and the effectiveness of the analgesic was not assessed for 8 hours after the administration of the pain medication. Medical record review of a Nurse's Note for Resident #236 dated 8/13/18 at 1:50 PM revealed pain on a scale of 10 while dressings being changed . Interview with the Licensed Practical Nurse (LPN) #13 on 8/15/18 at 9:30 AM, on the 300 unit, confirmed the resident had complained of pain during dressing changes on 8/13/19 and 8/15/18 and had been given the medication prior to dressing change but did not report the unrelieved pain to the Physician. Interview with Certified Nursing Assistant (CNA) #23 on 8/15/18 at 9:40 AM, on the 300 hallway confirmed she had been in the resident's room during a dressing change and the Resident #236 .hollered out . when the dressing was changed and when the resident was repositioned. Observation and interview with Resident #236 on 8/15/18 at 9:55 AM, in the resident's room revealed the resident was awake and alert, resting in bed. Continued observation revealed mild facial grimacing noted with movement. Continued interview with the resident confirmed she received pain medication before the dressing change but still had severe pain during the dressing changes twice a day. Further interview confirmed she had reported the pain to the nurses and the Nurse Practitioner. Continued interview confirmed on a scale of 1 to 10 the pain is a 10, and that she has yelled out and asked the staff to stop during the dressing change. Further interview confirmed she just bears it .I don't think the pain medication is strong enough to control it . Continued interview confirmed she had refused to have dressing changes done due to the dressing changes being so painful. (continued on next page)

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	445017	A. Building B. Wing	08/20/2018

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview with the Wound Nurse on 8/15/18 at 11:25 AM, in the conference room, confirmed the resident had experienced pain during dressing changes, and she required a lot of emotional support and encouragement to get through the treatment. Further interview confirmed she had not notified the Nurse Practitioner of Resident #236 having pain during the dressing changes. Continued interview confirmed .The dressing change cannot be pain free . Telephone interview with Registered Nurse (RN) #5 on 8/15/18 at 1:45 PM, confirmed the resident had extreme pain during dressing changes. Continued interview revealed she tried to give her the pain medication 20 minutes before dressing changes and she hollered out each time. Further interview revealed the nurse had not notified the Physician or Nurse Practitioner that she had pain. My thought processes were that she was being seen by the wound care team . Continued interview confirmed she asked the resident if it always hurt like this and the resident stated yes. Telephone interview with RN #3 on 8/15/18 at 2:00 PM, confirmed she had completed dressing changes on the resident and most times she has pain during the dressing changes. Further interview confirmed the nurse gave pain medication 30 minutes to an hour prior to the dressing change. Continued interview confirmed .I think it [wound] hurts because it is so deep . Further interview confirmed sometimes the resident will ask the staff to stop because of the pain and will refuse dressing changes at times. Continued interview revealed .I think the Doctor already knows about the pain. I didn't report it because it's the nurse's discretion to assess if the patient can tolerate the dressing change . Further interview confirmed pain is to be monitored every shift. Interview with the Nurse Practitioner #1 on 8/16/18 at 10:05 AM, in the conference room, confirmed she addressed the resident's complaints of pain with the resident when she was first admitted and did not want to increase the pain med at that time but discussed timing of the pain medication related to timing of the dressing changes. Continued interview confirmed she was not made aware by staff that the resident was experiencing extreme pain during the dressing changes. Interview with the Director of Nursing on 8/16/18 at 5:20 PM, in the conference room confirmed staff failed to monitor, manage and report unrelieved pain for Resident #236 and failed to follow the facility's pain management policy to use the numerical pain scale with a cognitively intact resident and reassess pain within 1 hour after administration of an analgesic[pain medication.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35200 Based on facility policy review, medical record review, observation, and interview the facility failed to assess and monitor a Central Venous Catheter (CVC) for 1 resident (#133) of 3 residents receiving dialysis, of 52 sampled residents. The findings include: Review of the facility dialysis protocol, revised 5/2018 revealed .The dialysis organization will work with the Clinical Mentors in regards to proper care and treatment of the patient's vascular access . Medical record review revealed Resident #133 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease, Diabetes and Hypertension. Medical record review of the Minimum Data Set (MDS) dated [DATE] revealed the resident received dialysis. Continued review revealed the resident scored 5 on the Brief Interview For Mental Status, indicating severe cognitive impairment. Review of a Physicians Orders dated 7/24/18 revealed the resident receives dialysis 3 times per week. Medical record review of a care plan undated, revealed .Has ESRD [End Stage Renal Disease] and is at risk for complications .Interventions .Monitor shunt site for any s/s [signs and symptoms] of infection, occlusion, etc . Medical record review of a Dialysis Treatment Sheet print date 8/6/18 revealed current dialysis access of CVC catheter right chest. Medical record review of the Treatment Administration Record (TAR) dated 7/25/18-8/14/18, revealed no documentation the facility assessed the resident's catheter or dressing after dialysis treatment. Observation and interview with Resident #133 on 8/15/18 throughout the day revealed the resident had a CVC to the right upper chest for dialysis vascular access. Continued interview with the resident on 8/15/18 confirmed she was new to dialysis and didn't not know much about it. Interview with the Director of Nursing on 8/15/18 at 4:55 PM, in the conference room, confirmed there was no documentation the dialysis CVC had been monitored. Further interview confirmed it should be documented on the TAR.