Printed: 06/02/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIE Church Hill Post-Acute and Rehab			P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and neglect by anybody. **NOTE- TERMS IN BRACKETS IN	AVE BEEN EDITED TO PROTECT Codical record review, observation, and in #65 and #45) from abuse of 16 residence implemented to prevent continued was ailure of a Certified Nursing Assistant (in them arguing in the hallway, with Resime to Resident #65. Resident #30 contings rooms, then entered Resident #45's ty's failure to prevent abuse by Resident y (a situation in which the provider's not caused, or is likely to cause serious injustment interventions to address Resident all to affect all residents in the facility the Immediate Jeopardy (IJ) in the correspondent of the immediacy of the jeopath was effectively the removed the immediacy of the jeopath was every validated onsite by the surveyors.	ONFIDENTIALITY** 40105 Interview, the facility failed to prevent the reviewed for abuse. The facility's indering of Resident #30 in and out CNA) to separate Resident #30 and dent #30 hitting Resident #65 in the mued to wander throughout the room, attempted to choke her, and in the standard Resident #65 and incompliance with one or more cury, harm, impairment, or death to a dent #30's wandering and inference room on 7/10/2021 at Substandard Quality of Care. The S/3/2021-7/11/2021. Try, was received on 7/12/2021 at Interview of the standard Resident #30's wandering and Interview of the standard Resident #30's wandering

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 445237

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLII Church Hill Post-Acute and Rehab		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	showed .The purpose of this writter prevention and action steps taken and to review practices and omissi this program shall apply to the preventative steps will be interventions to deal with aggressive Services] defines abuse .Identifying Management .Understanding behaviors .Outburst or yelling out .likely to occur .assure that the staff behavioral symptoms .The identificand monitoring of residents with neinterventions to deal with aggressive and their reaction to other resident: appropriate actions when abuse .is residents with needs and behaviora aggressive behaviors, residents with Medical record review showed Res [DATE] with diagnoses including D Disorder, Major Depressive Disord Review of Resident #30's compreh [as evidenced by] History of attempt becomes aggressive/combative will frequent redirection .Distract her from the conversation, television, book .Mor diversional interventions in behavior Review of Resident #30's Plan of C and out of other resident rooms .direction .Review of Resident #30's Respirate currently experiencing unwanted by noted. Resident wanders at night Review of Resident #30's admission severe cognitive impairment and her required supervision to walk in the Review of Resident #30's Care Plan Review of Resident #30's Ca	Freedom of Abuse, Neglect and Exploration Freedom of Abuse, Neglect, Exploitation reduce the potential for abuse, mistrons which if allowed to go unchecked, vention of an abuse committed by anyon of resident mistreatment physical and/e taken to reduce the potential for such ve reactions of residents. How CMS [Cog what constitutes abuse. Recognizing vioral symptoms of residents that may reatastrophic reactions of residents. We identifying, correcting and intervening if assigned have knowledge of the individuation, ongoing assessment, care plannieds and behaviors which might lead to ve and/or catastrophic reactions by residents and behaviors which might lead to easier and developed in the such as a suspected. Assess, monitor and developed in the such as a suspected and such as	tion Standard is to outline the eatment and neglect of residents . could lead to abuse .The scope of one including .Residents .This or mental abuse .by any .other occurrences .Appropriate enters for Medicare and Medicaid signs of abuse .Dementia increase the risk of abuse and /andering or elopement-type on situations in which abuse .is more idual residents' care needs and oing for appropriate interventions, oconflict .Train staff in appropriate idents .Observe resident behaviors of abuse by residents .Take lop appropriate plans of care for residents with a history of other resident's rooms . In [DATE] and readmitted on Type 2 Diabetes Mellitus, Anxiety of outliness to wear socks and shoes, she outliness to wea

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED 07/13/2021
	443237	B. Wing	01/10/2021
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Church Hill Post-Acute and Rehab	ilitation Center	701 West Main Blvd Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG		SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)	
F 0600 Level of Harm - Immediate jeopardy to resident health or safety	Note dated 5/3/2021 at 1:52 PM, sl	uality Assurance and Performance Imp howed .Resident remains a wandering nterdisciplinary Team] will continue to r entions and intervene accordingly .	risk with behaviors present. Close
Residents Affected - Many	reported to this nurse an Resident	n Notification Progress Note dated 5/3/ to resident altercation. [Resident #30] v ir back, [Resident #65] was screaming	who was hitting [Resident #65] on
		on Administration Progress Note dated ital for evaluation after the incident .res	
	Review of Resident #30's hospital documentation dated 5/3/2021, showed .PT [patient] SENT FROM [name of facility] AFTER HITTING A RESIDENT. PT SENT HER [here] FOR A MENTAL EVALUATION AND HAS A DX [diagnosis] OF DEMENTIA .sent here for mental eval [evaluation] as she apparently hit another resident at the nursing home today .		IENTÄL EVALUATION AND HAS
	Review of Resident #30's Risk Meeting Progress Note dated 5/4/2021, showed .IDT will continue to monitor for effective/appropriateness of interventions and intervene accordingly. IDT met, reviewed, discussed, and in agreement . Review showed no additional interventions were implemented after the resident-to-resident abuse on 5/3/2021.		OT met, reviewed, discussed, and
	Review of Resident #30's Plan of Care Progress Note dated 5/4/2021 at 11:14 AM, showed .Resident returned to facility at 0630 [6:30 AM] via [by] stretcher with no new orders received .		
	occurred on 05.03.21 @ [at] 1659 #30] was in a central location of ha [wheelchair] backwards with [Resic on top of the head several times. [f successfully. [Resident #30] was u chair when all of a sudden [Reside [wheelchair] backwards'. Called the send [Resident #30] to .ER [emerg	s Risk Meeting Note dated 5/4/2021, showed .Resident to Resident [altercat [at] 1659 [4:59 PM]. This is Resident [Resident #30] and the aggressor - [Reation of hallway holding resident [Resident #65's] wheelchair and pulling the with [Resident #65's] foot in the wheel of the chair. [Resident #30] hit [Resident times. [Resident #65] started screaming for help. [Resident #30] was redicted was unable to give description. [Resident #65] stated 'I was just sitting in [Resident #30] started hitting me on top of the head and pulling my w/c Called the psych [psychiatric] NP [Nurse Practitioner] and new orders receing [Remergency room] for psychiatric evaluation and treatment .Monitor residuers] 15 minutes and document x [for] 72 hours. Maintain personal space of	
	began hitting the other resident [Rewas screaming for help .Mental he	n's Progress Note dated 5/4/2021, shown sesident #65] on her head and pulling .walth nurse practitioner was notified and mergency department for evaluation.	heelchair back .The other resident
	(continued on next page)		

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NAME OF PROVIDER OR SUPPLIE Church Hill Post-Acute and Rehabi		STREET ADDRESS, CITY, STATE, ZIP CODE 701 West Main Blvd Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Psychiati behaviors-patient having increased eval [evaluation] and was returned delusions, reasonable to add Serod aggression .Combativeness .Sever daily] delusions . Review of Resident #30's Behavior wandering through out facility this s redirection, but generally will redire Review of Resident #30's Room Chin a .a resident to resident altercation. Review of Resident #30's Behavior to wander facility .Resident continu Review of Resident #30's Psycholog referred by the Medical Director (Mand even appeared angry .walked dismissive, has poor contract and selection of Resident #30's Behavior frequently walks throughout the buil what to do. She shakes her head a immediately per SS [social services Review of Resident #30's Behavior [wanders] the halls. Resident frequently drinks, food, etc. Resident has bee Review of Resident #30's Social Services (DSS) documented .Resident called and left a message with profurther recommendations or interesidents [residents] rooms taking away from another Resident because Review of Resident #30's Medication or dated 5/4/2021 to monitor the great residents and the resident #30's Medication or dated 5/4/2021 to monitor the great residents and the resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great residents [resident #30's Medication or dated 5/4/2021 to monitor the great re	ric Evaluation dated 5/4/2021, showed agitation, restlessness, aggression. W without medication changes. Patient had puel [an anti-psychotic medication] to take restlessness. Recommendations: see Note/Anxiety Progress Note dated 5/5 shift. Entering residents' room and nursect. In ange Progress Note dated 5/5/2021, soon, and the facility moved Resident #3 Note/Anxiety Progress Note dated 5/5 es 15 minute checks. In ange Diagnostic Interview dated 5/6/20 D) on 5/6/2021 to be seen by the Psycodirectly into another patient's room after seems angry. Note/Anxiety Progress Note dated 5/2 Idling and goes into offices and just sits and gets upset when things don't go her seems and goes into other Resident's [resident involved in a couple of verbal argument ervice Progress Note dated 5/2 entity goes into other Resident's [resident involved in a couple of verbal argument ervice Progress Note dated 5/20/2021, dent exhibiting inappropriate behaviors sych NP to assess for any needed mental erventions were implemented. Note/Anxiety Progress Note dated 5/2 items, food, etc. that doesn't belong to see she thought it was hers.	Evaluating mood and das sent out to ER for emergency aving increased psychosis and arget symptoms .Agitation: Physical roquel 25 mg [milligrams] bid [twice d/2021, showed .Resident es' station. Becomes agitated with showed Resident #30 was involved 0 to a room on a different hall. d/2021, showed .Resident continues d/2021, showed .Resident continues d/2021, showed .Resident down ar leaving this area . patient is down. She tells other residents away .Psych to be notified d/2021, showed .Resident wonders ents' rooms and takes belonging, ents with other residents . showed the Director of Social .Discussed in team meeting this a. dications . Further review showed d/1/2021, showed .entering other to her. Resident tried to take a drink 15/1/2021-5/31/2021, showed an 15 minutes for 72 hours.
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	445237	A. Building	07/13/2021
	440207	B. Wing	
NAME OF PROVIDER OR SUPPLI	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		P CODE
Church Hill Post-Acute and Rehab	ilitation Center	701 West Main Blvd	
		Church Hill, TN 37642	
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F 0600		Note/Anxiety Progress Note dated 6/4	
Level of Harm - Immediate		ngly more intrusive into other Resident esident upsets other Residents with he	
jeopardy to resident health or safety	other Residents in their wheelchair	around the halls. Resident takes a quit	te a bit of time to manage.
Residents Affected - Many	Review of Resident #30's Social So	ervice Progress Note dated 6/8/2021, s in rooms, grabbing things out of reside	howed .Resident displaying
Trestactive villested many		any medication changes . Further revie	
		Note/Anxiety Progress Note dated 6/3	
		ident wandering into other resident rooi igs from nurses [nurses'] station, and o	
	Review of Resident #30's Behavioral Note/Anxiety Progress Note dated 7/5/2021, showed .Resident		
	continues to wander this shift. Resident wandering into other resident rooms causing distress to other residents. Resident is also taking things from nurses [nurses'] station, med carts, and other residents room PRN's [as needed medications] unsuccessful. Attempts to redirect are unsuccessful.		d carts, and other residents rooms.
	Medical record review showed Resident #65 was admitted to the facility on [DATE] with diagnoses includir Bipolar Disorder, Dementia Without Behavioral Disturbance, Difficulty Walking, Anxiety Disorder, Insomnia and Acquired Absence of Right Leg Below Knee.		
	attention seeking behaviors as evid	ensive care plan dated 11/20/2020, she denced by often becoming tearful for no ecessary to protect the rights and safet alternate location as needed.	particular reason .states she has
	cognitive status, the resident was in	s quarterly MDS dated [DATE], showed Resident #65 had moderately impaire dent was independent for locomotion on the unit, and used a wheelchair for mented, and no wandering was documented.	
	Review of Resident #65's Physician's Notification Progress Note dated 5/3/2021, showed .Resi Resident altercation. This is [Resident #65] sitting in wheelchair while [Resident #30] was pushi back and hitting [Resident #65] on top of head. Residents redirected with success .		sident #30] was pushing wheelchair
	behaviors-patient was involved in a	ric Evaluation dated 5/4/2021, showed an incident with another resident since to reasonable to restart as needed Valiunions.	that time she had increased anxiety
		n's Telephone Order dated 5/4/2021, si ce daily] .Valium 2 mg po BID PRN x [fo	
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NAME OF PROVIDER OR SUPPLII Church Hill Post-Acute and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 701 West Main Blvd Church Hill, TN 37642	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #65's Physicial resident on the resident violence [w since that time .The patient reports and hit her right parietal [top of hea exacerbation of patient's underlying when moving about the community Review of Resident #65's Medication received a dose of Valium 2mg .Resher room . Review of Resident #65's Behavior crying, stating 'I'm not going up the expressed some concern. PRN and and is resting in bed with eyes closs. Review of Resident #65's MAR dat twice daily as needed with a start of time on 5/5/2021. Review of Resident #65's Psychoth distressed. She was hit recently by approached the clinician stating she the patient stating she is having has significant stressor (being attacked as opposed to a manipulative qualie evaluation outside of the facility. Ther in the morning as resources worked Resident #65's Progress screening before going to [name of Review of Resident #65's Admission readmitted . Observation on 7/6/2021 at 12:15 Fin the room setting up a lunch tray hallway. Observation on 7/6/2021 at 2:46 Pl resident's room) while a CNA was in the room setting up a lunch tray hallway. During an interview on 7/6/2021 at into other residents' rooms. She stated if Resident #30 was noticed stated .there's not much we can do stated .there's not much we can do	n's Progress Note dated 5/4/2021, show with Resident #30] earlier in the week .1 the other individual [Resident #30] car and and temporal [side of head] area .The granuity disorder To become increasing in her wheelchair. On Administration Progress Note dated esident in hall crying, repeatedly saying the Note/Anxiety Progress Note dated 5/5 re' pointing towards room. I'm scared'. it is anxiety administered, and resident traced. Ded 5/1/2021-5/31/2021, showed an order of 5/4/2021. The Valium was administered of 5/4/2021. The Valium was administered was distressed, and she asked if she ellucinations was significant this time, are by another patient [Resident #30] and he e was distressed, and she asked if she illucinations was significant this time, are by another patient) is highly consistently. The patient was crying, and insistently in the clinician discussed this with the staff ould be more supportive.	wed .The patient was a victim of the The patient's been very anxious me up from behind her and grabbed his incident unfortunately set off rigly anxious and avoids individuals 5/4/2021, showed the resident had 'I'm not going up there' referring to 1/2021, showed .Earlier in shift, Resident reassured, but still ansferred to room on another hall therefore a value of the patient was quite a room was moved. The patient are could be sent to a psychiatric unit and having them directly after a the with the literature on psychosis, and to being considered for the patient was the state of the patient was quite at with the literature on psychosis, and on being considered for the patient was quite at a the patient was quite at with the literature on psychosis, and on being considered for the patient was a point at [name of hospital] for 1/2021, showed .Resident In [ROOM NUMBER]. A CNA was been and she wandered down the 1/2021, showed requently and did go sidents' water pitchers. CNA #1 are to come out of the room. She are to come out of the room. She are to come out of the room. She are to come out of the room.
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NAME OF PROVIDER OR SUPPLII Church Hill Post-Acute and Rehab		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	open the door to room [ROOM NUI 100 hallway and attempted to oper walked past a nurse seated at the in the office. She picked up a noteboon nurse's station, and went down the During an interview on 7/7/2021 at been in a resident-to-resident altered different room. She stated that Resident the incident on 5/3/2021, Resident wander and redigher the incident rooms and that pretty much let her wander and redigher prevent Resident #30's wandering that she has a fondness to go into wander into resident rooms, offices had stated they had belongings that Medical record review showed Resident prevent Disorder, Syncope and Col Supplemental Oxygen. Review of Resident #45's compreh for impaired cognitive function relation prevent other residents from enterior Review of Resident #45's 5-day Mi impairment, no behaviors noted, shwalk, used a wheelchair for mobility Review of Resident #45's Plan of Coriented] x 3 [person, place, time]. Review of Resident #45's Physician supervised the patient [Resident #45's Physician supervised Physician supervised the patient [R	2:07 PM, the Director of Social Service cation with Resident #65. She stated Rident #65 had .psych issues . and .docident #65 .became fearful .crying . The t's a problem .there is only so much me lirect her . She further stated the intervibehavior was .redirecting and put stop .the residents that complain . The DSS s, and nurse's stations, and she had be at were missing. Sident #45 was admitted to the facility of luscle Wasting, Chronic Obstructive Put lapse, General Anxiety Disorder, Wheelensive care plan dated 3/23/2021, sho ted to confusion, with an update on 7/9 and resident's room- Monitor Stop Sign of DS dated [DATE], showed the resident ne was totally dependent on staff for be	id not go in. She then went to the wandered to the nurse's station, Unit Secretary's office, and entered ed past the nurse seated at the es (DSS) stated Resident #30 had esident #30 had been moved to a sen't like to be touched. She stated DSS stated Resident #30 goes in edication you can mess with .we entions the facility had in place to signs on some residents' rooms confirmed Resident #30 would en informed that some residents In [DATE] and readmitted on elimonary Disease, Difficulty ental and Behavioral Disorders, ezing, and Dependence on wed Resident #45 had a potential /2021 for .stop sign to doorway to every 15 minutes for placement . had moderate cognitive and mobility and transfers, did not every 15 minutes for glacement . ed .Resident [Resident #30] ng .Resident [Resident #30] placed dit .The patient [Resident #45]

