STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445501	A. Building B. Wing	03/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hills Health and Rehab	6801 Middlebrook Pike Knoxville, TN 37919

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31210 Based on review of facility policy, medical record review, review of facility documentation, and interview the facility failed to follow the plan of care for bed mobility for 1 resident (#9) of 5 residents reviewed for falls of 24 sampled residents. The facility's failure to follow the plan of care for Resident #9 resulted in actual harm. The findings include: Review of the facility policy Falls Management, undated, revealed, .The facility strives to reduce the risk for falls and injuries by promoting the implementation of the Risk Reduction: Falls and Injuries Program. Residents are assessed for the fall risk factors. The interdisciplinary team works with the residents and family to identify and implement appropriate interventions to reduce the risk of falls or injuries . Continued review of the facility's fall policy revealed, .Procedure .3. Discuss goals and interventions with resident/family for inclusion in the interdisciplinary plan of care. 4. Implement the Plan of Care- Fall Risk Reduction based on individual resident needs. 5 Complete the individual resident care plan. 6. Communicate interventions during shift report and clinical rounds to the care teams as appropriate . Resident #9 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Multiple Sclerosis, Epilepsy, Chronic Pain Syndrome, Cerebral Infarction, Aphasia, Hemiplegia Left Side, Muscle Weakness, Dysphagia, Chronic Obstructive Pulmonary Disease, Contracture Left Wrist and Left Hand, and History of Falling. Medical record review of a Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #9 scored a 2 on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired. Continued review revealed Resident #9 required the extensive assistance of 2 staff for bed mobility, and the total dependence of 2 staff for transfers, toileting and hygiene. Medical record review of the comprehensive care plan dated 12/11/18 revealed, .Risk for falls will be minimized/managed and resident will suffer no serious injury related to falls . Continued review revealed, .2 person assist for bed mobility . Medical record review of an undated Certified Nurse Assistant (CNA) ADL (Activities of Daily Living) Care Guide revealed, .two person [staff] for ADLs, bed mobility, and transfers . (continued on next page)

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Medical record review of a Fall Scene Investigation form dated 3/2/19 revealed, .Rolled out of bed while being assisted by one CNA . Medical record review of local hospital History and Physical Reports dated 3/2/19 revealed, .Chest x-ray reveals .rib fractures on the left 2 through 7 .Pneumothorax [collapsed lung] . Further review revealed Resident #9 had a chest tube placed due to the collapsed lung. Review of a Personnel Action Form dated 3/6/19 revealed, .[CNA #1] was providing patient care, alone, on a person who required the assist [assistance] of 2 [staff]. The patient [Resident #9] fell from the bed and sustained injury. Associate did not adhere to the ADL care guide . Interview with CNA #1 on 3/19/19 at 2:20 PM, by phone, confirmed, .changed her [Resident #9] by myself, I always changed her with 1 CNA . Interview with the Director of Nursing (DON) and the Administrator on 3/19/19 at 4:05 PM, in the DON's office, confirmed Resident #9 was care planned for requiring the assistance of 2 staff members for bed mobility. Further interview with the DON and Administrator confirmed CNA #1 had provided care to Resident #9 alone, and had failed to follow the resident's care plan resulting in Resident #9's fall from the bed and sustaining fractured ribs and a collapsed lung.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31210 Based on review of the facility policy, medical record review, and interview the facility failed to administer an ordered medication to 1 resident (#318) of 24 sampled residents. The findings include: Review of the facility policy Medication Administration, revised 3/16/15, revealed .administer medications within 60 minutes of the scheduled time .routine medications are administered according to the established medication administration schedule for the facility . Medical record review revealed Resident #318 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Anxiety, Chronic Heart Failure, Rash and other Nonspecific Skin Eruption. Medical record review of a Physician Telephone Order dated 3/16/19 revealed .Triamcinolone [medication for itching and inflammation of the skin] cream 0.1% [percent]. Apply to rash on back TID [3 times daily] x [times] 14 d [days] . for diagnosis of heat urticaria (skin rash with itchy red bumps). Medical record review of the MR (Medication Record) revealed no documentation Resident #318 had received the Triamcinolone cream 7 out of 11 ordered doses dated 3/16/19 to 3/20/19. Further review of the MR revealed no documentation for the explanation of the missed Triamcinolone cream administration. Interview with Resident #318 on 3/18/19 at 8:45 AM, in the resident's room, revealed she was concerned about not receiving the Triamcinolone cream three times a day as ordered. Interview with Registered Nurse (RN) #2 on 3/19/19 at 8:30 AM, at the medication cart and review of Resident #318's MR, confirmed Resident #318 had not received the medication as ordered. Interview with RN #3, Account Manager of the Pharmacy on 3/19/19 at 3:30 PM, at the main nursing station, revealed the Triamcinolone cream had been delivered to the facility on [DATE]. Interview with Licensed Practical Nurse (LPN) #1 on 3/20/19 at 8:22 AM, in the rehabilitation nursing station, revealed when an ordered medication is not given, it is to be circled and documented with the rationale on the back of the MR. Continued interview confirmed the Nurses's Medication Notes on the back of the MR had no documentation of missed or held Triamcinolone cream. Interview with the Director of Nursing (DON) on 3/20/19 at 9:00 AM, in the DON's office, confirmed the facility failed to administer a medication as ordered and failed to document the rationale for not administrating the Triamcinolone cream for Resident #318.