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 36450 Based on review of the facility's CMS-672 Resident Census and Conditions of Residents, review of the Matrix for Providers, review of the facility's Daily Census Report, review of facility staffing schedules, observation, medical record review, review of facility incident reports, and interview, the facility failed to maintain adequate staffing levels to ensure the supervision of residents to prevent repeated falls for 7 residents (#28, #34, #39, #40, #47, #80, #119) of 40 residents reviewed for falls in the facility, and to ensure residents were provided assistance with activities of daily living (ADLs) care for 3 residents (#53, #80, and #89) of 52 residents reviewed. The facility's failure to ensure adequate staffing levels resulted in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) for 7 residents (#28, #34, #39, #40, #47 #80, #119) with serious injuries after falls. The facility's failure to provide assistance with toileting resulted in Harm to Residents #80 and #89. The Administrator and the Director of Nursing (DON) were informed of the Immediate Jeopardy on 8/20/18 at 8:10 PM, in the conference room. The IJ was effective 11/10/17 and is ongoing. The findings include: Review of the facility's CMS-672 Resident Census and Conditions of Residents signed by the Administrator on 8/13/18 revealed the facility had a census of 137 residents. Further review revealed 90 residents were occasionally or frequently incontinent of bladder; 80 residents were occasionally or frequently incontinent of bowel; 25 residents ambulated with assistance or assistive devices; 92 residents had dementia; 86 residents had behavioral healthcare needs; and 8 residents had pressure ulcers. Review of the Matrix for Providers completed on 8/13/18 revealed the facility had 40 residents who had experienced falls while in the facility, with 10 residents having an injury with a fall and 7 residents having a major injury as a result of a fall. Residents who had major injuries after a fall were Residents #119, #47, #28, #34, #39, #40, and #80. Review of the facility's Daily Census Report dated 8/13/18 for the Secured Unit revealed the unit had 31 residents and 2 empty beds. Review of the facility's staffing schedule for the Secured Unit for August 2018 revealed the unit was to have 1 Licensed Practical Nurse (LPN) and 4-5 Certified Nursing Assistants (CNAs) working Monday through Friday day shift; 1 LPN and 3 CNAs working weekend day shift; 1 LPN and 3-4 CNAs working Monday through Friday evening shift; 1 LPN and 2 CNAs working weekend evening shift; either 1 LPN or 1 Registered Nurse (RN) and 2-3 CNAs working Monday through Friday night shift; and 1 LPN or RN and 2 CNAs working weekend night shift. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on Thursday 8/16/18 at 10:50 AM, in the Secured Unit dining room, revealed residents seated in chairs and wheelchairs. Continued observation revealed no CNA or nurses were in the line of sight of the residents in the dining room and sunroom. Further observations revealed all the residents' doors were open without a staff member in line of sight. Further observation revealed the Wound Care Nurse and Wound Nurse Practitioner were in one of the resident's rooms. Medical record review and review of facility incident reports revealed Resident #119 had 9 falls between 7/1/17 and 7/10/18, with 3 falls requiring transfer to the emergency room , and 2 falls resulting in fractures of the legs. Interview with CNA #16 on 8/16/18 at 2:42 PM, in the Secured Unit hallway, revealed .We don't have enough supervision for her [Resident #119] .If we do have enough staff they pull us . Interview with Household CNA Coordinator #4 on 8/16/18 at 2:47 PM, in the Secured Unit hallway, revealed . We always have staff, but [they are] pulled .When [they] get pulled, don't have enough staff .With 3 people just can't do it . Interview with CNA #5 on 8/18/18 at 8:59 AM, on the Secured Unit hallway, revealed .Right before supper we position them [residents] [in chairs] that is how we supervise .last 3 months before it was horrible . Observation on Saturday 8/18/18 at 9:10 AM, in the secured unit sunroom, revealed Resident #119 was seated in her wheelchair. Continued observation revealed no CNAs or nurses were in line of sight of the resident. Medical record review and review of facility incidents revealed Resident #47 had 10 falls between 4/9/18 and 6/13/18 with one fall requiring sutures for a laceration. Further review revealed the resident was not safe to ambulate independently. Observation on 8/18/18 at 10:30 AM, in the Secured Unit dining room, in front of the kitchen, revealed LPN #5 was at the medication cart between the dining room and the sunroom, preparing medications for a medication pass. Continued observation revealed 16 total residents were in the dining room, sitting area, and sunroom. Further observation revealed Resident #47 ambulated into the dining room, in front of the kitchen, pushing his wheelchair towards the sunroom. Further observation revealed LPN #5 began to yell out to the homemaker/cook staff member, who was located in the kitchen, to find a staff member to help assist the resident, who was observed to be unsteady on his feet. Further observation revealed the other CNAs were in resident rooms. Further observation revealed the homemaker staff member went out on the unit and tried to find a CNA to help with Resident #47. Continued observation revealed LPN #5 assisted the resident back into a wheelchair and continued to prepare medications for medication pass while the homemaker was locating a CNA to assist. Review of the facility's Daily Census Report dated 8/13/18 for 2 South revealed the unit had 31 residents and one empty bed. Review of the facility's staffing schedule for 2 South for August 2018 revealed the unit was to have 1 nurse and 3 CNAs per shift Monday through Friday and 1 nurse and 2 CNAs per shift on the weekends. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Resident #61, who lived on 2 South, on 8/13/18 at 10:31 AM, in the resident's room, revealed Resident #61 did not think there was always enough staff to provide baths. Continued interview confirmed . the girls [CNAs] will come in and say there are only 2 of us [CNAs] and we can't do your bath today . Further interview revealed .sometimes there is only 1 to 2 to take care of all of us [residents] .because they have to go to the kitchen to work sometimes . Interview with Resident #96, who lived on 2 South, on 8/13/18 at 10:39 AM, in the resident's room, revealed . [the facility] short staffed .staff have quit and they haven't replaced them .a lot of times there is just 1 or 2 [CNAs] on the floor . Interview with Resident #53, who lived on 2 South, on 8/13/18 at 11:08 AM, in the resident's room, revealed . didn't get a shower last week at all .not Tuesday or Friday they told me they were short staffed .it has happened .several times .not enough of them . Interview with CNA #3 on 8/15/18 at 9:25 AM, in the 2 South dining rooms, revealed the facility did not always have enough help to take care of the residents. Continued interview revealed there had been times when residents had not received showers. Interview with Household CNA Coordinator #1 on 8/15/18 at 9:40 