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Physicia into another resident's room [Resident making the resident [Resident #45] the residents [resident's] room [Repatient [Resident #45] is able to pure One-on-one observation if available Review of a facility witness statemed [Resident #45] stated she was sleed #30] standing over her. She claimed hurt her/die. The facility's video surveillance food 1:49 PM, with the Administrator and on 7/8/2021 showed Resident #30 5:47:24 AM. CNA #4 exited the she the other resident in the hallway with nurses station away from the residentered room [ROOM NUMBER] and AM. Resident #30 then entered Read to 5:48:42 AM. Resident #30 exited resident's room at 5:49:41 AM. Resident #30 exited resident's room at 5:49:41 AM. Resident #30 in the room the room with Resident #45). Observation on 7/8/2021 at 7:45 And another resident's room at the end During an interview on 7/8/21 at 8: room we [Resident #40 and Resident #40 stated she had report During an interview on 7/8/2021 at assigned to Resident #30 and Resident #40 stated she tried to the 300 hallway, but Resident #30 Resident #30 had wandered into ouse stop signs on the doors of som stop signs. Observation on 7/8/2021 at 8:30 A entered another resident's room.	n's Progress Note dated 7/8/2021, showed the shower hand about the shident #45] and placed her hand about the shident #45]. Frequently up and about the shident #45]. Frequently up and about the shident was from her neck .PLAN expressions. Plant given by Certified Nursing Assistant entry and thought was one of us shaking at Eastern the end of the 300 hallway at 5:46.10 ower room with another resident at 5:45 one just came out of the shower room, at the end of the shower room, at the end of the shower tower tower with another resident #30 stood by the shower tower the state of the shower tower tower was seen walking at 5:48:00 AM, and came back out of rower was seen walking at 5:51:39 AM (she had not been in the sident #45's roommate was seen walking at 5:51:39 AM (she had not been in the eone might do .she [Resident #30] has ted it to all the nurses and her roommate was and her roommate was and her roommate was seen walking at a fraid she will come in the eone might do .she [Resident #30] has ted it to all the nurses and her roommate was and her roommate was seen walking at the treatment of the was unsure which was an another than the was unsure which was an another was unsure which was unsure which was showed Resident #30 wandering by the showed Resident #30 wanderin	wed .Yesterday this patient went be residents [resident's] neck Resident #30] had wandered into be building, restless .Eventually the N .Mental health consult . It (CNA) #5, undated, showed . In the showed and her awake. But it was [Resident down her heek and told her she would the she went to the linen cart at the she went to the linen cart at the she went to the linen cart at the she would be sh
	Observation on 7/8/2021 at 8:45 A down the 300 hallway carrying a fo		the nurse's station and started

-	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(VZ) DATE CUDYEY
	DENTIFICATION NUMBER: 445237	A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitat	NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center STREET ADDRESS, CITY, STATE, ZIP CODE 701 West Main Blvd Church Hill, TN 37642		P CODE
For information on the nursing home's plan	n to correct this deficiency, please cont		agency.
` '	SUMMARY STATEMENT OF DEFIC Each deficiency must be preceded by t	IENCIES full regulatory or LSC identifying information	on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Residents Affected - Many Residents Affected - Many Residents Affected - Many	During an interview on 7/8/2021 at 9 proom. Resident #43 stated she final During observation on 7/8/2021 at 9 puring an interview on 7/8/2021, after Resides 1 puring an interview on 7/8/2021 at 1	9:13 AM, Resident #43 stated .that cra ally .ran crying to a nurse and she helped 9:22 AM, there was not a stop sign on 19:32 AM, Registered Nurse (RN) #2 stated approached Resident #65 in the hallow 5 had told Resident #30 to get away frow 19:34 the sident #30 to get away frow 19:35 AM, the medication cart. Resident was afraid to go in her room alone. If the resident is not was afraid to go in her room alone. If the facility had put stop signs up for the medication to the facility had put stop signs up for the medication was unaware of a sent #30 from wandering. 10:21 AM, CNA #2 stated that she had go near Resident #65. Resident #65 did was afraid to do .something . down tation, CNA #3 reported to her that Resident management was unaware of a sent #30 would go well the complaints to a nurse, there are ect the resident but was not made away might into other residents' rooms. 10:33 AM, CNA #3 stated on 5/3/2021, 1655 .screaming bloody murder . She can see to the nurse's station and Resident was set to the residents and Resident #30 was she has water on the brain and that the residents' rooms. She stated Resident was provide redirection but was unaware of an overland to the prevention of the prevent	zy one [Resident #30] comes in my ed me file a grievance. Resident #43's door. ated a few days after Resident #30 way as if she had recognized her om her because there was a and pulled her in the wheelchair on #65 approached her and stated The RN assisted her to the enight. RN #2 stated Resident #65 ed Resident #30 would wander into the rooms .we find may be an signs on their doors. RN #2 stated any other interventions the facility I been at the nurse's station on not want Resident #30 near her, the hallway without intervening. Sident #30 had hit Resident #65. It do some residents did complain. Into her room and go through her ally wasn't anything we could do are of any other interventions to I she was in a room on the 300 me out into the hallway and saw #30 was .tapping . Resident #65 of then .wandered off . CNA #3 could hurt her . CNA #3 stated ent #41 had complained about her to the Resident #30 from going into her my other interventions, including Is his call light on when other on one occasion, a resident had a resident .grabbed my wheelchair

			10. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIE Church Hill Post-Acute and Rehab		STREET ADDRESS, CITY, STATE, Z 701 West Main Blvd Church Hill, TN 37642	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety	into her room and woke her up. Re	11:10 AM, Resident #46 stated in the sident #46 stated that she did not know esident #46 stated it made her feel und	w her name but said .she walks
Residents Affected - Many	considers abuse to be a purposefu and the resident must have the cor (Interdisciplinary Team) team revie behaviors, diagnoses, and the caus Interview for Mental Status (BIMS) a score of 13-15 indicates cognitive make their own decisions. The ADG situation was and whether it was al and had been going through the harm Resident #30 approached Residen very behavioral . and the altercation the facility had provided close mon facility was her home. The ADON's decision would be made as to where the determined to be abuse. The AI residents were seen/heard arguing Resident #65 on 5/3/2021 that CN/ #30 had made willful physical contawandering had been discussed in I	1:31 PM, the Assistant Director of Nurl and willful physical act toward anothe apprehension and knowledge of what the was resident to resident altercations and sative factors. She stated the facility's score of 8 (a score of 8-12 indicates mely intact) or above, that the residents in DN stated each resident-to-resident altouse. She stated Resident #65 had be allway .crying and screaming. She stated the stated all was more of a tap. She further it met abuse. She stated all reside DON confirmed it was her expectation and she had not been aware of the area act with Resident #65 on 5/3/2021. The DT meetings. The ADON stated she hut the IDT had stated the facility was all the IDT ha	r such as punching, hitting, kicking, hey are doing. She stated the IDT dereviews the resident's history of standard is if a resident had Brief noderately impaired cognitive status, know what is going on and can ercation depended on what the en having behaviors on 5/3/2021 and it had been reported to her that urther stated both residents were are by the facility. The ADON stated eright to wander because the eviewed by the IDT team and a sunt-to-resident altercations would not for a staff member to intervene if 2 gument between Resident #30 and tion. The ADON confirmed Resident #30's ad suggested Resident #30 may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) PART STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X4) Building B. Wing (X3) DATE STATEMENT OF DEFICIENCIES (COMPLETED TO 1 West Main Blvd Church Hill, TN 37642 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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many FNOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY and the property and allegation of abuse for 2 residents (Residents #65 and #45) and report an allegation of abuse for 2 residents (Residents #65 and #45) and report an allegation of abuse for 2 residents (Residents #65 and #45) and report an allegation of abuse for 2 residents (Residents #65 and #45) and report an allegation of abuse for 2 residents (Residents #45) or 16 resident #45 in the head. Resident #45) or 16 resident fallure to ensure allegations of abuse were reported timely placed all residents in the facility Jeopardy (a situation in which the provider's non-compliance with one or more requirement has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room or 12:50 PM. The facility was cited F-609 at a scope and severity of L which constitutes Substandard Q The Immediate Jeopardy was removed 7/12/2021 and was effective 5/3/2021 - 7/11/2021 An acceptable Removal Plan, which removed the immediacy of the jeopardy, was receive 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and showed. All employees are required to immediately notify the administrative or nursing su	
Church Hill Post-Acute and Rehabilitation Center 701 West Main Blvd Church Hill, TN 37642 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) Timely report suspected abuse, neglect, or theft and report the results of the investigation authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY and interview, and interview, the facility failed to the state Survey Agency an allegation of abuse for 2 residents (Residents #65 and #45) and report an allegation of abuse to Administration for 1 resident (Resident #45) of 15 resident abuse. Resident #30 hit Resident #65 in the head. Resident #30 continued to display wan aggressive behavior and entered Resident #45's room and attempted to choke Resident failure to ensure allegations of abuse were reported timely placed all residents in the facility depardy (a situation in which the provider's non-compliance with one or more requirement has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room or 12:50 PM. The facility was cited F-609 at a scope and severity of L which constitutes Substandard Q The Immediate Jeopardy was removed 7/12/2021 and was effective 5/3/2021 - 7/11/2021 and An acceptable Removal Plan, which removed the immediacy of the jeopardy, was receive 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and The findings include: Review of the facility's policy titled, Freedom of Abuse, Neglect and Exploitation Standard	
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) F 0609 Timely report suspected abuse, neglect, or theft and report the results of the investigation authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on facility policy review, medical record review, and interview, the facility failed to the state Survey Agency an allegation of abuse for 2 residents (Residents #65 and #45) and report an allegation of abuse to Administration for 1 resident (Resident #45) and report an allegation of abuse were reported timely placed all residents in the facility be onesure allegations of abuse were reported timely placed all residents in the facility be onesure allegation of abuse were reported timely placed all residents in the facility abuse were reported timely placed all residents in the facility abuse were reported timely placed all residents in the facility accused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room or 12:50 PM. The facility was cited F-609 at a scope and severity of L which constitutes Substandard Q The Immediate Jeopardy was removed 7/12/2021 and was effective 5/3/2021 - 7/11/2021 An acceptable Removal Plan, which removed the immediacy of the jeopardy, was receive 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 at The findings include: Review of the facility's policy titled, Freedom of Abuse, Neglect and Exploitation Standard	
(Each deficiency must be preceded by full regulatory or LSC identifying information) F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Timely report suspected abuse, neglect, or theft and report the results of the investigation authorities. ***NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on facility policy review, medical record review, and interview, the facility failed to the State Survey Agency an allegation of abuse for 2 residents (Resident #45) and report an allegation of abuse to Administration for 1 resident (Resident #45) of 16 resident abuse. Resident #30's room and attempted to choke Resident #abuse. Resident #45's room and attempted to choke Resident #abuse. Agency (a situation in which the provider's non-compliance with one or more requirement has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room or 12:50 PM. The facility was cited F-609 at a scope and severity of L which constitutes Substandard Q The Immediate Jeopardy was removed 7/12/2021 and was effective 5/3/2021 - 7/11/2021 An acceptable Removal Plan, which removed the immediacy of the jeopardy, was receive 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 at The findings include: Review of the facility's policy titled, Freedom of Abuse, Neglect and Exploitation Standard	
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Residents Affected - Many Based on facility policy review, medical record review, and interview, the facility failed to tis State Survey Agency an allegation of abuse for 2 residents (Resident #45) of 16 resident abuse. Resident #30 hit Resident #65 in the head. Resident #30 continued to display wan aggressive behavior and entered Resident #45's room and attempted to choke Resident failure to ensure allegations of abuse were reported timely placed all residents in the facility Jeopardy (a situation in which the provider's non-compliance with one or more requirement has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room or 12:50 PM. The facility was cited F-609 at a scope and severity of L which constitutes Substandard Q The Immediate Jeopardy was removed 7/12/2021 and was effective 5/3/2021 - 7/11/2021 An acceptable Removal Plan, which removed the immediacy of the jeopardy, was receive 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 at The findings include: Review of the facility's policy titled, Freedom of Abuse, Neglect and Exploitation Standard	
is on duty of any complaint, allegation, observation or suspicion of resident abuse, mistreas of that the resident's needs can be attended to immediately and investigation can be undiall violations involving abuse are reported immediately, but not later than 2 hours after the .The abuse coordinator will contact the State Agency and the local Ombudsman office to abuse. Report the results of all investigations .to the State Survey Agency, within 5 workin incident. Medical record review showed Resident #30 was admitted to the facility on [DATE] and re [DATE] with diagnoses including Dementia with Behavioral Disturbance, Type 2 Diabetes Disorder, Major Depressive Disorder, Insomnia, and Delusional Disorders. Review of Resident #30's comprehensive care plan dated 4/13/2021, showed .elopement [as evidenced by] History of attempts to leave facility unattended .she becomes aggressiv other residents at times, she goes in and out of residents rooms . Review of Resident #30's admission Minimum Data Set (MDS) dated [DATE], showed the severe cognitive impairment and had wandered 1-3 days during the assessment period. (continued on next page)	timely report to the difailed to timely reviewed for andering and at #45. The facility's lility in Immediate ents for participation on 7/10/2021 at Quality of Care. 21. 22. 23. 24. 25. 26. 27. 27. 27. 28. 29. 29. 20. 20. 20. 20. 20. 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIE	-D	STREET ADDRESS, CITY, STATE, ZI	P CODE
Church Hill Post-Acute and Rehabi		701 West Main Blvd Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Physician #30 had been in a resident to resid #65] on the head and pulling her will Review of Resident #30's Physician other resident [Resident #65] on he for help. Review of Resident #30's Psychiating behaviors-patient having increased #30 was having physical aggression. Review of Resident #30's Behavior frequently goes into other Resident involved in a couple of verbal argurn. Review of Resident #30's Behavior to wander the halls, but is increasing and takes items and hides them. Rother Residents in their wheelchair Review of Resident #30's Behavior continues to wander this shift. Resi residents. Resident is also taking the Medical record review showed Resignolar Disorder, Dementia Withou and Acquired Absence of Right Legal Review of Resident #65's compreh particular reason states she has a of others. Review of Resident #65's quarterly cognitive status, the resident was in Review of Resident #65's Physician been in a resident to resident alterone Review of Resident #65's Psychiating Review of Resident #	In Notification Progress Note dated 5/3/ent altercation with Resident #65. This heelchair back, [Resident #65] was scrul's Progress Note dated 5/4/2021, shower head and pulling .wheelchair back .This head and pulling .wheelchair back .This rice Evaluation dated 5/4/2021, showed agitation, restlessness, aggression . Fin and combativeness. Note/Anxiety Progress Note dated 5/2's rooms and takes belonging, drinks, finents with other residents . Note/Anxiety Progress Note dated 6/4 gely more intrusive into other Resident esident upsets other Residents with he around the halls . all Note/Anxiety Progress Note dated 7 dent wandering into other resident roomings from nurses station, med carts, and ident #65 was admitted to the facility of the Behavioral Disturbance, Difficulty Wall grade Below Knee. ensive care plan dated 11/20/2020, she hole in her head' .intervene as necession. MDS dated [DATE], showed the resident progress Note dated 5/3/2021. Resident #30 was head to the second of	2021 at 5:16 PM, showed Resident Resident .was hitting [Resident earning for Help . wed .This person began hitting the he other resident was screaming .Evaluating mood and further review showed Resident food, etc. Resident has been . /2021, showed .Resident continues rooms. Resident enters every room er actions. Resident also pushes . /5/2021, showed .Resident ms causing distress to other and other residents rooms . In [DATE] with diagnoses including liking, Anxiety Disorder, Insomnia, . wed .often becoming tearful for no early to protect the rights and safety . ent had moderately impaired and used a wheelchair for mobility. 3/2021, showed Resident #65 had atting Resident #65 in the head. Evaluating mood and

	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MILLTIDLE CONSTRUCTION	
	IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
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` '	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #65's Physiciar resident on resident violence earlier reports the other individual came up temporal [side of head] area .This in disorder To become increasingly ar wheelchair . Review of Resident #65's Behavior crying and did not want to return to room for the night. Review of Resident #65's Psychoth distressed. She was hit recently by clinician stating she was distressed stating she is having hallucinations stressor (being attacked by another to a manipulative quality. The patient the facility . During an interview on 7/7/2021 at did not report resident to resident a report allegations of abuse. The AD Resident #65 was considered to be . During an interview on 7/7/2021 at would only be reported to the State resident altercation that occurred be to be abuse by the facility .those we the altercation was due to those be resident to resident altercation and to the State Survey Agency. Medical record review showed Res [DATE] with diagnoses including Mi Walking, Presence of a Cardiac Pa Bipolar Disorder, Syncope and Coll Supplemental Oxygen. Review of Resident #45's 5 day MD Review of Resident #45's Physiciar supervised the patient [Resident #46 right hand on the left side of the	a's Progress Note dated 5/4/2021, show in the week. The patient's been very a progress of from behind her and grabbed and hit incident unfortunately set off exacerbation incident in	wed .The patient was a victim of the anxious since that time .The patient her right parietal [top of head] and on of patient's underlying anxiety ving about the community in her //2021, showed the resident was The nurse moved her to a different showed .The patient was quite yed. The patient approached the resident unit .the patient nem directly after a significant terature on psychosis, as opposed onsidered for evaluation outside of sing (ADON) confirmed the facility . She stated the facility would recation between Resident #30 and a resident hits another resident, it ation. She stated the resident to 5 on 5/3/2021 was not considered this had a history of behaviors and olinary Team) would discuss any an abuse allegation or reported in [DATE] and readmitted on Imonary Disease, Difficulty ental and Behavioral Disorders, sizing, and Dependence on that moderate cognitive impairment. Ded .Resident [Resident #30] placed dit .The patient [Resident #45]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		<u>-</u>	
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #30's Physician's Progress Note dated 7/8/2021, showed .Yesterday this patient went into another resident's room [Resident #45] and placed her hand about the residents neck making the resident think she was being choked .Patient had wandered into the resident's room .Frequently up and about the building, restless .Eventually the patient is able to push the hand away from her neck .PLAN . Mental health consult .One-on-one observation if available . Review of a facility witness statement given by CNA #5, undated, showed .Resident [#45] stated she was			
	sleeping, and thought was one of us shaking her awake. But it was [Resident #30] standing over her. She claimed [Resident #30] had her hands around her neck and told her she would hurt her/die. Review of facility documentation dated 7/8/2021, showed the resident to resident abuse between Resident #30 and Resident #45 that had been reported to the staff on 7/8/2021 at 6:00 AM, had not been reported to the State Survey Agency until 7/8/2021 at 12:01 PM (4 hours after the occurrence). During an interview on 7/8/2021 at 8:27 AM, Licensed Practical Nurse (LPN) #2 confirmed she had been assigned to Resident #30 and Resident #65 on the day of the altercation between the 2 residents on 5/3/2021. A CNA had reported the altercation to her. LPN #2 stated Resident #65 .was distraught and upset crying .tearful .			
	aware of the resident to resident al 5/3/2021. She confirmed she had a delusions. She had also seen Resi about the incident and thought the NP confirmed the altercation did tri	1:40 PM, the Psychiatric (Psych) Nurs tercation between Resident #30 and Radded an antipsychotic medication for Edent #65 after the altercation and state woman (Resident #30) was out to get I gger some increased anxiety for Residation did cause Resident #65 some sig	esident #65 that occurred on Resident #30 after the incident for d Resident #65 had delusions her and out to kill her. The Psych ent #65 which required medication	
	During an interview on 7/9/2021 at 2:19 PM, the Medical Director (MD) stated he was aware of Resident #30's wandering into other resident's rooms and stated .she has bumped into a few folks along the way . He stated the resident to resident altercation that occurred between Resident #30 and Resident #65 .really set off [Resident #65's] anxiety .caused a significant amount of anxiety . He further confirmed the incident had caused Resident #65 to have psychosocial harm and there was a continued risk to other residents due to Resident #30's continued wandering.			
	Review of facility documentation dated 7/11/2021, showed the resident to resident abuse between Reside #30 and Resident #65 that occurred on 5/3/2021 was not reported to the State Survey Agency until 7/11/2021 (69 days after the occurrence). (continued on next page)			

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NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #45 to therapy in the mid-Resident #45 stated her morning h someone came into the room and sout when she looked up it was anoon. The PTA told Resident #45 he wo incident to a nurse. The PTA stated not been made aware of the incident his supervisor about 1-1 1/2 hours reported the incident to the ADON. During an interview on 7/13/2021 a Resident #30 and Resident #45 to incident to her supervisor RN #1. Let report. During a telephone interview on 7/17/2021 into the morning of 7/8/20 worked on all halls. CNA #5 reports (who resided on the 300 hallway) hor report the incident because she During an interview on 7/13/2021 a 7/8/2021. LPN #2 reported to her a Resident #45. RN #1 went immediate management was already aware. During an interview on 7/13/2021 a 7/8/2021 when the Rehabilitation Daltercation between Resident #30 a been notified of the incident and the after incident occurred). During an interview on 7/13/2021 a the Administrator confirmed Resident #30 had entered. Set them leaving their shift at 6:00 AM administration. She confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found in the state Survey Agency and confirmed the found i	th the thick that the thick the thic	er how her morning had been and at #45 stated to the PTA that had felt a hand on her upper chest #30 said to Resident #45. I'll kill you as he had already reported the incident. LPN #2 told him she had ated he also reported the incident to ad his supervisor then immediately and reported the incident between PN #2 stated she reported the ot reported the incident during shift the had worked the night shift on any that night and CNA #4 had reshift at 6:00 AM that Resident #45 #30 to her. CNA #4 stated she did supervisor of the 300 hallway on courred between Resident #30 and RN #2) and was told by RN #2 that the head worked to resident to resident at long before lunch when they had histrator (approximately 4 1/2 hours are for a period of 34 seconds from the happened in the room other than an ate had not been in the room the altercation to CNA #4 prior to out the second of 7/8/2021 to the her entity such as the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
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(X4) ID PREFIX TAG	G SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An acceptable Removal Plan, which AM, and the corrective actions were review of documents, review of facing The Removal Plan presented to the corrective actions implemented. On 7/10/2021 the Regional Director Nursing, Nursing Educator, Unit Markehab, Dietary, Admissions Liaison 1. the Abuse policy 2. types and reporting and investigated 3. process of identifying, preventing 4. how to recognize a potential behability of the Abuse Coordinator 6. suspected or observed abuse, all All staff not working on 7/10/2021 when a diagnosis of Deresident specific behavioral intervention of the Abuse Coordinator 2. All residents with a diagnosis of Deresident specific behavioral intervention of the Abuse Coordinator 3. All residents with a diagnosis of Deresident specific behavioral intervention of the Abuse Coordinator 3. All residents with a diagnosis of Deresident specific behavioral intervention of the Abuse Coordinator 3. All residents with a diagnosis of Deresident specific behavioral intervention of the Abuse Coordinator 3. All residents with a diagnosis of Deresident specific behavioral intervention of the Abuse Coordinator 3. All residents with a diagnosis of Deresident specific behavioral intervention and the Abuse Coordinator 3. All residents with a diagnosis of Deresident specific behavioral intervention and the Abuse Coordinator 4. All residents with a diagnosis of Deresident specific behavioral intervention and the Abuse Coordinator 4. All residents with a diagnosis of Deresident specific behavioral intervention and the Abuse Coordinator 4. All residents with a diagnosis of Deresident specific behavioral intervention and the Abuse Coordinator 4. All residents with a diagnosis of Deresident specific behavioral intervention and the Abuse Coordinator 4. All residents with a diagnosis of Deresident specific behavioral intervention and the Abuse Coordinator 4. All residents with a diagnosis of Deresident specific behavioral intervention and the Abuse Coordinator 4. All residents with a diagnosis of Deresident speci	in removed the immediacy of the jeopal evalidated on-site by the surveyors on lity policies, and staff interviews. It is survey team by the facility documents or of Operations provided training to the lanager, MDS Coordinator, Medical Recon, and Human Resources. The training lating and prevention of abuse and reporting abuse avior that is escalating, and to intervent of types, reported to the Administrator in lating and in-serviced. It is in-serviced by the Regional Director of egations of abuse. Interviewable residents were introns. Interviewable residents were introns. Interviewable residents were introns. Interviewable residents were introns. Residents that were not interviewable on 7/10/2021. The Regional Director of Rehab, and Human Resourt of that is escalating and to intervent exaministrator.	rdy, was received 7/12/2021 at 8:40 7/12/2021-7/13/2021 through ed the following immediate Administrator, Assistant Director of cords, Social Services, Director of included: The mediately of Operations on how to identify, eviewed and revised to reflect terviewed by the Social Service iewed had a skin assessment Director of Clinical services added to be investigated as an

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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Audits will be performed by the DO exacerbations of behaviors 5 times week for 4 weeks. The Nurse Educusing Hand-in-Hand. The Kardex's interventions that are resident spec of Clinical Services will monitor nur potentially could be exacerbated be 2 times per week for 4 weeks. Cha reviewed by the Administrator to er plan development is overseen by the and Rehab. Revisions to the behave plan updates are the responsibility. The QAPI committee will meet week Weekly updates will be provided by and/or the Regional [NAME] President of Ope until substantial compliance is achi. On 7/12/2021, Surveyors reviewed plans. The documentation showed education on abuse, types of abuse reporting, and investigating abuse. Residents affected by the wanderinharm had occurred. Twenty-two resupdated and Dementia care had be updated to include interventions on working on 7/12/2021-7/13/2021 harelated to abuse/behavior, Dement. On 7/12/2021, Surveyors validated DON, Nurse Educator, MDS Coord training, 2 therapists and 2 housek abuse, what to do when abuse occinvestigating all allegations of abus resident with Dementia and behavi Dementia and behaviors and how the Administrator interview confirmed a hours of the allegation. Noncomplia	N/designee of progress notes to identification per week for 4 weeks, 3 times per week actor will perform behavior management will be printed from Point Click Care and iffic, on 7/11/2021 by the ADON and United Standard	fy any potential new or ek for 4 weeks, and 2 times per at training monthly for 6 months and updated to reflect the behavioral nit manager. The Regional Director to identify any areas that 3 times per week for 4 weeks, and pment by the IDT team will be occur. The comprehensive care ocial Services, Activities, Dietary, and Social Services. Nursing Care of Norsing etings in person or by phone. This hall Director of Nursing and/or compliance at a minimum weekly of the dentifying abuse/behaviors, ouse by the corporate nurse. The records had been behaviors. The records had been behaviors are plans had been behaviors. The records had been behaviors. The records had been behaviors with the Administrator, 2 LPN's, 8 CNA's, 2 nurse aides in ff were educated on how to prevent the to the Administrator immediately, erson centered care plans for each elopment of care plans for no centered needs/interventions.