AM, in the 2 South dining room, revealed there had been .call offs and have lost some employees and do not always have enough staff to take care of the residents about 2 to 3 days out of the week . Continued interview revealed .pulled to the kitchen sometimes 3 to 4 times a week . Further interview confirmed there had been times the residents had not received showers because of staffing. Interview with CNA #4 on 8/15/18 at 9:56 AM, in the 2 South dining room, revealed there was not always enough staff to meet the needs of the residents .it upset me .we are understaffed. I can't do my job the way I would like . Continued interview revealed .At least once a week we try to give a shower .there have been times on the weekends that we have not been able to get some residents up out of bed because there is not enough staff . Interview with LPN #2 on 8/15/18 at 10:05 AM, in the 2 South living room area, revealed there was not always enough staff to meet the needs of the residents. Continued interview confirmed .like today the person I was working with put her notice in so there is only 1 nurse. The weekends are not enough CNAs. Last Sunday there was only 1 nurse and 2 CNAs .there have been times the residents have not received a shower due to staffing . Review of the facility's staffing schedule for 1 South for August 2018 revealed the unit was to have 1-2 nurses for each shift Monday through Friday; 3-4 CNAs on day shift, 2-3 CNAs on evening shift, and 2 CNAs on night shift Monday through Friday; 1 nurse each shift on weekends; and 2 CNAs on day and evening shift and 1 CNA on night shift on the weekends. Further review revealed there were no nurses scheduled for 7:00 AM - 3:00 PM shift on 8/18/18 and 8/19/18. Interview with Nurse Mentor #5 on 8/14/18 at 7:50 AM, in the 1 South nursing station, revealed .we need the help last night .I only have 1 nurse [LPN #13] working today . Review of the staffing schedule for 8/14/18 day shift on 1 South revealed the unit was supposed to be staffed with 2 nurses. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LPN #13 on 8/14/18 at 8:25 AM, in the 1 South hallway, confirmed .I am the only nurse on the floor today .I have 30 patients today .it happens all the time being the only nurse on the floor . Interview with Resident #89, who lived on 1 South, on 8/14/18 at 9:47 AM in the resident's room, confirmed . They are real short on day shift. I have called out because I need the bed pan and they did not get to me for a while and I had an accident on myself. It made me feel shamed . Interview with RN #4 (night shift nurse on 1 South) on 8/17/18 at 6:35 AM revealed .I had 30 patients last night .I was the only nurse with 1 CNA . Review of the staffing schedule for 2 South for 8/16/17 11:00 PM - 7:00 AM shift revealed the unit was to be staffed with an RN and 2 CNAs. Interview with CNA #2 on 8/17/18 at 5:45 PM, on the 2 South hallway, revealed .just 2 of us working down here and I don't even know these patients .I work upstairs on the skilled .I was pulled from the 3rd floor and that left 1 CNA up there to take care of 17 or 18 patients . Review of the staffing schedules for 2 South and 3rd floor for the evening shift of 8/17/18 revealed 2 South was to have 2 CNAs and the 3rd Floor was to have 2 CNAs. Interview with LPN #1 on 8/18/18 at 9:12 AM, on the 2 South hallway, revealed .is never enough staff . recently had a setback with a CNA getting fired, a nurse quit, a CNA quit .they haven't been replaced .I have reported to the DON [Director of Nursing] and the Administrator . Interview with the DON on 8/20/18 at 5:30 PM, in the conference room, revealed the Nurse Mentors and Household CNA Coordinators schedule staff 6 weeks in advance and staffing is to be reviewed by each house daily. The DON stated staffing in the facility was consistent, unless a staff member needed to be pulled to another unit in the facility. Further interview revealed staffing was based upon census and acuity in each house and was determined by utilizing a computerized staffing calculator. Further interview revealed staff turnover was discussed in the leadership meetings every 2 weeks and CNA turnover was high, but nursing turnover was stable. Interview with the DON on 8/20/18 at 5:35 PM, in the conference room, revealed staff had reported to the DON there was not enough staff, but the DON stated staffing was adequate. The DON stated if someone was pulled to work on another unit or another role, then staff felt they didn't have enough adequate staff. Interview with the Medical Director on 8/20/18 at 11:14 AM, in the conference room, confirmed .greatest trend identified is the multiple changes in leadership and large turn-over in staff that are unfamiliar. Difficult to do training with mostly on the job training, and turnovers in leadership have not been helpful .Falls .We can't tie them up [restrain residents] . Telephone interview with the Chair of the Board on 8/20/18 at 3:47 PM, confirmed .the facility had staff turnover .turnover in these positions are critical . (continued on next page)

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	445017	A. Building B. Wing	08/20/2018

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Refer to F-550, F-657, F-677, F-689, F-726, F-835, F-841, F-867, and F-947.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 36450 Based on review of the facility's Quality Assurance and Performance Improvement Plan, review of the facility's 2018 Assessment, and interview, the facility failed to implement a program to ensure nursing staff education and competency were completed The failure to ensure nursing staff were educated and competent placed 7 residents (#28, #34, #39, #40, #47, #80, and #119) in Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Administrator and the Director of Nursing (DON) were informed of the IJ in the conference room on 8/18/18 at 8:10 PM. The IJ was effective 11/10/17 and is ongoing. The findings include: Review of the facility Quality Assurance and Performance Improvement Plan, revised 2/27/18, revealed .The Quality Assurance (QA) Committee consists of the Director of Nursing Services, the Medical Director, the Administrator, at least two other members of the facility staff, and the Infection Preventionist .All associates including contracted staff are educated on the principles of QAPI .Associates will be trained on using QAPI process including participation on a Performance Improvement Project (PIP Team) .The QAPI program is sustained during transitions in leadership and staffing through all-associate education and involvement in the QAPI process . Facility associates and management have been trained on Root Cause Analysis .The QAPI program will be evaluated annually by the QAPI Steering Committee with input from the Leadership Team/Executive Leadership. This review will include whether goals were met, if standards of practice are being followed, any training needs will be identified and addressed . Review of the 2018 Facility Assessment revealed .Each job description identifies the required education . Additional competencies are determined according to the amount of resident interaction required by the job role, job specific knowledge, skills and abilities and those needed to care for the resident population . competencies are based on the care and services needed by the resident population .competencies are verified upon orientation, at least annually and as needed .The Staff Development Coordinator tracks and trends course completion history and performance trends, reporting those to the Administrator and Director of Nursing (DON) . Interview with the DON on 8/18/18 at 10:36 AM, in the conference room, and review of falls investigations and interventions put in place by staff to prevent further falls, revealed and intervention for Resident #119 included Velcro noodles to the bed. The DON stated .I don't know what Velcro noodles would be exactly, maybe pool noodles . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Telephone interview with Registered Nurse (RN) #5 on 8/15/18 at 1:45 PM, confirmed Resident #236 had extreme pain during dressing changes. Continued interview revealed she tried to give her the pain medication 20 minutes before dressing changes and she hollered out each time. Further interview revealed the nurse had not notified the Physician or Nurse Practitioner that she had pain. My thought processes were that she was being seen by the wound care team . Telephone interview with RN #3 on 8/15/18 at 2:00 PM, confirmed she had completed dressing changes on Resident #236 and most times she had pain during the dressing changes. Further interview confirmed the nurse gave pain medication 30 minutes to an hour prior to the dressing change. Continued interview confirmed .I think it [wound] hurts because it is so deep . Further interview confirmed sometimes the resident will ask the staff to stop because of the pain and will refuse dressing changes at times. Continued interview revealed .I think the Doctor already knows about the pain. I didn't report it because it's the nurse's discretion to assess if the patient can tolerate the dressing change . Interview with the Staff Development Coordinator on 8/18/18 at 4:30 PM, in the conference room, revealed the nursing staff has an orientation period that begins with Human Resources (HR) onboarding. The nurses have HR videos they watch and Relias (computer-based training modules) they watch. Some modules are for all staff and some are specific to nursing. The Staff Development Coordinator conducts a diabetic lab with the nurses that lasts approximately 1/2 a day with competency checked on insulin administration. When the nurses have completed the videos, the Staff Development Coordinator sends them to their nursing unit with an orientation checkoff sheet and then the House Mentor is responsible for the nurse's training. The nurses are paired with a preceptor of the House Mentor's choosing. The Staff Development Coordinator only receives the orientation checkoff sheet from the Mentors when they are done and states she is not involved in decision making of when nurses are competent. Further interview revealed she did not recall any specific training on falls other than the computer based Relias training assigned during orientation and annually. When asked if falls was covered in that training, the Staff Development Coordinator stated that she thought she remembered something on falls, like what to do if you see water in the floor. Further interview revealed she was new to the position and stated she did not have an annual plan or monthly plan for education. The Staff Development Coordinator stated she was still trying to find where deficiencies in education were, where annual trainings were due and had not been done, and was developing education month to month if someone told her there was a need. The Staff Development Coordinator stated the monthly trainings she had developed since being in her role was on the evacuation policy in May 2018, then they conducted mock evacuation drills in June and July 2018 and she was currently conducting one on one training with everyone on Personal Protective Equipment (PPE) and handwashing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the Director of Nursing (DON) on 8/18/18 at 7:13 PM, in the conference room, confirmed the facility staff were responsible for investigating falls. Falls were reported to the nurse on duty and the accident report was turned into the Clinical Mentor. The Clinical Mentor checked for completeness of the report and the nurse and Clinical Mentor discussed the interventions to put in place to prevent further falls. The DON stated the current facility practice was for the nurse Clinical Mentor to decide on a fall intervention and to put it in place immediately after an incident. The nurse was to do a fall risk assessment after every fall and it was put with the investigation packet. Any interventions put in place depended on interventions already in place. The DON stated the nurses knew what options were available and they used .nursing clinical judgement [used when deciding which intervention to put in place] .no education on falls .just their [staff] clinic experience . The DON stated the nurses did not do any root cause analysis at the time of the fall and the leadership was also not doing a root cause to determine the cause of the fall in order to implement interventions to prevent further falls. The DON stated they were aware the care plans were not updated, I don't know when the care plans [were updated] .the mentor in the house should be updating the care plans .I think that there is work to be done .doing weekly meetings we will be able to get more in depth and with dementia they [residents] forget they can't get up . Interview with the DON on 8/18/18 at 7:15 PM, in the conference room, revealed, .I am not familiar with long-term care, and she [Administrator] had taught me regarding [fall] interventions . Further interview with the DON revealed the DON was familiar with Resident #47 and stated as far as she was aware the resident had not had any further falls once he was admitted to the secured unit following his return to the facility after a psychiatric hospital stay (resident had 2 falls since his return). Refer to F-657, F-689, F-725, and F-947.