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all allege **NOTE- TERMS IN BRACKETS I- Based on facility policy review, mere allegation of abuse for 2 residents. Certified Nursing Assistant (CNA) is them arguing in the hallway, which Resident #65 in the head. This rest wandering led to Resident #30 enters stating she would kill Resident #45 abuse that occurred between Resid Immediate Jeopardy (a situation in participation has caused, or is likely facility's failure to investigate an all interventions based on the investig residents in the facility. The Administrator was informed of 12:50 PM. The facility was cited F-610 at a score The Immediate Jeopardy was removed. An acceptable Removal Plan, whice 8:40 AM and the corrective actions. The findings include: Review of the facility's policy titled, showed .The facility will consider factor of abuse .Physical abuse of a reside prevent and prohibit all types of abuse glect or exploitation occur, an invistreatment, abuse or neglect will Administrator and in accordance we ensue that the investigation is commedical record review showed Res [DATE] with diagnoses including D	d violations. IAVE BEEN EDITED TO PROTECT Condical record review, and interview, the final record record review of the resident #30 and Resident #30 and Resident alterounted in psychosocial harm for Resident record re	ONFIDENTIALITY** 40105 facility failed to investigate an a reviewed for abuse when a sident #65 when she overheard ration when Resident #30 hit at #65. Resident #30's continued ring to choke Resident #45 and reviewed for an administration of the resident resident. The resident resi

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	aggressive/combative with other reredirection. Review of Resident #30's admissic severe cognitive impairment and herequired supervision to walk in the Review of Resident #30's Respirate disruptive behavior noted. Chronic Review of Resident #30's QAPI (Q Note dated 5/3/2021 at 1:52 PM, si Review of Resident #30's Risk Medoccurred on 05.03.21 @ [at] 1659 #30] was in a central location of habackwards with her [Resident #65] the head several times. [Resident #my chair when all of a sudden [Resident #30's Called the psych [psyc [Resident #30] to .ER [emergency] Review of Resident [Resident #65] of screaming for help. Further review responded with an order to send Review of Resident #30's Behavior would frequently wander into other other residents. Review of Resident #30's Behavior continued to wander .but is increas room and takes items and hides the pushes other Residents in their where Review of Resident #30's Social Scinappropriate behaviors and had be redirect.	uality Assurance and Performance Imphowed Resident #30 was a wandering eting Note dated 5/4/2021, showed .Ref. 4:59 PM]. This is Resident A [Resident Ilway holding [Resident #65's] wheelch foot in the wheel of the chair. [Resident #65] started screaming for help .[Resident #30] started hitting me on top of chiatric] NP [Nurse Practitioner] and ne room] for psychiatric evaluation and trois Progress Note dated 5/4/2021, shown her head and pulling .wheelchair backs showed the Mental Health Nurse Prace esident #30 to the emergency department of Note/Anxiety Progress Note dated 5/2 resident rooms and take their belonging the Note/Anxiety Progress Note dated 6/4 singly more intrusive into other Resident em. Resident upsets other Residents versident resident upsets other Residents versidents versident upsets other Residents versidents versidents versident upsets other Residents versidents verside	TE], showed the resident had sament period. Resident #30 illity devices. 15/2021, showed .Chronic provement)/Risk Meeting Progress risk with behaviors noted. sident to Resident [altercation] the #30 and the aggressor [Resident air and pulling the w/c [wheelchair] the #30 hit [Resident #65] on top of ent #65] stated 'I was just sitting in the head and pulling my w/c worders received to send eatment. wed Resident #30 .began hitting the hitting was notified and had ent for evaluation. 20/2021, showed Resident #30 ags and had verbal arguments with with the received to send eatment. 20/2021, showed Resident #30 ags and had verbal arguments with the resident enters every with her actions. Resident also thowed Resident #30 had so out of residents hands, hard to decrease in the resident wandering into other decrease in the resident wandering in the resident wandering in the resident wa

			No. 0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021	
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0610 Level of Harm - Immediate jeopardy to resident health or safety	Review of Resident #30's Physician's Progress Note dated 7/8/2021, showed .Yesterday this patient went into another resident's room [Resident #45] and placed her hand about the resident's neck making the resident think she was being choked . Eventually the patient is able to push the hand away from her neck . One-on-one observation if available .			
Residents Affected - Many		sident #65 was admitted to the facility o t Behavioral Disturbance, Difficulty Wa g Below Knee.		
		ensive care plan dated 11/20/2020, sh d become tearful for no particular reaso		
	Review of Resident #65's quarterly MDS dated [DATE], showed the resident had moderately impaired cognitive status with no behaviors documented.			
	involved in a resident to resident al	n's Notification Progress Note dated 5/3 tercation with Resident #30. Resident a e wheelchair back and hitting resident	#65 had been sitting in a wheelchair	
	Review of Resident #65's Psychiatric Evaluation dated 5/4/2021, showed .patient was involved in an incident with another resident since that time she had increased anxiety and delusions. Increasing distress reasonable to restart as needed Valium [a medication used for anxiety] as well as increase Seroquel [an anti-psychotic medication] to target delusions.			
	Review of Resident #65's Physician's Progress Note dated 5/4/2021, showed .The patient was a victim of resident on the resident violence earlier in the week .The patient's been very anxious since that time . Further review showed Resident #30 had come up behind Resident #65 and hit her on the top and side of the head .This incident unfortunately set off exacerbation of patient's underlying anxiety disorder To becon increasingly anxious and avoids individuals when moving about the community in her wheelchair .			
	I .	on Administration Progress Note dated there referring to her room. The reside		
	distressed. She had been hit by an sent to a psychiatric unit .the patier them directly after a significant stre literature on psychosis, as opposed considered for evaluation outside of	of Resident #65's Psychotherapy Progress Note dated 5/6/2021, showed Resident #65 was qui ed. She had been hit by another resident .stating she was distressed, and she asked if she coul a psychiatric unit .the patient stating she is having hallucinations was significant this time, and have the country of the patient stressor (being attacked by another patient) is highly consistent with the e on psychosis, as opposed to a manipulative quality. The patient was crying, and insistent on b red for evaluation outside of the facility. Further review showed her request was discussed with different the patient was to be sent out for evaluation the next morning.		
	Review of Resident #65's medical the facility on [DATE].	record showed she was sent out to a h	ospital on 5/7/2021 and returned to	
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED	
	445237	B. Wing	07/13/2021	
NAME OF PROVIDER OR SUPPLI	NAME OF PROVIDER OR SUPPLIER		P CODE	
Church Hill Post-Acute and Rehab	ilitation Center	701 West Main Blvd Church Hill, TN 37642		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0610 Level of Harm - Immediate jeopardy to resident health or safety	Medical record review showed Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Muscle Wasting, Chronic Obstructive Pulmonary Disease, Difficulty Walking, Presence of a Cardiac Pacemaker, Personal History of Other Mental and Behavioral Disorders, Bipolar Disorder, Syncope and Collapse, General Anxiety Disorder, Wheezing, and Dependence on Supplemental Oxygen.			
Residents Affected - Many	Review of Resident #45's 5 day MI with no behaviors noted.	DS dated [DATE], showed the resident	had moderate cognitive impairment	
	Review of Resident #45's Physician Progress Note dated 7/8/2021, showed Resident #30 entered her room. Resident [Resident #30] placed her right hand on the left side of the patient's [Resident #45] neck and held it. The patient [Resident #45] stated she turned and tried to push the arm away but it was very stiff. Ultimately she got the hand removed. Event was unprovoked.			
	During an interview on 7/7/2021 at 2:34 PM, the Assistant Director of Nursing (ADON) confirmed there had been no investigation completed related to the resident to resident altercation between Resident #30 and Resident #65 that occurred on 5/3/2021.			
	During an interview on 7/7/2021 at 2:37 PM, the Administrator stated the resident to resident altercation that occurred between Resident #30 and Resident #65 on 5/3/2021 was not considered to be abuse by the facility .those were behaviors. She stated both residents had a history of behaviors and the altercation was due to those behaviors. She stated the IDT (Interdisciplinary Team) discusses any resident to resident altercations and decides if they should be investigated as an abuse allegation. She confirmed the facility felt this was not abuse but just a behavior and it had not been investigated. The Administrator stated the facility would only do a full abuse investigation if they decided it was abuse and not a behavior.			
	5/3/2021. Resident #30 was walkin	terview on 7/8/2021 at 10:21 AM, CNA #2 stated she had been at the nurse's station on esident #30 was walking near Resident #65 and they had started to argue. CNA #2 then went to g. down the hallway without intervening. When she returned to the nurse's station, CNA #3 ter that Resident #30 had hit Resident #65		
	During an interview on 7/8/2021 at 10:33 AM, CNA #3 stated on 5/3/2021 she was in a room on the 300 hallway when she heard Resident #65 .screaming bloody murder . She came out into the hallway and saw Resident #30 and Resident #65 close to the nurse's station and Resident #30 was .tapping . Resident #65 on the head. CNA #3 stated she separated the residents and Resident #30 then .wandered off . CNA #3 stated Resident #65 .freaks out .says she has water on the brain and that could hurt her .			
	(continued on next page)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	(4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and willful physical act toward anot comprehension and knowledge of altercations and reviews the resident the facility's standard is if a resident indicates moderately impaired cognithey know what is going on and are resident altercation depended on wabuse. The ADON stated staff are Incident and Accident (I&A) report. be made as to whether an abuse is resident altercations would not be in behaviors on 5/3/2021 and had been reported to her that Resident stated both residents were every been of abuse. The ADON confirmed Resident altercation between Resid confirmed the altercation did trigge. During an interview on 7/9/2021 at resident altercation between Resid confirmed the altercation did trigge. During an interview on 7/9/2021 at #30's wandering into other resident MD confirmed Resident #30's contaltercation. He stated the resident #65 residents due to Resident #65's] incident had caused Resident #65 residents due to Resident #30's contaltercation. He stated the resident #65 residents due to Resident #30's contaltercation due to Resident #30's contaltercation due to Resident #65 residents due to Resident #30's contaltercation due to Resident #30's contaltercation due to Resident #65 residents due to Resident #30's contaltercation due to Resident #30's contaltercation due to Resident #65 residents due to Resident #30's contaltercation due to Resident #65 residents due to Resident #65 resident	ch removed the immediacy of the jeopa e validated on-site by the surveyors on ility policies, and staff interviews. e survey team by the facility documente or of Operations provided training to the anager, MDS Coordinator, Medical Red n, and Human Resources. The training	and the resident must have the T team reviews resident to resident and the causative factors. She stated (BIMS) score of 8 (a score of 8-12 cognitively intact) or above, that a ADON stated each resident to incident would be investigated as the IDT team would complete an and a decision would she confirmed all resident to ated Resident #65 had been having and screaming. She stated it had was more of a tap. She further been investigated as an allegation contact with Resident #65 on The was aware of the resident to do on 5/3/2021. The Psych NP #65 and psychosocial harm. The ated he was aware of Resident into a few folks along the way. The of another resident to resident to the same and the was a continued risk to other. The arty, was received 7/12/2021 at 8:40 and 7/12/2021-7/13/2021 through and the following immediate. Administrator, Assistant Director of cords, Social Services, D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS CITY STATE 71	ID CODE
Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd	CODE
		Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con-	tact 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)		ion)
F 0610	3. process of identifying, preventing	g, and reporting abuse	
Level of Harm - Immediate jeopardy to resident health or	4. how to recognize a potential beh	avior that is escalating, and to interver	ne
safety	5. who is the Abuse Coordinator		
Residents Affected - Many	6. suspected or observed abuse, a	Il types, reported to the Administrator in	mmediately
	All staff not working on 7/10/2021 v	vere called and in-serviced.	
	On 7/10/2021 the Administrator wa report, and investigate potential alle	s in-serviced by the Regional Director egations of abuse.	of Operations on how to identify,
	All residents with a diagnosis of Dementia/behaviors had their care plan reviewed and revised to reflect resident specific behavioral interventions. Interviewable residents were interviewed by the Social Service Director on any concerns related to abuse. Residents that were not interviewed had a skin assessment completed by the ADON and Unit Manager on 7/10/2021. The Regional Director of Clinical services reviewed the last 72 hours of nursing notes to identify any issues that needed to be investigated as an allegation with no issues identified.		
	On 7/10/2021 the Nurse Educator, included:	Director of Rehab, and Human Resou	rces educated staff. The training
	how to recognize potential behave	vior that is escalating and to intervene	
	2. who the abuse coordinator is- the	e Administrator	
	3. suspected or observed abuse		
	4. all types reported to the Adminis	trator immediately	
	All staff not working on 7/10/2021 v	vere called and in-serviced.	
	On 7/11/2021 all staff started comp prevention, reporting, and investiga	etency tests on Hand-in-Hand Demenating test.	tia module part 1 & 2, abuse
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Church Hill Post-Acute and Rehabilitation Center		701 West Main Blvd Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	hours to identify any potential report weeks, 3 times per week for 4 week interviewed daily to ensure no resic rooms by Social Services. A Licens week for 4 weeks, and 2 times per Director of Clinical Services will more potentially could be a reportable evitimes per week for 4 weeks. The Nevent log will be maintained in the reviewed and updated on 7/10/202 interventions for behaviors. Nursing new behaviors observed and/or exportable evitimes per week for 4 weeks. The Nevent log will be maintained in the reviewed and updated on 7/10/202 interventions for behaviors. Nursing new behaviors observed and/or exportance of Nursing reviewed the pastenation of Nursing reviewed behavior than a pastenation of Nursing Nursing Nursing Nursing Hand-in-Hand. The Kardex's interventions that are resident spectof Clinical Services will monitor nur potentially could be exacerbated be 2 times per week for 4 weeks. Chareviewed by the Administrator to er plan development is overseen by the and Rehab. Revisions to the behavior to the behavior of the behavior of the behavior of the behavior to the behavior of the behavior to the behavior of the behavior to the behavior the behavior to the behavior to the behavior to the beh	r of Nursing Services in-serviced the Activities Director on behavioral manage iffic to their behaviors with interventions viors that is escalating and to intervene r of Clinical Services in-serviced the Activities on behavior management inclusion that is escalating and to intervene it is escalating and to intervene were called and in-serviced by the Nurselection will be educated on hire regardinent specific interventions and including	ormed 5 times per week for 4 Five random residents will be er residents wandering into their s per week for 4 weeks, 3 times per e not interviewable. The Regional 24 hours to identify any areas that these per week for 4 weeks, and 2 and skin sweeps, a reportable ehaviors/Dementia care plans were es to reflect resident specific and the Unit Manager to identify any ere identified. The Regional for new and/or exacerbations of DON, Unit Manager, Social ement policy including: Social diministrator, ADON, Nursing rices, Director of Rehab, Dietary, uding: The Educator. No employee will work and behavioral management and care how to recognize a potential Ty any potential new or ek for 4 weeks, and 2 times per at training monthly for 6 months and updated to reflect the behavioral nit manager. The Regional Director to identify any areas that a times per week for 4 weeks, and pment by the IDT team will be occur. The comprehensive care ocial Services, Activities, Dietary, the Social Services. Nursing Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF DROVIDED OD CURRUI	-n	CTREET ADDRESS CITY STATE 7	D CODE
NAME OF PROVIDER OR SUPPLIE Church Hill Post-Acute and Rehabi		STREET ADDRESS, CITY, STATE, ZI	P CODE
Church Fill Fost-Acute and Kenabi	ilitation Center	Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The QAPI committee will meet wee Weekly updates will be provided by Director of Nursing and/or the Regi or by phone. This will include input Nursing and/or Regional [NAME] P minimum weekly until substantial or On 7/12/2021, Surveyors reviewed surveyors reviewed education and was provided by the Administrator. had been provided the education of abuse/behaviors, reporting, and invocorporate nurse. Residents affected if psychosocial harm had occurred. plans had been updated and Demerecords had been updated to include validated all staff working on 7/12/2 new procedures related to abuse/b. On 7/12/2021, Surveyors validated DON, Nurse Educator, MDS Coord training, 2 therapists and 2 houseke abuse, what to do when abuse occullegations of abuse, documentatio Dementia and behaviors. Staff verbehaviors and how to assess reside Administrator confirmed she would	ekky to analyze all events that may requive responsible members on the progressional [NAME] President of Operations of and review of data collected for the management of Operations will do facility viscompliance is achieved and maintained the abuse policy which included invessign in sheets which validated the corrective actions of abuse, preventing, preventing, and buse, types of abuse, preventing, preventing abuse. The Administrator will be a care had been added to those with de interventions on the 22 resident records were revential care had been added to those with the corrective actions on site through it inator, Dementia Care, and personce the corrective actions onsite through it inator, Social Service Director, 4 RNs, eepers. The interviews showed the staturs, reporting of abuse to the administration, and implementing person centered control of the corrective actions on the administration, and implementing person centered the control of the corrective actions on the administration, and implementing person centered necessarily and oversee the abuse investigated at a scope and severity of F for monitined compliance.	cire investigation and reporting. It is of each citation. The Regional will attend QAPI meetings in person eeting. The Regional Director of sits to monitor compliance at a citigating and reporting of abuse. The ective action plans onsite which orking on 7/12/2021 and 7/13/2021 rotecting, recognizing/identifying as educated on abuse by the essed and interviewed to determine iewed randomly to ensure care in Dementia and behaviors. The ords reviewed. The surveyors diverse with the Administrator, 2 LPN's, 8 CNA's, 2 nurse aides in ff were educated on how to prevent rator immediately, investigating all care plans for Dementia and eds/interventions. Interview with the pations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) PROVIDER/SUPPLIER Church Hill Post-Acute and Rehabilitation Center STREET ADDRESS, CITY, STATE, ZIP CODE 7011/3/2021 SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency, please contact the nursing home or the state survey agency. (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Ensure that the facility palse stricted staff members who possess the competencies and skills to meet the behavioral health or safety Residents Affected - Many Residents Affected - Many Residents Affected - Many The Council of the staff members who possess the competencies and skills to meet the behavioral health needs of 2 residents (50 and 455) of 4 residents reviewed for behavior and placing her health or address of the staff members who possess the competencies and skills to meet the behavioral health needs of 2 residents (50 and 455) of 4 residents reviewed for behavior application and interview, the facility failed to ensure staff had the knowledge and skill set required to develop appropriate behavior and that can be a competent staff to implement appropriate behavior sentition and placerion behaviors health needs of 2 residents (60 and 455) of 4 residents reviewed for behavior and placing her health on Resident 456 and Resident 456 and 455 of 4 residents reviewed for behavior and placing her healths on Resident 456 and Resident 456 and 455 of 4 residents reviewed for behavior and placing her healths on Resident 456 and Resident 450 and Resident 45				NO. 0936-0391
Church Hill Post-Acute and Rehabilitation Center 701 West Main Blvd Church Hill, This 37842 For Information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. 504 SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40606 Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure staff had the knowledge and skill set required to develop appropriate behavior health care plans and provide care to meet the behavioral health needs of 2 residents (870) and #850 of the residents reviewed for behaviors. The facility's failure to have competent staff to implement appropriate behavioral interventions resulted in an altercation between Resident #30 and Res		IDENTIFICATION NUMBER:	A. Building	COMPLETED
F 0741 Level of Harm - Immediate Jeopardy to resident health or safety Residents Affected - Many Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. "NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 40606 Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure staff had the knowledge and skill set required to develop appropriate behavioral interventions resulted in an altercation between Resident #30 and resi			701 West Main Blvd	P CODE
Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health or safety Residents Affected - Many Ensure that the facility policy review, medical record review, observation, and interview, the facility failed to ensure staff had the knowledge and skill set required to develop appropriate behavior health care plans and provide care to meet the behavioral health needs of 2 esidents (#30 and #65) of 4 residents reviewed for behaviors. The facility's failure to have competent staff to implement appropriate behavior health care plans and provide care to meet the behavioral health needs of 2 esidents (#30 and #65) of 4 residents reviewed for behaviors. The facility's failure to have competent staff to implement appropriation. Resident #30 sontinued wandering behavior led to Resident #65 suffered psychosocial harm. Resident #30 sontinued wandering behavior led to Resident #65 suffered psychosocial harm. Resident #30 and Resident #65, and the resident #30 and Resident #65, and the resident with behavior care needs placed Resident #30 and Resident #65, and Resident #65, and immediate Jeopardy (a situation in which the providers non-compliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) and had the potential to place all residents in immediate Jeopardy. The Administrator was informed of the Immediate Jeopardy (JJ) in the conference room on 7/10/2021 at 12:50 PM. The Immediate Jeopardy was removed onsite 7/12/2021 and was effective 5/3/2021 - 7/11/2021. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 7/12/2021 at 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and 7/13/2021. The findings include: Review of the facility policy titled, Resident Centered Care Plans, dated 3/2019, showed. Qualified staff responsibilifies for caring (carrying) out interventions, specified in the care pl	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
Level of Harm - Immediate jeopardy to resident health or safety **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40606 Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure staff had the knowledge and skill set required to develop appropriate behavior health care plans and provide care to meet the behavioral health needs of 2 residents (#30 and #65) of 4 residents reviewed for behaviors. The facility's failure to have competent staff to implement appropriate behavioral interventions resulted in an altercation between Resident #30 and Resident #65 where Resident #30 wandering into Resident #45 suffered psychosocial harm. Resident #30's continued wandering behavior led to Resident #30 wandering into Resident #45's room and placing her hands-on Resident #45's neck and attempting to choke her. The facility's failure to ensure staff were knowledgeable and competent to provide services for residents with behavior care needs placed Resident #30 and Resident #45's neck and attempting to choke her. The facility's failure to ensure staff were knowledgeable and competent to provide services for residents with behavior care needs placed Resident #30 and Resident #45's in Immediate Jeopardy (a situation in which the providers non-compliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) and had the potential to place all residents in Immediate Jeopardy. The Administrator was informed of the Immediate Jeopardy (IJ) in the conference room on 7/10/2021 at 8:40 AM and the corrective actions were validated onsite by the surveyors on 7/12/2021 and 7/13/2021. The findings include: Review of the facility policy titled, Resident Centered Care Plans, dated 3/2019, showed. Qualified staff responsibilities for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out interventions specified in	(X4) ID PREFIX TAG			
	Level of Harm - Immediate jeopardy to resident health or safety	Ensure that the facility has sufficier behavioral health needs of resident **NOTE- TERMS IN BRACKETS IN Based on facility policy review, mestaff had the knowledge and skill scare to meet the behavioral health. The facility's failure to have compesite altercation between Resident #30 and Resident #30 and Resident #45 were knowledgeable and competer Resident #30 and Resident #65, an non-compliance with one or more rinjury, harm, impairment, or death for Jeopardy. The Administrator was informed of 12:50 PM. The Immediate Jeopardy was removed an acceptable Removal Plan, whice 8:40 AM and the corrective actions. The findings include: Review of the facility policy titled, For responsibilities for carrying out interver responsibilities for carrying out interver responsibilities for care and evaluation of care and evalua	Int staff members who possess the contists. HAVE BEEN EDITED TO PROTECT Contical record review, observation, and in et required to develop appropriate behanneeds of 2 residents (#30 and #65) of tent staff to implement appropriate behand Resident #65 where Resident #65 and behavior led to Resident #30 wanders is neck and attempting to choke her. That to provide services for residents with and Resident #45 in Immediate Jeopard requirements for participation has cause to a resident) and had the potential to put the Immediate Jeopardy (IJ) in the continuous of the Jeopard was effectively the removed the immediacy of the jeopart were validated onsite by the surveyors are were validated onsite by the surveyors of the interventions, initially and when the services to residents with the appropriate the safety maintain the highest practicable sident .Planning and implementing apping the effectiveness of pharmacological activities which promote engagement address the resident's customary rout. Purpose to implement the most desiral ange, modify, decrease or eliminate because in the safety of the promote of the propose to implement the most desiral ange, modify, decrease or eliminate because is the resident of the propose to the promote of the propose to implement the most desiral ange, modify, decrease or eliminate because is the resident of the propose to th	Inpetencies and skills to meet the ONFIDENTIALITY** 40606 Interview, the facility failed to ensure avior health care plans and provide 4 residents reviewed for behaviors, avioral interventions resulted in an suffered psychosocial harm, ring into Resident #45's room and the facility's failure to ensure staff to behavior care needs placed by (a situation in which the providers ed, or is likely to cause serious place all residents in Immediate and the facility and the facility and 7/10/2021 at 1 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Church Hill Post-Acute and Rehabi	litation Center	701 West Main Blvd Church Hill, TN 37642	
For information on the nursing home's p	plan to correct this deficiency, please con	tact 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)		
Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Medical record review showed Res [DATE] with diagnoses including D Disorder, Insomnia, and Delusional Review of Resident #30's compreh [as evidenced by] History of attemptother residents at times, she goes if from wandering by offering pleasar Document wandering behavior and Review of Resident #30's Plan of C and out of other resident rooms. difference of Resident #30's admissions severe cognitive impairment and have required supervision to walk in the Review of Resident #30's care plan activities. we will continue to invite had no individualized interventions. Review of Resident #30's Physicial reported to this nurse a Resident to [Resident #65] on the head and pure Review of Resident #30's Behavior wandering through out facility this stredirection. Further review revealed behaviors. Review of Resident #30's Behavior the halls. Resident frequently goes Resident had been involved in a constaff had provided redirection out of the wandering behaviors. Review of Resident #30's Social Soci	sident #30 was admitted to the facility of ementia with Behavioral Disturbance, A I Disorders. ensive care plan dated 4/13/2021, shoots to leave facility unattended is begin and out of residents rooms, needs from diversions, structured activities, food, I attempted diversional interventions in Care Progress Note dated 4/14/2021, slifficult to get vital signs iredirection. In Minimum Data Set (MDS) dated [DA and wandered 1-3 days during the assessment of the structure of the s	In [DATE] and readmitted on Anxiety Disorder, Major Depressive wed .elopement risk/wanderer AEB comes aggressive/combative with equent redirection .Distract her conversation, television, book . behavior log . howed .Patient has been going in TE], showed the resident had assment period. Resident #30 illity devices. quires assistance to participate in tivities] as needed . The care plan (Resident #30], who was hitting is was screaming for Help . (2021 at 5:16 PM, showed .Staff (Resident #30], who was hitting is was screaming for Help . (2021, showed .Resident e's station. Becomes agitated with to address the wandering (20/2021, showed .Resident wanders belonging, drinks, food, etc. sidents . Further review revealed action of staff inventions to address showed .Resident exhibiting eft a message with psych s . Further review revealed no showed .Resident displaying ints hands, hard to redirect .

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021	
NAME OF PROVIDER OR SUPPLI	NAME OF PROVIDER OR SUPPLIER		P CODE	
Church Hill Post-Acute and Rehab	ilitation Center	701 West Main Blvd Church Hill, TN 37642		
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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 0741 Level of Harm - Immediate jeopardy to resident health or safety	Review of Resident #30's Behavior Note/Anxiety Progress Note dated 6/20/2021, showed .Resident continues to wander this shift. Resident wandering into other resident rooms and causing distress to other residents. Attempts to redirect are unsuccessful. Further review revealed no documentation of staff inventions to address the wandering behaviors. Medical record review showed Resident #65 was admitted to the facility on [DATE] with diagnoses including			
Residents Affected - Many	Bipolar Disorder, Dementia Without Behavioral Disturbance, Anxiety Disorder, and Insomnia. Review of Resident #65's comprehensive care plan dated 11/20/2020, showed .behavior problem .has attention seeking behaviors as evidenced by often becoming tearful for no particular reason .states she ha 'hole in her head' .intervene as necessary to protect the rights and safety of others .Divert Attention. Remove from situation and take to alternate location as needed . Further review showed no documentation of interventions to address crying and tearful behaviors.			
	Review of Resident #65's quarterly MDS dated [DATE], showed the resident had moderately impaired cognitive status, the resident was independent for locomotion on the unit, and used a wheelchair for mobility. No behaviors were documented, and no wandering was documented. Review of Resident #65's Physician's Notification Progress Note dated 5/3/2021, showed .Resident to Resident altercation. This is [Resident #65] sitting in wheelchair while resident [Resident #30] was pushing wheelchair back and hitting [Resident #65] on top of head . Review of Resident #65's Psychotherapy Progress Note dated 5/6/2021, showed .The patient was quite distressed. She was hit recently by another patient and her room was moved. The patient approached the clinician stating she was distressed, and she asked if she could be sent to a psychiatric unit .the patient stating she is having hallucinations was significant this time, and having them directly after a significant stressor (being attacked by another patient) is highly consistent with the literature on psychosis, as opposed to a manipulative quality. The patient was crying, and insistent on being considered for evaluation outside of the facility. The clinician discussed this with the staff, who stated that they would send her in the morning .			
	Review of Resident #65's medical of 5/7/2021 and returned to the facility	record showed she was sent to the hos y on [DATE].	spital for psychiatric evaluation on	
	Nursing Assistant (CNA) was in the	PM, showed Resident #30 entered roor e room setting up a lunch tray and redir esident #30's wandering was attempted	ected the resident out of the room.	
	Observation on 7/6/2021 at 2:46 PM, showed Resident #30 entering room [ROOM NUMBER] while a was in the room. The CNA redirected the resident to exit the room and no other intervention to address Resident #30's wandering was attempted.			
	During an interview on 7/6/2021 at 2:55 PM, CNA #1 stated Resident #30 did wander frequently and did wander into other residents' rooms. She stated Resident #30 would take other residents' water pitchers. C #1 stated .there's not much we can do . CNA #1 stated she did not attempt any diversional activities or ot interventions to address Resident #30's wandering.			
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			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 7/6/2021 at 2:59 Pl open the door to room [ROOM NUI to open the double doors into the hand she was unable to get onto the nurse seated at the nurse's station. She picked up a notebook from the station, and went down the 300 hal from her. No other intervention to a During an interview on 7/7/2021 at been in a resident-to-resident alternursing facility and that Resident # #30 goes in and out of resident roo She further stated the interventions and put stop signs on some resider Further interview confirmed she waand redirection, to prevent Resider Medical record review showed Res [DATE] with diagnoses including M Walking, Presence of a Cardiac Pa Bipolar Disorder, Syncope and Col Supplemental Oxygen. Review of Resident #45's compreh for impaired cognitive function relaing prevent other residents from enterior Review of Resident #45's 5-day MI impairment, no behaviors noted, she a wheelchair for mobility, and used Review of Resident #45's Physician supervised the patient [Resident #45's physician supervised supervised patient [Resident #45's physician supervised the patient [Resident #45's physician supervised the patient [Resident #4	M, showed Resident #30 wandering in MBER] but did not go in. She then wen all way which is under construction. The 100 hallway. She then wandered to the 100 hallway. She then wandered to the 100 hallway. She then wandered to the 100 hallway. A staff member walked up to Resident #30's wandering was address Resident #30's wandering was 2:07 PM, the Director of Social Service cation with Resident #65. She stated R 65 had .psych issues . and .doesn't like 30 and Resident #65, .became fearful oms and .that's a problem .we pretty must staff took to prevent Resident #30's wents' rooms that she has a fondness to go as unaware of any other behavioral intent #30 from wandering into other resident #30 from wandering into other resident #45 was admitted to the facility of luscle Wasting, Chronic Obstructive Puracemaker, Personal History of Other Melapse, General Anxiety Disorder, Wheelensive care plan dated 3/23/2021, should the confusion with an update on 7/9/ng resident's room- Monitor Stop Sign of DS dated [DATE], showed the resident me was total dependence for bed mobility of loxygen daily. In Progress Note dated 7/8/2021, shown 45] while she was lying on her left resting patient's [Resident #45] neck and helen the arm [Resident #45] neck and helen the arm [Resident #30's arm] away but the arm [Resident #30's	the 400 hallway. She attempted to t to the 100 hallway and attempted ere was a cart blocking the door lee nurse's station, walked past a station, walked past a station, walked past a station, and entered the office. In the nurse's station and took the notebook attempted. See (DSS) stated Resident #30 had esident #30 used to work in a station to be touched. She stated after crying. The DSS stated Resident such let her wander and redirect her andering behavior was redirecting go into the residents that complain inventions, other than medication ints' rooms. In [DATE] and readmitted on almonary Disease, Difficulty ental and Behavioral Disorders, exing, and Dependence on weed Resident #45 had a potential 2021 for .stop sign to doorway to every 15 minutes for placement. had moderate cognitive ty and transfers, did not walk, used led .Resident [Resident #30] placed dit .The patient [Resident #45]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PEAN OF CORRECTION	445237	A. Building	07/13/2021
	443237	B. Wing	01/10/2021
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Church Hill Post-Acute and Rehab	ilitation Center	701 West Main Blvd	
		Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 7/8/30 would wander frequently, and them [other residents] upset. The the other residents would scream a resident's belongings from their roothe staff hear the residents scream stated Resident #30 would often redisappear .we don't realize they are #1 stated staff were unable to watch During an interview on 7/8/2021 at residents' rooms, the staff try to redund unaware of any other residents. During an interview on 7/8/2021 at into other residents' rooms and won attempts to redirect Resident #30, from wandering into other residents. During an interview on 7/8/2021 at they could .with demented patients resident doors had been attempted was unaware of which residents restated stop sign placement was de resident. During an interview on 7/8/2021 at residents' rooms, would take items #3 stated the facility had placed stothem down and carry them around unaware of any other interventions. During an interview on 7/8/2021 at residents' rooms. RN #2 stated the she was not sure which residents was not sure which residents.	8/2021 at 7:41 AM, Licensed Practical would wander into other resident's roor LPN stated at times Resident #30 would the to get out. The LPN confirmed Resons such as socks, toothbrushes, and ring, they go redirect her, but she is not amove the stop signs placed on other residence, we may find them on another her wandering residents at all times. 8:27 AM, LPN #2 confirmed Resident and the wandering residents at all times. 8:27 AM, LPN #2 confirmed Resident and the was wandering into other residents at all times. 8:28 AM, LPN #2 confirmed Resident and the was wandering into other residents was and she was unaware of any other intest rooms. 8:48 AM, the DSS confirmed the facility [wandering] would occur. The DSS st., but had been taken down, and they was quired stop signs and was unaware of termined when a resident had made a get and the other residents rooms, and was unaware of the resident #30 from the other residents rooms, and was unaware of the resident #30 is redired to prevent Resident #30 from wandering get and put stop signs up for the rower supposed to have stop signs on the direct, but was unaware of any other in	Nurse (LPN) #1 stated Resident ms. Resident #30's wandering .gets d enter other resident rooms and esident #30 would pick up other decorations. LPN #1 stated when easily redirectable. The LPN esidents' rooms and they would . all or another nurses station . LPN #30 had wandered into other ors of some residents, but she was ot aware of any diversional ints' rooms. ated Resident #30 would wander is often difficult and required multiple riventions to prevent Resident #30 y .would divert the resident as best ated the stop signs on some were effective at times. The DSS how to obtain that information. She complaint about a wandering would wander in and out of other would drink everybody's drinks. LPN is but Resident #30 would take stable most of the time. She was ong, including diversional activities. 30 would wander into other oms .we find may be an issue . but neir doors. RN #2 stated the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021	
	NAME OF PROVIDER OR SUPPLIER		IP CODE	
Church Hill Post-Acute and Rehab	ilitation Center	701 West Main Blvd Church Hill, TN 37642		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/8/2021 at 10:21 AM, CNA #2 stated that she had been at the nurse's station on 5/3/2021. Resident #30 was walking near Resident #65. Resident #65 did not want Resident #30 near her, and they had started to argue. CNA #2 then went to do .something . down the hallway without intervening. When she returned to the nurse's station, she was told Resident #30 had hit Resident #65. CNA #2 stated Resident #30 would wander into other residents' rooms and some residents did complain. CNA #2 stated Resident #65 had complained that Resident #30 would go into her room and go through her stuff. CNA #2 stated Resident #30 would wander into other residents' rooms and some residents did complain. CNA #2 stated there .really wasn't anything we could do . CNA #2 stated the staff would redirect the resident but was not aware of any other interventions, including diversional activities, to prevent wandering. During an interview on 7/8/2021 at 10:33 AM, CNA #3 stated Resident #30 would wander into other			
	residents' rooms. CNA #3 stated sh diversional activities, were used to	ne would provide redirection but no oth prevent wandering.	er interventions, including	
	During a telephone interview on 7/8/2021 at 12:47 PM, RN #3 stated Resident #30 would wander .nons into any room that was not locked, in and out of other residents' rooms, and would move/take other resibelongings. RN #3 had witnessed Resident #30 remove a stop sign from a resident's door and had tried explain to Resident #30 that she could not enter those rooms, but she was unable to understand. RN #3 unsure which residents wanted a stop sign on their door and stated the information was passed on in she report but not documented in the chart. RN #3 had reported Resident #30's wandering behavior to the Assistant Director of Nursing (ADON) and had been instructed to document the behaviors in the resider chart, but no other interventions were utilized by staff.			
	During an interview on 7/8/2021 at 1:31 PM, the ADON stated the facility had provided close monitoring Resident #30, but she had the right to wander because the facility was her home. The ADON stated Resident #30's wandering had been discussed in IDT meetings. The ADON stated she had suggested Resident #30 may need placement in a locked unit, but the IDT had stated the facility was able to meet resident's needs.			
	During an interview on 7/9/2021 at 9:09 AM, the Activity Director stated she had not had a conversal Resident #30's family to obtain her likes or interests, and the resident could not answer questions for activity assessment. She stated .I went by what people told me to put down . The Activity Director st was aware of the resident's past occupation of working in a health care facility, then confirmed she had taken that information into consideration when developing the resident's activity care plan. The Activ Director confirmed she was not aware of what person-centered care planning meant and was not aware plan needed to be individualized to the resident's likes and interests.			
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			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Church Hill Post-Acute and Rehabi	ilitation Center	Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	had been seen grabbing stuffed an was aware of the resident-to-reside #30 had gotten physically aggressidiscussed with Administration, IDT. The MDS Coordinator stated after I Resident #30 needed one on one sconfirmed Resident #30 had divers determined those activities and unsthought staff just get to know the reshe had not had a conversation wit facility had not developed diversion. During an interview on 7/9/2021 at Resident #30's behaviors, including been adding behavioral intervention residents' rooms from discussions interventions of redirection and meany manner. She stated Resident attempting to exit a door) placed or behaviors. She further stated Resident #65 had confirmed Resident #65 had onfirmed Resident #65 had a histo susceptible to a negative outcome 5/3/2021. The DSS confirmed she #65's crying and tearful behaviors. During an interview on 7/9/2021 at residents' rooms and take things. He successful. He stated the resident-#65 really set off [Resident #65's] a incident had caused Resident #30's conducted the properties of the resident was an analysis of the resident was an an an an an an	3:20 PM, the Assistant Director of Nurs She stated the interventions used to pro psychological services, and activities. S d not participate in activities. The ADO had not been individualized and had b	ggressive. The MDS Coordinator ent #65. She confirmed Resident #30's wandering had been , as well as in morning meetings. nembers of the IDT had suggested did not approve this. She out was unsure how the facility had nal activities. She stated she exities she needs. She confirmed es or dislikes. She confirmed the ors for Resident #30. In the developed any interventions for thought the MDS Coordinator had Resident #30 wandering into other estated Resident #30 needed the her down .you can't restrict her in to alert staff when a resident is the resident for her wandering ble and had been more irritated rmine individualized interventions. It is a history of abuse . She ble in her head, making her more as occurred with Resident #30 on staff had taken to address Resident was a continued risk to other stain (ADON) confirmed Resident #30 and Resident