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38390 Based on facility policy review, observation and interview, the facility failed to maintain 2 of 13 resident refrigerators in a safe operating manner and failed to keep foods stored at an appropriate temperature, potentially affecting 29 residents on the Secure Unit and 33 residents on the 2 South hall. The findings include: Review of the facility policy Food Safety dated 1/2016 revealed .Refrigerators must maintain Temperature Controlled for Safety (TCS) foods at 41 [degrees] or below. Refrigeration and freezer thermometers must be accurate to at least +/- [plus or minus] 2 degrees. If temperatures are above 41 [degrees] for TCS foods, corrective actions must be implemented . Observation and interview with the Food Director on 8/13/18 at 12:20 PM, of the 2 South resident refrigerator revealed an internal thermometer at 44 degrees. Further observation revealed (1) 1/2 pint of reduced fat buttermilk with a temperature of 49 degrees. Interview with the Food Director confirmed the refrigerator was not at the appropriate temperature. Continued interview confirmed the following TSC foods stored in the refrigerator would be discarded: 12 cheese slices9-1/2 pints of chocolate milk 9- 1/2 pints of free milk 9-1/2 pints of chocolate milk 5- 1/2 pints of buttermilk 4-1/2/pints of 2% milk 2 cartons of peach yogurt 1 carton of strawberry yogurt 1 carton of cherry yogurt Observation and interview with the Food Director and Dietary Manager on 8/13/18 at 12:30 PM, of the 1 South resident refrigerator revealed an internal thermometer at 42 degrees. Further observation revealed (1) 1/2 pint of vitamin D milk and (1) 1/2 pint of chocolate milk with a temperature of 44 degrees and (1) 1/2 pint of 2% milk with a temperature of 47 degrees. Interview with the Food Director and Dietary Manager confirmed the refrigerator was not at an appropriate temperature. Continued interview confirmed the following TSC foods stored in the refrigerator would be discarded: 5- 1/2 pints of fat free milk (continued on next page)

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	445017	A. Building B. Wing	08/20/2018

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10- 1/2 pints of 2% milk 5- 1/2 pints of buttermilk 10 cheese slices 1 unopened package of approximately 30 cheese slices 1 unopened package of bologna slices 1 opened package of approximately 25 bologna slices 2 qts vanilla pudding and 3 qts chocolate pudding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 36450 Based on facility policy review, medical record review, review of facility falls investigations, review of facility dailycensus and staffing, observation, and interview, the Administrator failed to ensure facility policy and procedures were implemented for falls; failed to ensure revision of care plans was completed with appropriate and individualized interventions to prevent falls; failed to prevent avoidable pressure ulcers; failed to ensure an effective falls program was implemented to prevent residents from having multiple falls and multiple injuries with falls; and failed to ensure adequate staffing to supervise residents who had falls and adequate staffing to provide activities of daily living care (ADL) care to residents. The Administrator's failure to ensure an effective falls program was implemented placed 7 residents (#28, #34, #39, #40, #47, #80, and #119) in Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Administrator's failure to ensure residents were provided assistance with toileting resulted in Harm to Residents #80 and #89. The Administrator's failure to ensure residents received pain control resuled in Harm to Resident #236. The Administrator's failure to ensure residents did not develop pressure ulcers resulted in Harm to Resident #80. The Administrator and the Director of Nursing (DON) were informed of the IJ in the conference room on 8/18/18 at 8:10 PM. The facility was cited Immediate Jeopardy at F-657, F 689, F725, F 726, F 841, F 867 and F 947. The facility was cited Substandard Quality of Care (SQC) at F-689 The IJ was effective 11/10/17 and is ongoing. The findings include: During the annual Recertification survey conducted 8/13/18 - 8/20/18, review of clinical notes, accident reports, and fall investigations revealed Resident #119 had 9 falls between 7/1/17 - 7/10/18 and sustained 3 major injuries: a right tibia fracture, left femur fracture, and left hip fracture; Resident #28 had 2 falls between 2/15/18 - 6/7/18 and sustained 1 major injury: a fracture of the left femur; Resident #34 had 2 falls between 2/25/18 - 7/14/18 and sustained 2 injuries: a left hip fracture and a laceration to the back of the head requiring staples; Resident #39 had 9 falls between 4/2018 - 8/2018; Resident #47 had 8 falls between 4/5/18 - 6/13/18 and sustained 1 injury: a right eye injury requiring sutures. Resident #40 had 4 falls between 4/2018 - 8/2018 and sustained 1 injury: a subdural hematoma [a collection of blood outside the brain]; and Resident #80 had 5 falls between 1/27/18 - 7/2/18 and sustained 1 major injury: a Cervical 1 - Cervical 2 fracture. During the Recertification survey, review of wound reports, Wound Nurse Practitioner documentation, and interviews, revealed Resident #80 developed 1 avoidable unstageable wound to the right clavicle. (continued on next page)

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	445017	A. Building B. Wing	08/20/2018

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the Administrator on 8/20/18 at 12:20 PM, in the conference room, revealed the Administrator led the Quality Assurance and Performance Improvement (QAPI) meeting. During the meeting they discussed how many falls during a month looking for trends and patterns. Falls were reviewed during the morning meeting. The Administrator stated .some things I was concerned about .some of the interventions were not appropriate .after doing it that month [review of falls in AM meeting] our teams were educated . educate as we go .if nursing staff used same intervention or inappropriate intervention we would educate the mentor at that time . Further interview confirmed the facility had not used root cause analysis during falls and a resident's historical falls was not being discussed. The facility conducted the first root cause analysis in July. Further interview revealed, .saw increase in falls .increase multiple resident falls .we knew fall rate increased . Further interview revealed, .have not discussed pressure ulcers in huddle .not sure if they're talking about them in therapy .we have not done it in morning meeting yet . Interview with the Consultant, who was the facility's previous Administrator from 3/18 - 6/18, on 8/20/18 at 1:47 PM, in the conference room, revealed the falls program included household huddles daily to find interventions. The previous Administrator stated he did not attend the meetings and did not have clinical experience and relied on the nurses for interventions. Further interview revealed that approximately the 3rd week of April he became aware falls had increased. The previous Administrator called on the Minimum Data Set (MDS) nurse to assist in decreasing falls. The previous Administrator stated there was a falls task force with in the form of huddle meetings. The previous Administrator confirmed he had no involvement in the huddles or Interdisciplinary Team (Interdisciplinary Team) meetings. He stated MDS would facilitate those meetings and .informal monitoring to ensure meetings [huddles] being held with [MDS #1] were informal . nothing formal . Refer to Refer to F-550, F-657, F-677, F-686, F-689, F-697, F-725, F-726, F-867, F-947