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NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd	P CODE	
		Church Hill, TN 37642		
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F 0741 Level of Harm - Immediate jeopardy to resident health or		h removed the immediacy of the jeopal e validated on-site by the surveyors on lity policies, and staff interviews.		
safety	The Removal Plan presented to the corrective actions implemented.	e survey team by the facility documente	ed the following immediate	
Residents Affected - Many	On 7/10/2021 the Regional Director of Operations provided training to the Administrator, Assistant Director of Nursing, Nursing Educator, Unit Manager, MDS Coordinator, Medical Records, Social Services, Director of Rehab, Dietary, Admissions Liaison, and Human Resources. The training included:			
	1. the Abuse policy			
	2. types and reporting and investigating and prevention			
	3. process of identifying, preventing, and reporting abuse			
	4. how to recognize a potential beh	avior that is escalating, and to interven	e	
	5. who is the Abuse Coordinator			
	6. suspected or observed abuse, al	I types, reported to the Administrator in	mmediately	
	All staff not working on 7/10/2021 v	vere called and in-serviced.		
	All residents with a diagnosis of Dementia/behaviors had their care plan reviewed and revised to reflect resident specific behavioral interventions. Interviewable residents were interviewed by the Social Service Director on any concerns related to abuse. Residents that were not interviewed had a skin assessment completed by the ADON and Unit Manager on 7/10/2021. The Regional Director of Clinical services reviewed the last 72 hours of nursing notes to identify any issues that needed to be investigated as an allegation with no issues identified.			
	On 7/10/2021 the Nurse Educator, Director of Rehab, and Human Resources educated staff. The training included:			
	1. how to recognize potential behav	vior that is escalating and to intervene		
	2. who the abuse coordinator is- the Administrator			
	3. suspected or observed abuse			
	4. all types reported to the Adminis	trator immediately		
	All staff not working on 7/10/2021 v	vere called and in-serviced.		
	On 7/11/2021 all staff started competency tests on Hand-in-Hand Dementia module part 1 & 2, abuse prevention, reporting, and investigating test.			
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NAME OF DROVIDED OD SUDDIU		STREET ADDRESS, CITY, STATE, ZI	D CODE
	NAME OF PROVIDER OR SUPPLIER		PCODE
Church Hill Post-Acute and Rehab	ilitation Center	701 West Main Blvd Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0741 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Audits will be conducted by the Adhours to identify any potential repoweeks, 3 times per week for 4 wee interviewed daily to ensure no resic rooms by Social Services. A Licensweek for 4 weeks, and 2 times per Director of Clinical Services will more potentially could be a reportable extimes per week for 4 weeks. The Nevent log will be maintained in the reviewed and updated on 7/10/202 interventions for behaviors. Nursing new behaviors observed and/or ex Director of Nursing reviewed the path behaviors on 7/10/2021, no issues On 7/10/2021 the Regional Director Services, MDS Coordinator, and A. 1.Making resident care plans specion 2. how to recognize potential behaviors on 7/10/2021 the Regional Director Educator, Unit Manager, MDS Coordinator, and Human Rehow to recognize a potential behavior to being trained. Future employelan revisions as it relates to reside behavior that is escalating and to in the Audits will be performed by the DO exacerbations of behaviors 5 times week for 4 weeks. The Nurse Educusing Hand-in-Hand. The Kardex's interventions that are resident specifical Services will monitor nurpotentially could be exacerbated by 2 times per week for 4 weeks. Chareviewed by the Administrator to erplan development is overseen by the and Rehab. Revisions to the behavior t	ministrator and Director of Nursing (DO rtable events. These audits will be perfeks, and 2 times per week for 4 weeks. I dent to resident and no incidents of other sed Nurse will do 5 skin sweeps 5 times week for 4 weeks on residents who are week for 4 weeks on residents who are week for 4 weeks on residents who are week for 4 weeks, 3 times are to stime the perfect of the perfe	on of nursing notes for the past 24 formed 5 times per week for 4 five random residents will be er residents wandering into their is per week for 4 weeks, 3 times per enot interviewable. The Regional 24 hours to identify any areas that these per week for 4 weeks, and 2 and skin sweeps, a reportable enaviors/Dementia care plans were esto reflect resident specific and the Unit Manager to identify any ere identified. The Regional for new and/or exacerbations of ADON, Unit Manager, Social ement policy including: Administrator, ADON, Nursing ices, Director of Rehab, Dietary, uding: Be Educator. No employee will work g behavioral management and care how to recognize a potential tify any potential new or extended to reflect the behavioral internal manager. The Regional Director to identify any areas that 3 times per week for 4 weeks, and pment by the IDT team will be occur. The comprehensive care incial Services, Activities, Dietary, the Social Services. Nursing Care
	and Rehab. Revisions to the behaving plan updates are the responsibility	rioral care plan is the responsibility of the	ne Social Services. Nursing Care

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NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE
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Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Weekly updates will be provided by Director of Nursing and /or the Regperson or by phone. This will include Director of Nursing and/or Regional compliance at a minimum weekly update. The Surveyors reviewed the onsite which was provided by the And 7/13/2021 had been provided recognizing/identifying abuse/behaton abuse by the corporate nurse. Finterviewed to determine if psychos randomly to ensure care plans had Dementia and behaviors. The recoreviewed. The surveyors validated knowledgeable about the new proceare planning. On 7/12/2021, Surveyors validated DON, Nurse Educator, MDS Coord training, 2 therapists and 2 housek abuse, what to do when abuse occimplementing person centered care determine person centered needs/iperson-centered care plans to addieducation on behavioral interventic individualized to each resident. The updating the care plans with person	at a scope and severity of F for monitoned compliance.	s of each citation. The Regional will attend QAPI meetings in r the meeting. The Regional do facility visits to monitor and maintained. It policy, person-centered care plan alidated the corrective action plans ared all staff working on 7/12/2021 e., preventing, protecting, see The administrator was educated sidents were assessed and resident records were reviewed been added to those with entions on the 22 resident records 21 had been educated and were mentia Care, and person-centered enterviews with the Administrator, 2 LPN's, 8 CNA's, 2 nurse aides in ff were educated on how to prevent buse, documentation and a and behaviors. Staff verbalized how to assess residents to as provided education on care plans. The DSS had received avioral management interventions as on centered care planning and

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F 0744	Provide the appropriate treatment a	and services to a resident who displays	or is diagnosed with dementia.
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	**NOTE- TERMS IN BRACKETS IN Based on facility policy review, medevelop and implement individualize Dementia care needs for 5 residento Dementia care needs resulted in a with Resident #30 hitting Resident #30's continued wandering led to stating she would kill her. The facility resident-centered care plan for Resin Immediate Jeopardy (a situation participation has caused, or is likely had the potential to effect all resident The Administrator was informed of 12:50 PM. The facility was cited F-744 at a score The Immediate Jeopardy was remadeceptable Removal Plan, which read AM and the corrective actions were acceptable Removal Plan, which read AM and the corrective actions were The findings include: Review of the facility policy titled, E with confirmed dementia, the IDT [I maximize remaining function and quepending on the individual's response acute medical conditions or confirmed to develop and implement a resident's medical, nursing, focus on the resident as the locus or resident's strengths and needs. The to attain or maintain the resident's locumprehensive care plan will be president as the locus of resident's strengths and needs. The to attain or maintain the resident's locus of the facility care plan will be president.	dical record review, observation, and in ted care plan interventions to include at ts (Residents #30, #65, #41, #43, and #2 to develop, implement and maintain in resident to resident altercation between #65 in the head resulting in psychosocial in the head resulting in psychosocial resident #30 entering Resident #45's rocative's failure to develop, implement and residents' #30, #65, #41, #43, and #46 plain which the provider's non-compliance by to cause serious injury, harm, impairments with dementia care needs. The Immediate Jeopardy (IJ) in the constitutes are not to be provided and was effective the provided on	constitution of the control of the c

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	staff who provide direct services to nursing and related services to ass mental, and psychosocial well-bein plans of care .Implementing non-pl interventions into the resident's pla non-pharmacological interventions meaningful relationships between ractivities are those that address the the resident's well- being .Purpose needs of the residents, to change, resident and/or are decreasing or in Medical record review showed Res [DATE] with diagnoses including D Disorder, Insomnia, and Delusiona Review of Resident #30's compreh [as evidenced by] History of attempother residents at times, she goes from wandering by offering pleasar Monitor location every shift. Documbehavior log . Review of Resident #30's Activity a determine her interests. The review for the resident to have books, must services. The section titled, Previous goals were to .attend 1 out of room showed there was no documentation family involvement in completing. Review of Resident #30's Plan of Coresident rooms and was difficult to Review of Resident #30's Respirate. experiencing unwanted behavior(s Further review showed Resident #30's admission severe cognitive impairment and he customary routine and activities shows somewhat important to her. Both section in the province of the resident was somewhat important to her. Both sections are serviced to the province of the resident was somewhat important to her. Both sections are serviced to the province of t	ensive care plan dated 4/13/2021 show ofts to leave facility unattended .she begin and out of residents rooms, needs from the diversions, structured activities, foodment wandering behavior and attempted assessment dated [DATE], showed the variable showed .Attention span .easily distraction, go outside, do things with groups of us Leisure Areas of Interest was not an eleisure activity 3-5 x's [times] per weel on of her previous leisure areas of interest the assessment. Care Progress Note dated 4/14/2021, since the progress of the control of the progress of the control o	encies and skill sets to provide ain the highest practicable physical, ent assessments and individual and implementing appropriate ess of Pharmacological and promote engagement and positive ents and the community. Meaningful sts, preferences, etc. and enhance ents that are distressing to the ents are distressing to the ents. In [DATE] and readmitted on Anxiety Disorder, Major Depressive ents aggressive/combative with equent redirection. Distract her enconversation, television, book. In diversional interventions in entered and it was not very important for people, or attend religious swered. The resident's activity is for 3 months. Further review east being assessed and there was showed .going in and out of other entered ent

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Church hill Fost-Acute and Nehab	ilitation center	Church Hill, TN 37642		
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F 0744 Level of Harm - Immediate jeopardy to resident health or safety	Review of Resident #30's comprehensive care plan showed an update on 4/21/2021, .Requires assistance to participate in activities .we will continue to invite to activities & [and] 1'1 [one on one activities] as needed . The care plan did not include individualized, person-centered interventions to address the resident's dementia-related behaviors.			
Residents Affected - Many	Review of Resident #30's QAPI/Risk Meeting Progress Note dated 5/3/2021 at 1:52 PM, showed the resident remained a wandering risk with behaviors present, and staff were to provide close monitoring. The IDT (Interdisciplinary Team) would continue to monitor the interventions for .effective/appropriateness and intervene accordingly.			
	Review of Resident #30's Physician Notification Progress Note dated 5/3/2021 at 5:16 PM, showed a resident to resident altercation between Resident #30 and Resident #65 had occurred. Resident #30 was hitting Resident #65 on the head and pulling her wheelchair back as Resident #65 was screaming for help.			
	Review of Resident #30's Behavior Note dated 5/4/2021, showed .Resident to Resident occurred on 05.03. 21 @ [at] 1659 [4:59 PM] .Monitor resident's location and activity q [every] 15 minutes and document x [for] 72 hours. Maintain personal space of comfort for other residents x 72 hours and then re-evaluate .			
	I .	record showed no documentation the refor the dates of 5/4/2021-5/7/2021. Furted every shift.	•	
	Review of Resident #30's Risk Meeting Progress Note dated 5/4/2021, showed the IDT team would continue to monitor for effective/appropriateness of interventions .and intervene accordingly. IDT met, reviewed, discussed, and in agreement . Review revealed no individualized behavior interventions were implemented after the resident to resident abuse on 5/3/2021.			
	Review of Resident #30's Psychiatric Evaluation dated 5/4/2021, showed .Evaluating mood and behaviors-patient having increased agitation, restlessness, aggression .Patient having increased psych and delusions, reasonable to add Seroquel [an anti-psychotic medication] to target symptoms .Agitatio Physical aggression .Combativeness .Severe restlessness .Recommendations: seroquel 25 mg [milligibid [twice daily] delusions . Further review showed no non-pharmacological behavioral interventions we recommended.			
	I .	r Note/Anxiety Progress Note dated 5/5 ering resident's room and nurses station	The state of the s	
	Review of Resident #30's Psychological Diagnostic Interview dated 5/6/2021, showed .Patient was shut down .appeared angry .walked directly into another patient's room after leaving this area .THIS PATIEN NOT A CANDIDATE FOR PSYCHOTHERAPY .			
	Review of Resident #30's Behavior Note/Anxiety Progress Note dated 5/20/2021, showed .Resident frequently walks throughout the building .She tells other residents what to do. She shakes her head and go upset when things don't go her way . Further review showed the Psychiatric NP would be notified due to increased behaviors.			
	(continued on next page)			

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Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	frequently wandered into other resi Resident has been involved in a co- Review of Resident #30's Social So- inappropriate behaviors. Further re- medications. There was no docume Review of Resident #30's Behavior Residents rooms taking items, food another Resident because she thou Review of Resident #30's Behavior continued to wander .is increasingl and takes items and hides them. R other Residents in their wheelchair Review of Resident #30's Social So- displaying inappropriate behaviors, review showed Resident #30 was hemedication changes. There was no to be attempted. Review of Resident #30's Behavior wandering into other resident room other residents in their wheelchair a unable to redirect the resident. Doc Review of Resident #30's Behavior wandering into other residents' roo from nurse's station, and other resi Review of Resident #30's Behavior wandering into other resident room	Note/Anxiety Progress Note dated 6/4 y more intrusive into other Resident rolesident upsets other Residents with he around the halls. Pervice Progress Note dated 6/8/2021, service Pro	showed .Resident exhibiting d assess the resident for needed ehavioral interventions attempted. 21/2021, showed .entering other lent tried to take a drink away from er actions. Resident enters every room er actions. Resident also pushes showed Resident #30 was . at of residents hands . Continued would be notified to assess for nacological behavioral interventions actions. Staff were would be continued. S1/2021, showed the resident was . Resident was attempting to push and other residents. Staff were would be continued. S1/2021, showed Resident #30 was . Resident was also taking things s1/2021, showed the resident was . Resident was also taking things s1/2021, showed the resident was . Resident #30 was taking things from .

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Review of the facility's video surveillance footage dated 7/8/2021 from the 300 hallway, reviewed on 7/13/2021 at 1:49 PM, with the Administrator and the Plant Operations Manager present. The video sho Resident #30 at the end of the 300 hallway at 5:46:14 AM, she went to the linen cart at 5:47:24 AM. CN		anager present. The video showed e linen cart at 5:47:24 AM. CNA #4 0 walked past the other resident in oward the nurses station away from then entered room [ROOM at 5:48:27 AM. Resident #30 then ent's room at 5:48:42 AM. Resident d another resident's room at on [DATE] with diagnoses including rder, and Insomnia. In [DATE] with diagnoses including rder, and safety of the head and enteresident #65 was sitting in her and grabed and hit her right including resident had been involved anxious since that time. The later and grabbed and hit her right in very anxious since that time. This disorder . Further review showed moving about in her wheelchair. In [DATE] with diagnoses including resident in hall included past from the properties of the resident in hall included past from the resident in hall i

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety	Review of Resident #65's Behavior Note/Anxiety Progress Note dated 5/5/2021, showed Resident #65 continued to not want to go into her room after the resident to resident abuse .crying, stating 'l'm not going up there' pointing towards room. 'l'm scared'. Resident reassured, but still expressed some concern . Further review showed Resident #65 required a PRN dose of Valium to be administered and was transferred to another room for the night.				
Residents Affected - Many	Review of Resident #65's Psychotherapy Progress Note dated 5/6/2021, showed the resident was hit recently by another patient and thereafter relocated to a different room. The patient informed the clinician she was distressed and requested to be sent out to a psychiatric unit. Resident #65 stated she was having hallucinations. The clinician documented .having them [hallucinations] directly after a significant stressor (being attacked by another patient) is highly consistent with the literature on psychosis, as opposed to a manipulative quality . Further review showed Resident #65 was crying, and insistent on being considered for evaluation outside of the facility.				
	Review of Resident #65's medical record showed she was sent to the hospital for psychiatric evaluation on 5/7/2021 and returned to the facility on [DATE]. There was no individualized Dementia or behavioral plan developed after the resident's return from the hospital.				
	I .	PM, showed Resident #30 entered roo e room setting up a lunch tray and redir			
		M, showed Resident #30 entering room ed the resident to exit the room with no			
	During an interview on 7/6/2021 at 2:55 PM, CNA #1 stated Resident #30 did wander frequently and did go into other resident's rooms. She stated Resident #30 would take other residents' water pitchers. CNA #1 stated redirection was provided, and .there's not much we can do .I have suggested putting up stop signs on the doors but we would have to put them on every door because you never know which room she will go in . CNA #1 was unaware of any diversional activities that Resident #30 was to be offered.				
	Observation on 7/6/2021 at 2:59 PM, showed Resident #30 wandering in the 400 hallway. She attempted to open the door to room [ROOM NUMBER] but did not go in. She then went to the 100 hallway and attempted to open the double doors. She then wandered to the nurse's station, walked past a nurse seated at the nurse's station, opened the door to the Unit Secretary's office, and entered the office. She picked up a notebook from the Unit Secretary's desk, walked past the nurse seated at the nurse's station, and went down the 300 hallway. A staff member walked up to Resident #30 and took the notebook from her. No diversional activity was offered.				
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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	been in a resident to resident altered different room. She stated Resident issues and doesn't like to be toud the DSS confirmed Resident #30 is so much medication you can mess the interventions the facility had in put stop signs on some residents'in During a telephone interview on 7/8 #30 would wander frequently, and them [other residents] upset. The lithe other residents would scream a resident's belongings from their root the staff hear the residents scream sometimes a little mouthy and do Resident #30 would often remove to we don't realize they are gone and we we don't realize they are gone and the letter to the DSS and verbally to the residents at all times. LPN #1 state in regard to Resident #30's continual Control of the dors of some and without any diversional activities of During an interview on 7/8/2021 at head during a resident to resident a #30 had been moved to another had in and out of other residents' rooms signs on the doors of some resident LPN #2 was not aware of any diversional activities offered. During an interview on 7/8/2021 at 8:30 All entered another residents' rooms. Observation on 7/8/2021 at 8:30 All entered another residents' room and diversional activities offered.	8:27 AM, LPN #2 confirmed Resident #65 altercation, which caused Resident #65 allway after the altercation, but continues. LPN #2 confirmed the staff try to redit the staff try to redit the staff try to redit the staff were to offer form of the staff were to offer form of the staff member redirected her back in the staff mem	esident #30 had been moved to a and that Resident #65 had .psych sident #65 .became fearful .crying . nd .that's a problem .there is only nd redirect her . She further stated tring behavior was .redirecting and to .the residents that complain . Nurse (LPN) #1 stated Resident ms. Resident #30's wandering .gets d enter other resident rooms and esident #30 would pick up other decorations. LPN #1 stated when easily redirectable. Resident #30 is ents' rooms. The LPN stated s' rooms and they would .disappear mer nurses station . LPN #1 stated er wandering had been reported by ere unable to watch wandering been communicated by the facility ms. If the 200 hallway, she entered irected her back into the hallway #30 had hit Resident #65 on the is to be upset and tearful. Resident ed to wander throughout the facility, rect Resident #30 and use stop is were supposed to have them. Resident #30 when she wandered wander on the 200 hallway. She not the hallway without any

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F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 7/8/2021 at 8:45 Al down the 300 hallway carrying a fo offering any diversional activities. During an interview on 7/8/2021 at they could .with demented patients resident doors had been attempted unaware of which residents require stated stop sign placement was deresident. During an interview on 7/8/2021 at residents' rooms, would take items #3 stated the facility had placed stothem down and carry them around other residents' doors. LPN #3 state interventions the facility had implem activities. During an interview on 7/8/2021 at residents' rooms. RN #2 stated the she was not sure which residents wonitor Resident #30 and try to recimplemented to prevent Resident #40 During an interview on 7/8/2021 at residents' rooms and some resident Resident #30 would go into her roo complaints to a nurse, there .really resident but was not made aware of wandering. During an interview on 7/8/2021 at residents' rooms and some resident wandering.	M, showed Resident #30 wandering by Ided tablecloth. A staff member took the 8:46 AM, the DSS confirmed the facilit [wandering] would occur. The DSS stout had been taken down and are effed stop signs and was unaware of how termined when a resident had made a 9:23 AM, LPN #3 stated Resident #30 from the other residents' rooms, and was proposed to have stop signs on some of the residents' door LPN #3 stated she had witnessed Resident #30 is redirectable at time mented to prevent Resident #30 from was 9:32 AM, RN #2 confirmed Resident #facility had put stop signs up for the rowere supposed to have stop signs on the lirect, but was unaware of any other into 30 from wandering, including diversion 10:21 AM, CNA #2 stated Resident #3 ts did complain. CNA #2 stated Resident #3 ts did complain. CNA #2 stated Resident #3 fany other interventions, including diversion 10:33 AM, CNA #3 stated Resident #3 ts had complained. CNA #3 stated she, including diversional activities the staff including diversional activities activities the staff including diversi	the nurse's station and started e tablecloth from her without y .would divert the resident as best ated the stop signs on some active at times. The DSS was to obtain that information. She complaint about a wandering would wander in and out of other rould drink everybody's drinks. LPN is, but Resident #30 would take sident #30 take the stop sign off its. but was unaware of any other randering, including diversional 30 would wander into other oms .we find may be an issue . but heir doors. RN #2 stated the staff iterventions the facility had hal activities. 0 would wander into other ent #65 had complained that ated she had reported the stated the staff would redirect the ersional activities, to prevent 0 would wander into other event would provide redirection but was