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 36450 Based on review of the Medical Director Contract, review of the Advanced Practice Nurse (APN) Protocol, review of the Facility Assessment, medical record review, review of facility falls investigations, observation, and interview, the Medical Director failed to ensure identification, development, and implementation of appropriate plans of action and ensure the effective use of its resources to maintain the highest practicable well-being of all residents, failed to ensure performance improvement was implemented and monitored, failed to provide an individualized pain management plan to avoid pain and mental anguish, failed to ensure interventions were implemented for residents with repeated occurrences with falls which placed residents at risk of harm, failed to ensure revision of care plans were done with appropriate and individualized interventions to prevent falls, failed to prevent avoidable pressure ulcers, failed to ensure an appropriate falls intervention program was implemented to prevent residents from having multiple falls and injuries, and failed to ensure a facility assessment was performed and implemented. The Medical Director's failure placed 7 residents (#119, #28, #34, #39, #40, #47, #80) in Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Administrator and the Director of Nursing (DON) were informed of the IJ in the conference room on 8/18/18 at 8:10 PM. The facility was cited Immediate Jeopardy at F-657, F725, F 726, F 835, F 841, F 867 and F 967. The facility was cited Substandard Quality of Care (SQC) at F-689 The IJ was effective 11/10/17 and is ongoing. The findings include: Review of the Medical Director Contract revealed .4. Services to be performed by provider .Responsible for the overall coordination of medical care at the Facility. Coordination of care means Provider shares responsibility for assuring Facility is providing appropriate care as required which involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of medical services and medical care of residents .Evaluate and take appropriate steps to correct any problems associated with any possible inadequate care Provider identifies .Participate, upon request, in personnel evaluations and other quality monitoring programs established by the Facility including attendance at the Facility's Quality Assurance Committee meetings .Provider will deliver high quality services that .Promote standards of timeliness .enhance continuity of service to all Health Center residents .conform to federal and state regulations . Review of the Advanced Practice Nurse (APN) Protocol, undated, revealed .Requiring Authority .the [APN] will provide health care services under the general supervision of [Medical Director] .F. Interpret and analyze patient data to determine patient status, care management and treatment and effectiveness of interventions . (continued on next page)

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	445017	A. Building B. Wing	08/20/2018

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F 0841 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Facility Assessment 2018, dated 6/2/18, revealed .Community Staff .The Medical Director oversees medical practice and provides guidance in the development of clinical policies and programs at our community .Currently, there is 1 Medical Doctor and 2 Nurse Practitioners who visit the community two to three times a week to see residents . During the annual Recertification survey conducted 8/13/18 - 8/20/18, review of clinical notes, accident reports, and fall investigations revealed Resident #119 had 9 falls between 7/1/17 - 7/10/18 and sustained 3 major injuries: a right tibia fracture, left femur fracture, and left hip fracture; Resident #28 had 2 falls between 2/15/18 - 6/7/18 and sustained 1 major injury: a fracture of the left femur; Resident #34 had 2 falls between 2/25/18 - 7/14/18 and sustained 2 injuries: a left hip fracture and a laceration to the back of the head requiring staples; Resident #39 had 9 falls between 4/2018 - 8/2018; Resident #47 had 8 falls between 4/5/18 - 6/13/18 and sustained 1 injury: a right eye injury requiring sutures. Resident #40 had 4 falls between 4/2018 - 8/2018 and sustained 1 injury: a subdural hematoma; and Resident #80 had 5 falls between 1/27/18 - 7/2/18 and sustained 1 major injury: a Cervical 1 - Cervical 2 fracture. During the Recertification survey, review of wound reports, Wound Nurse Practitioner documentation, and interviews, revealed Resident #39 developed 3 avoidable wounds: 1 stage II on the right buttock, 1 stage III to left buttock, and an unstageable to the coccyx; Resident #80 developed 1 avoidable unstageable wound to the right clavicle; Resident #86 developed 1 avoidable stage IV wound to the right hip; and Resident #119 developed 2 avoidable wounds: 1 unstageable to the left ischium and 1 stage II to the right foot. Review of facility Quality Assurance and Process Improvement Meeting (QAPI) meeting minutes dated 8/29/17 - 7/24/18 revealed the Medical Director attended 11 out of 13 QAPI meetings. Interview with the Medical Director on 8/20/18 at 11:14 AM, in the conference room, confirmed she attended the QAPI meetings and falls were reviewed monthly in the meetings. Continued interview confirmed recurrent falls were reported to the Nurse Practitioners (NP) and any concerning issues went directly to the Medical Director. Further interview confirmed .I don't know how much detail is in QAPI meeting . Continued interview confirmed .involvement with pressure ulcers primarily supervisory. I use wound trained NP's and a wound Nurse . Further interview confirmed .greatest trend identified is the multiple changes in leadership and large turn-over in staff that are unfamiliar. Difficult to do training with mostly on the job training, and turnovers in leadership have not been helpful .Falls .We can't tie them up . Continued interview confirmed when the Medical Director signed the Incident/Accident reports she was agreeing with the interventions put in place. The Medical Director stated .the reports are not always timely . Refer to F 550, F657, F 677, F 686, F 689, F 697, F 725, F 726, F 835, F 867, and F 947.