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Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	into any room that was not locked, belongings. RN #3 stated Resident #3 stated the staff would look for or residents' glasses, but most items happy. with Resident #30 wanderi sign from a resident's door and had the resident was unable to underst and stated the information was pass reported Resident #30's wandering instructed to document the behavior interventions had been communicated. During an interview on 7/8/2021 at 5/3/2021 and had been going througher that Resident #30 approached were every behavioral. The ADON had the right to wander because the resident's complaint of Resident #30 wandering behaviors had been dismedications were monitored by the interventions had been attempted. During an interview on 7/9/2021 at interventions for Resident #30's be Coordinator had been adding behavioral interventions for Resident #30's be Coordinator had been aware of Resident #30's be coordinator. She stated Resident #3 attempting to exit a door) placed or behaviors. She stated Resident #3 attempting to exit a door) placed or behaviors. She stated Resident #3 attempting to exit a door) placed or behaviors. She stated Residents' belongings of the resident to resident altercation. She history of abuse and belief she negative outcome from someone here.	B/2021 at 12:47 PM, RN #3 stated Res in and out of other residents' rooms, and ther residents' belongings in her room a she took were never located. RN #3 stated took were never located. RN #3 stated to explain to Resident #30 that she and. RN #3 was unsure which resident issed on in shift report, but not documer to behavior to the Assistant Director of Nors in the resident's chart, but no further the ted. 1:31 PM, the ADON stated Resident # uph the hallway .crying and screaming Resident #65 and .it was more of a tap stated the facility had provided close in the facility was .her home . The ADON to wandering into her room. The ADON to wandering into her room. The ADON to Psychiatric NP and the facility staff me the total interventions into the care plans ident #30 wandering into other resident and the Resident #30 needed interventions in .you can't restrict her in any manner terventions that had been developed for had a wander guard (device used to a admission but she had not assessed the resident #30 had not been easily redirestroated the resident's past occupation SS stated she believed she had been as the stated she believed she had been as the stated she did feel the wandering in the had a hole in her had a hole in her head and hole in her head would have resident #65 believed she had a hole in her head and hole in her her had an hole in her head and hole in her her had an hole in her her had an hole in her head would have resident #65 believed she had and hole in her her had an hole in her her head would have resident #65 believed she had an hole in her her had an hole in her her had would have resident #65 believed she had an hole in her her had an hole	and would move/take other residents' and once drank a nurse's drink. RN and would sometimes find other atted most residents were .not sed Resident #30 remove a stop the could not enter those rooms, but its wanted a stop sign on their door atted in the chart. RN #3 had dursing (ADON) and had been a roon-pharmacological behavioral and been aware of another a confirmed Resident #30, but she ad been aware of another a confirmed Resident #30's onitor her wandering. No other at developed any care plan further stated she thought the MDS during the care plan meetings. She as of redirection and medications for . She was unaware of any other or Resident #30's wandering alert staff when a resident is the resident #30's wandering alert staff when a resident is the resident #30's wandering alert staff when a resident is the resident #30's had been more irritated and had been more irritated and her care plan to determine aware Resident #30 had been not other residents' rooms and the and and confirmed Resident made her more susceptible to a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Church Hill Post-Acute and Rehab	ilitation Center	701 West Main Blvd Church Hill, TN 37642	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0744 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 7/9/2021 at Resident #65 after the resident to radded an antipsychotic medication #65 had delusions about the incide kill her. The Psychiatric NP confirm required medication changes and a some significant distress and psychmedication recommendations to the interventions. During an interview on 7/9/2021 at #30's wandering into other resident MD stated that other residents had things. He stated he had tried to endiversional activities the facility had more appropriate for Resident #30 he did not state if he made any recistated the resident to resident alter Resident #65 a significant amount MD confirmed Resident #30's contial altercation.	1:40 PM, the Psychiatric NP stated shesident altercation that occurred on 5/3 for Resident #30 after the incident for that and thought the woman (Resident # led the altercation triggered increased is a hospitalization. She confirmed the altercation in the Psychiatric NP state is facility and had not provided any reconstruction of the incorrect of the psychiatric NP states for some and stated in incorrect of the psychiatric NP states for some and stated in incorrect of the psychiatric NP states for some and stated in incorrect of the psychiatric NP states for some and stated in incorrect of the psychiatric NP states for some and stated in incorrect of the psychiatric NP states for some and stated in incorrect of the psychiatric NP states for some incorrect NP states for states for some incorrect NP states for states for some incorrect NP states fo	e had evaluated Resident #30 and \$1/2021. She confirmed she had delusions. She confirmed Resident 30) was out to get her and out to anxiety for Resident #65 which ercation did cause Resident #65 ed she would only provide ammendations of behavioral ated he was aware of Resident into a few folks along the way. The not their rooms and would take e it personally. He confirmed the did a memory care unit might be informally with the facility staff, but a the continued wandering. He #30 and Resident #65 caused to have psychosocial harm. The fanother resident to resident

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NAME OF DROVIDED OD SUDDI II	NAME OF PROMPTS OF GURDUES		D CODE
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	PCODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessm corrective plans of action. **NOTE- TERMS IN BRACKETS IN Based on review of facility policy, in Performance Improvement (QAPI) to address the root causes of a reshead, which led to psychosocial haresident to resident abuse and to in Resident #30's continued wanderin #45's room and placing her hands QAPI program's failure to identify, Resident #30's continued wanderin situation in which the provider's noor is likely to cause serious injury, In The Administrator was informed of 12:50 PM. The Immediate Jeopardy was removed an acceptable Removal Plan, which is:40 AM and the corrective actions. The findings include: Review of the facility policy titled Quevealed Policy Explanation and Coursect identified quality deficien Study, Act (PDSA) cycle of improved linked to the root causes and will be Medical record review showed Rese [DATE] with diagnoses including Department, Insomnia, and Delusional Review of Resident #30's admission severe cognitive impairment, and in the second review of Resident #30's admissions and review of Resident #30's	HAVE BEEN EDITED TO PROTECT Connectical record review, and interview, the program failed to identify a quality deficient to resident altercation when Resident to Resident #65. The facility's failure implement individualized, person-centering throughout the facility resulted in Resident end the resident's neck and attempting the develop, and implement interventions to an and potential abuse placed all resident end in the Immediate Jeopardy (IJ) in the contract the Immediate Jeopardy (IJ) in the contract when the immediacy of the jeopard were validated onsite by the surveyors are validated onsite by the surveyors the facility will utilize Root Cause ement to improve existing processes. One designed to effect change at the systematical with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance, Assident #30 was admitted to the facility of ementia with Behavioral Disturbance.	ality deficiencies and develop ONFIDENTIALITY** 40639 The facility's Quality Assurance ciency and implement interventions dent #30 hit Resident #65 in the experience to investigate an instance of red behavior interventions for sident #30 later entering Resident to choke Resident #45. The facility's protect all residents from rents in Immediate Jeopardy (a ments for participation has caused, nt). Inference room on 7/10/2021 at resident entering Resident was received on 7/12/2021 at resident for participation has caused, nt). The foreign for the fact of the fact

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NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZI 701 West Main Blvd Church Hill, TN 37642	P CODE	
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F 0867 Level of Harm - Immediate jeopardy to resident health or	Review of Resident #30's Physician Notification Progress Note dated 5/3/2021, revealed .Staff reported to this nurse an [a] Resident to resident altercation. This resident [Resident #30] who was hitting [Resident #65] on the head and pulling her wheelchair back .order to send to [local hospital] emergency room for psych eval [mental health evaluation] and treatment .			
safety Residents Affected - Many	remains a wandering risk with beha	sk Meeting Progress Note dated 5/3/20 aviors present. Close monitoring provide fective/appropriateness of intervention	ed by staff. IDT [Interdisciplinary	
	Review of Resident #30's Risk Meeting Progress Note dated 5/4/2021, showed .IDT will continue to monitor for effective/appropriateness of interventions and intervene accordingly. IDT met, reviewed, discussed, and in agreement . Review showed no additional interventions were implemented after the resident-to-resident abuse on 5/3/2021.			
		notes from 5/4/2021 - 7/5/2021 reveale ident rooms, and was frequently aggre		
		Note/Anxiety Progress Note dated 7/5 Note/Anxiety Progress Note dated 7/5 Note into other resident rooms causing		
		sident #65 was admitted to the facility on t Behavioral Disturbance, Difficulty Wa g Below Knee.		
		MDS dated [DATE], showed the resid independent for locomotion on the unit, and no wandering was documented.		
	Review of Resident #65's Physician's Progress Note dated 5/4/2021, showed .The patient was a victim of the resident on the resident violence earlier in the week .The patient's been very anxious since that time .The patient reports the other individual came up from behind her and grabbed and hit her right parietal and temporal area .This incident unfortunately set off exacerbation of patient's underlying anxiety disorder To become increasingly anxious and avoids individuals when moving about the community in her wheelchair .			
		sident #65 experienced increased anxion in the side of the stail in the side of the side o		
	Medical record review showed Resident #45 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Muscle Wasting, Chronic Obstructive Pulmonary Disease, Difficulty Walking, Presence of a Cardiac Pacemaker, Personal History of Other Mental and Behavioral Disorders, Bipolar Disorder, Syncope and Collapse, General Anxiety Disorder, Wheezing, and Dependence on Supplemental Oxygen.			
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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	cognitive impairment with no behave not ambulate, used a wheelchair for Review of Resident #45's Physician supervised the patient [Resident #4 her right hand on the left side of the stated she turned and tried to push the hand removed .Event was unpositive for a facility witness statemer Resident stated she was sleeping, standing over her. She claimed [Resident stated she was sleeping, standing over her. She claimed [Resident #30 a was unaware of the nurse's notes a caused distress to those residents. In the hallway. During an interview on 7/8/2021 at reviewed the resident-to-resident add not identify the altercation as at behaviors due to both residents' his training. The Administrator confirminvestigated as abuse, and was no no other resident to resident altercated Resident #30 choking Resident #41 and how that led to the incidents of Refer to F-600, F-609, F-610, F-74 An acceptable Removal Plan, which AM, and the corrective actions were review of documents, review of factor The Removal Plan presented to the corrective actions implemented. On 7/10/2021 the Regional Director Nursing, Nursing Educator, Unit Martines and the corrective actions implemented.	n Progress Note dated 7/8/2021, show 45] while she was lying on her left resting patient's [Resident #45] neck and hele the arm [Resident 30's arm] away but rovoked. The patient she was lying on her left resting the arm [Resident 30's arm] away but rovoked. The patient she can be considered the she she can be she was an and thought was one of us shaking here as a shaking here and Resident #30] had her hands around here and Resident #65 as an abuse allegating Resident #30 had wandered into the she was a shaking Resident #30 had wandered into the she was an abuse allegating Resident #30 had wandered into the she was an abuse allegating Resident #30 had wandered into the she was a shaking here was a shaking resident #30 and Fouse. She stated the resident-to-resident altercation was at the reported to the State Agency. The Adations. The Administrator did not divulg to the patient abuse. 1, and F-744 The removed the immediacy of the jeopa e validated on-site by the surveyors on a shaking the surveyors on the survey team by the facility documented an anger, MDS Coordinator, Medical Recondance was a survey team by the facility documented anger, MDS Coordinator, Medical Recondance was a survey team by the facility documented anger, MDS Coordinator, Medical Recondance was a survey team by the facility documented anger, MDS Coordinator, Medical Recondance was a survey team by the facility documented anger, MDS Coordinator, Medical Recondance was a survey team Resources. The training the survey of the pager was a survey team Resources. The training the survey of the pager was a survey team Resources. The training the survey of the pager was a survey team Resources. The training the survey of the pager was a survey team Resources. The training the survey of the pager was a survey team Resources. The training the survey of the pager was a survey team Resources. The training the survey of the pager was a survey team Resources. The training the survey of the pager was a survey team Resources. The training the survey of th	ed .Resident [Resident #30] ng .Resident [Resident #30] placed d it .The patient [Resident #45] it was very stiff .Ultimately she got It (CNA) #5, undated, showed . r awake. But it was [Resident #30] neck and told her she would hurt facility had not investigated the on. The Administrator stated she of other residents' rooms and never harmed anyone .just wanders Interdisciplinary Team (IDT) Resident #65 and stated the facility nt altercation was considered we need more Dementia care was not identified as abuse, was not ministrator stated there had been the any details for the incident of the issue of resident wandering rdy, was received 7/12/2021 at 8:40 a 7/12/2021-7/13/2021 through and the following immediate Administrator, Assistant Director of cords, Social Services, Director of

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F 0867	3. process of identifying, preventing, and reporting abuse				
Level of Harm - Immediate jeopardy to resident health or	4. how to recognize a potential behavior that is escalating, and to intervene				
safety	5. who is the Abuse Coordinator				
Residents Affected - Many	6. suspected or observed abuse, a	Il types, reported to the Administrator in	mmediately		
	All staff not working on 7/10/2021 were called and re-in-serviced.				
	All residents with a diagnosis of Dementia/behaviors had their care plan reviewed and revised resident specific behavioral interventions. Interviewable residents were interviewed by the Soc Director on any concerns related to abuse. Residents that were not interviewed had a skin ass completed by the ADON and Unit Manager on 7/10/2021. The Regional Director of Clinical ser reviewed the last 72 hours of nursing notes to identify any issues that needed to be investigate allegation with no issues identified.				
	On 7/10/2021 the Nurse Educator, Director of Rehab, and Human Resources educated staff. The training included:				
	how to recognize potential behavior that is escalating and to intervene who the abuse coordinator is- the Administrator suspected or observed abuse				
	4. all types reported to the Adminis	e Administrator immediately			
All staff not working on 7/10/2021 were called and re-in-serviced.					
	On 7/11/2021 all staff started competency tests on Hand-in-Hand Dementia module part 1 & 2, abuse prevention, reporting, and investigating test.				
	hours to identify any potential repo 3xweek for 4 weeks, and 2xweek for resident to resident and no incident Licensed Nurse will do 5 skin sweet residents who are not interviewable written in the past 24 hours to ident weeks, 3xweek for 4 weeks, and 2 sweeps, a reportable event log will behaviors/Dementia care plans we Services to reflect resident specificand the Unit Manager to identify and were identified. The Regional Direct new and/or exacerbations of behaviors.	ministrator and Director of Nursing (DO rtable events. These audits will be perfor 4 weeks. 5 random residents will be to for the residents wandering into the teps 5xweek for 4 weeks, 3xweek for 4 vee. The Regional Director of Clinical Sertify any areas that potentially could be axweek for 4 weeks. The Nurse Educate be maintained in the Administrators of the reviewed and updated on 7/10/2021 interventions for behaviors. Nursing start of Nursing reviewed the past 72 how it is not a provious on 7/10/2021, no issues identified.	ormed 5x week for 4 weeks, interviewed daily to ensure no ir rooms by Social Services. A weeks, and 2xweek for 4 weeks on vices will monitor nursing notes a reportable event 5xweek for 4 or will track the interviews and skin fice. Residents with by the MDS Nurse and Social aff were interviewed by the ADON cerbations on 7/10/2021, no issues urs of nursing documentation for		
	(continued on next page)				

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2021
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Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 7/12/2021, Surveyors reviewed the education and sign in sheets which validated the corrective action plans onsite which was provided by the Administrator. The documentation showed all staff working on 7/12/2021 and 7/13/2021 had been provided the education on abuse, types of abuse, preventing, protecting, recognizing/dentifying abuse/behaviors, reporting, and investigating abuse. The administrator was educated on abuse by the corporate nurse. Residents affected by the wandering residents were assessed and interviewed to determine if psychosocial harm had occurred. 22 resident records were reviewed randomly to ensure care plans had been updated and Dementia care had been added to those with Dementia and behaviors. The records had been updated to include interventions on the 22 resident records reviewed. The surveyors validated all staff working on 7/12/2021-7/13/2021 had been educated and were knowledgeable about the new procedures related to abuse/behavior, Dementia Care, and person-centered care planning. On 7/12/2021, Surveyors validated the corrective actions onsite through interviews with the Administrator, DON, Nurse Educator, MDS Coordinator, Social Service Director, 4 RNs, 2 LPNs, 8 CNA's, 2 nurse aides in training, 2 therapists and 2 housekeepers. The interviews showed the staff were educated on how to prevent abuse, what to do when abuse occurs, reporting of abuse, investigating abuse, documentation and implementing person centered care plans for each resident with Dementia and behaviors. Staff verbalized knowledge of development of care plans for each resident with Dementia and behaviors. Staff verbalized knowledge of development of care plans for each resident with Dementia and behaviors. Staff verbalized knowledge of development of care plans for each resident with Dementia and behaviors. Staff verbalized knowledge of development of care plans for Dementia and behaviors and how to assess residents to determine plant of the plant of		