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 36450 Based on review of the facility Quality Assurance and Performance Improvement Plan, Facility Assessment review, medical record review, observation, and interview, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to have an effective, ongoing QAPI program to ensure an effective falls program was implemented to prevent repeated falls for residents, resulting in injuries after falls. The QAPI committee's failure to ensure an appropriate falls intervention program was implemented, failure to ensure care plans were revised after falls, failure to ensure sufficient staffing to supervise residents at risk for falls, and failure to ensure competent staff, resulted in residents having multiple falls and injuries, and placed 7 residents (#119, #28, #34, #39, #40, #47, and #80) of 40 residents in the facility who had falls, in Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Administrator and the Director of Nursing (DON) were informed of the IJ in the conference room on 8/18/18 at 8:10 PM. The facility was cited Immediate Jeopardy at F-657, F725, F 726, F 841, F 867 and F 967. The facility was cited Substandard Quality of Care (SQC) at F-689 The IJ was effective 11/10/17 and is ongoing. The findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility Quality Assurance and Performance Improvement Plan, revised 2/27/18, revealed . Purpose .[QAPI] Program utilizes an on-going, data driven, pro-active approach to advance the quality of life and quality of care for the residents .Quality Assurance and Performance Improvement principles drive our decision making as we endeavor to produce positive outcomes .QAPI committee consists of representatives from various departments .Performance Improvement Projects (PIPs) will be implemented when an opportunity for improvement is identified. These PIPs may apply to processes or systems throughout the community .QAPI program is ongoing, comprehensive and addresses the services provided .data will be obtained from the following reports .Clinical reports - infection, medication error, pressure injuries, falls .The QAPI team will meet monthly, or more often as needed, to review findings and identify potential PIPs .The Nursing Home Administrator (NHA) and Board of Directors are responsible and accountable for the development, implementation and monitoring of the QAPI program .The Quality Assurance (QA) Committee consists of the Director of Nursing Services, the Medical Director, the Administrator, at least two other members of the facility staff, and the Infection Preventionist .The QA Committee meets at least quarterly to coordinate and evaluate the activities under the QAPI program .The QAPI Steering Committee, which includes the Medical Director as co-chair, meets monthly and is accountable for the continuous improvement in Quality of Life and Quality of Care .The QAPI Steering Committee collects data from QA sub committees (e.g., pain, falls, and weight loss) .All associates including contracted staff are educated on the principles of QAPI .Associates will be trained on using QAPI process including participation on a Performance Improvement Project (PIP Team) .The QAPI program is sustained during transitions in leadership and staffing through all-associate education and involvement in the QAPI process .PIPS .identify areas where gaps in performance may negatively affect resident .In prioritizing activities, the team will consider: high-risk to residents .high-volume or problem prone areas .health outcomes .resident safety .resident choice .At least annually a project that focuses on high risk or problem-prone areas will be addressed through the QAPI program including PIP development .The team will utilize root cause analysis to identify the cause of the problem and any contributing factors. Plan-Do-Study-Act PDSA will also be used .Our community uses a systematic approach to determining the root cause of an issue and any contributing factors. Facility associates and management have been trained on Root Cause Analysis .The QAPI program will be evaluated annually by the QAPI Steering Committee with input from the Leadership Team/Executive Leadership. This review will include whether goals were met, if standards of practice are being followed, any training needs will be identified and addressed . Review of Facility Assessment 2018, dated 6/2/18, revealed .Community Assessment and QAPI .Information from the Community Assessment will be incorporated into the Quality Assurance Performance Improvement (QAPI) process .The identification of residents will help to drive the activities of the QAPI process. The description of care, services and resources available at our community provides both areas for monitoring of processes and outcomes as well as information for investigation of root causes of adverse events and gaps in performance .Community Staff .Our community is overseen by a Board of Directors, an Executive Director and a licensed Nursing Home Administrator. The Medical Director oversees medical practice and provides guidance in the development of clinical policies and programs at our community .Currently, there is 1 Medical Doctor and 2 Nurse Practitioners who visit the community two to three times a week to see residents . (continued on next page)

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	445017	A. Building B. Wing	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the Director of Nursing (DON) on 8/18/18 at 7:13 PM, in the conference room, confirmed the facility staff were responsible for investigating falls. Falls were reported to the nurse on duty and the accident report was turned into the Clinical Mentor. The Clinical Mentor checked for completeness of the report and the nurse and Clinical Mentor discussed the interventions to put in place to prevent further falls. The DON stated she was not familiar with Long Term Care and had a background in acute care. The DON stated the facility had plans to reinstate a weekly fall meeting that the facility used to conduct before her arrival in April of 2018. The DON was not sure when weekly fall meetings had stopped, but they had reviewed the falls and ensured care plans were updated. The DON stated the current facility practice was for the nurse Clinical Mentor to decide on a fall intervention and to put it in place immediately after an incident. The accident reports were filed and tracked by the Minimum Data Set (MDS) Coordinator in an excel spread sheet that was brought to QAPI. The nurse was to do a fall risk assessment after every fall and it was put with the investigation packet. Any interventions put in place depended on interventions already in place. The DON stated the nurses knew what options were available and they used .nursing clinical judgement [used when deciding which intervention to put in place] .no education on falls .just their [staff] clinic experience . The DON stated fall investigation reports were then brought to a leadership huddle with leadership staff, to the DON, to the Administrator, and to the Medical Director for signatures. The DON stated in the leadership huddles they just reviewed the investigation completed by the unit nurses and looked at what the nurses indicated was the probable cause, interventions nursing implemented, time of fall, and any patterns. The DON stated the nurses did not do any root cause analysis at the time of the fall and the leadership was also not doing a root cause to determine the cause of the fall in order to implement interventions to prevent further falls. The DON stated they were aware the care plans were not updated, I don't know when the care plans [were updated] .the mentor in the house should be updating the care plans .I think that there is work to be done .doing weekly meetings we will be able to get more in depth and with dementia they [residents] forget they can't get up . The facility started a PIP for falls in May after there had been 3 falls with injury and the facility needed to re-evaluate falls. The DON then stated the facility started looking at fall interventions when the new Administrator arrived in June. Interview with the Administrator on 8/20/18 at 12:20 PM, in the conference room, confirmed she led the QAPI meeting and staff discussed how many falls during a month and any trends or patterns. QAPI looked at residents with multiple falls in a month but did not look back further. The Administrator stated they didn't go back and look at every fall back in June or last year.we haven't gotten there yet . The Administrator started a PIP plan and they reviewed falls in the morning meeting. The Administrator stated .some things I was concerned about .some of the interventions were not appropriate .after doing it that month [review of falls in morning meeting], our teams were educated .educate as we go .if nursing staff used same intervention or inappropriate intervention we would educate the mentor at that time . The Administrator stated root cause analysis during falls and related to a history of falls was not being discussed and the first root cause analysis was conducted in July. The facility saw an increase in falls and increase in multiple resident falls, and they looked at one month of falls. The Administrator stated they knew the fall rate increased. The Administrator stated .as we are starting the PIP plan we would talk .about education .have not discussed pressure ulcers in huddle .not sure if they're talking about them in therapy .we have not done it in morning meeting yet . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the Consultant, who was the previous Administrator from 3/18 - 6/18, on 8/20/18 at 1:47 PM, in the conference room, revealed he did not attend the falls meetings or huddles and stated he did not have clinical experience. He stated he relied on the nurses for implementation of interventions. Further interview revealed he became aware approximately the 3rd week of April falls had increased and he .Called on MDS [Minimum Data Set nurse] . to address. He stated, .MDS would facilitate those meetings .informal monitoring to ensure meetings [huddles] being held with [MDS #1] were informal .nothing formal . Interview with the Medical Director on 8/20/18 at 11:14 AM, in the conference room, confirmed recurrent falls were reported to the Nurse Practitioners (NPs) and any concerning issues went directly to the Medical Director. Further interview confirmed .I don't know how much detail is in QAPI meeting . [Medical Director's] involvement with pressure ulcers primarily supervisory, I use wound trained NP's and a wound Nurse . Further interview confirmed .greatest trend identified is the multiple changes in leadership and large turn-over in staff .and turnovers in leadership have not been helpful .Falls .We can't tie them up . Refer to F-550, F-657, F-677, F-686, F-689, F-697, F-725, F-726, F-835, F 841, and F-947.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35200 Based on review of the facility's 2018 Assessment, review of the facility's computer based training documentation, and interview, the facility failed to implement a system to track nurse aide competency levels in order to ensure training was sufficient based on the resident population. The Administrator and the Director of Nursing (DON) were informed of the IJ in the conference room on 8/18/18 at 8:10 PM. The facility was cited Immediate Jeopardy at F657, F689, F725, F726, F841, F867 and F947. The facility was cited Substandard Quality of Care (SQC) at F-689 The IJ was effective 11/10/17 and is ongoing. The findings include: Review of the 2018 Facility Assessment revealed .Each job description identifies the required education . Additional competencies are determined according to the amount of resident interaction required by the job role, job specific knowledge, skills and abilities and those needed to care for the resident population. Certified nursing assistants may have additional required competencies .competencies are based on the care and services needed by the resident population .competencies are verified upon orientation, at least annually and as needed .The Staff Development Coordinator tracks and trends course completion history and performance trends, reporting those to the Administrator and Director of Nursing (DON) . Review of the facility's computer based training documentation revealed no tracking system in place to determine nurse aide competency after required annual training and in-service education, including understanding falls and skin checks. Interview with the Staff Development Coordinator on 8/18/18 at 4:30 PM, in the conference room, confirmed she was not involved in decision making of when nurse aides were competent and did not recall any specific training on falls other than the computer based Relias training assigned during orientation and annually. When asked if falls was covered in that training, the Staff Development Coordinator stated that she thought she remembered something on falls, like what to do if you see water in the floor. Further interview revealed she was new to the position and stated she did not have an annual plan or monthly plan for education. She was still trying to find out where deficiencies in education were and developing an education month to month if someone told her there was a need. Interview with the Staff Development Coordinator on 8/20/18 at 2:49 PM, in the conference room confirmed . [Nurse] Mentors check [computer based training] and HR [human resources] follows that .I just started . orientation begins with me .goes on to mentor .[mentors] pick a preceptor .[nurse mentors] evaluate in 1st 90 days and if not performing .mentors talk to DON [Director of Nursing] .[nurse mentors] keep in contact with HR for Relias [computer based training] .Excel [spreadsheet] is more for me to know who is with what mentor .what household they are [on] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Place at Maryville	2648 Sevierville Rd Maryville, TN 37804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the Staff Development Coordinator on 8/20/18 at 4:55 PM, in the conference room, confirmed the facility did not have a system in place to track and trend the competency levels of nurse aides. Refer to F-550, F-677, F-689, F-725 38390