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39794 Based on facility policy review, medical record review, and interview, the facility failed to prevent a fall resulting in actual Harm for 1 resident (#9) of 5 residents reviewed for falls of 24 sampled residents. The findings include: Review of the facility policy Falls Management, undated, revealed .Residents are assessed for the fall risk factors. The interdisciplinary team works .to identify and implement appropriate interventions to reduce the risk of falls or injuries . Medical record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Multiple Sclerosis, Epilepsy, Chronic Pain Syndrome, Cerebral Infarction, Aphasia, Hemiplegia (left side), Chronic Obstructive Pulmonary Disease (COPD), Contracture Left Wrist and Left Hand, Muscle Weakness, and History of Falling. Medical record review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #9 scored a 2 on the Brief Interview for Mental Status (BIMS) indicating the resident had severe cognitive impairment. Continued review revealed Resident #9 required extensive assistance of 2 staff with bed mobility, and total dependence of 2 staff for transfers, toileting, and hygiene. Medical record review of Resident #9's comprehensive care plan dated 12/11/18 revealed .Ensure fall precautions are in place . Continued review revealed the resident required 2 staff assistance for bed mobility. Medical record review of the untitled Certified Nursing Assistant (CNA) care guide dated 2/28/19 revealed Resident #9 required assistance of 2 staff for bed mobility. Medical record review of a Fall Scene Investigation form revealed on 3/2/19 at 5:45 AM, .Rolled out of bed while being assisted by one CNA . Medical record review of a nurse's note dated 3/2/19 at 6:43 AM, revealed .Nurse was alerted of a fall . Patient was on the floor parralel [parallel] to her bed, laying on her right side. CNA stated that she rooled [rolled] out of bed while .the CNA was trying to do peri-care [perineal care] .no s/s [signs/symptoms] of pain noted . Medical record review of a late entry nurse's note dated 3/2/19 at 5:41 PM, revealed .0700am .O2 [oxygen] sat [saturation] 82-88 on room air, res [resident] having difficulty breathing, neb [nebulizer] tx [treamtment] administered as per prn [as needed] orders, O2 sat improved to 90-93% [percent] on room air, res continues grunting noise and is continuing to be nonverbal, asking res about pain discomfort res still not answering questions. 0745am called on call doctor left voicemail requesting call back .continues to be having changes with resp [respiratory] status . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Medical record review of a Physician's Telephone Order dated 3/2/19 revealed .Send to ER for eval /[evaluation] & [and] tx [treatment] due to fall .Resp. status . Medical record review of a hospital History and Physical Report dated 3/2/19 revealed .Chest x-ray reveals subcutaneous emphysema with rib fractures on the left 2 through 7. Pneumothorax [collapsed lung] . Continued review revealed acute respiratory failure associated with COPD and multiple left sided rib fractures .Pneumothorax .Fall from bed .Patient has a history of multiple Cerebrovascular Accidents (CVAs) [stroke] with dense left hemiparesis [paralized or weakness to one side of the body] . Further review revealed a CT (computed tomography) scan of the chest revealed enlarging pneumothorax .chest tube placed . Continued review revealed, .I [the ER physician] have spoken to the patient's sister at bedside and the patient's daughter by telephone .end of life issues were discussed. Prognosis is very poor . Review of a Personnel Consultation form dated 3/6/19 revealed CNA #1's employment was terminated from the facility. Continued review revealed .associate was providing patient care, alone, on a person who required the assist [assistance] of 2 [staff]. The patient [Resident #9] fell from the bed and sustained injury. Associate [CNA #1] did not adhere to the ADL [Activities of Daily Living] care guide . Telephone interview with CNA #3 on 3/19/19 at 5:15 AM revealed CNA #3 was sitting at the nurse's station and heard CNA #1 hollered out to me from the resident's [Resident #9's] room door . Further interview revealed CNA #1 had .not asked for help all night . Telephone interview with CNA #1 on 3/19/19 at 12:55 PM, revealed CNA #1 was providing care to the resident on 3/2/19 at 5:45 AM .changed her by myself .I always changed her [alone] . Continued interview revealed Resident #9 was rolled onto the right side to provide peri-care, the left leg shifted .and threw her off the bed before I could catch her . Interview with CNA #5 on 3/19/19 at 2:46 PM, in the conference room, revealed the CNA had worked in the facility for 7 months. Continued interview revealed the CNA was aware Resident #9 required the assistance of 2 staff for bed mobility, and had always required the assistance of 2 staff since he had been employed in the facility. Interview with CNA #4 on 3/20/19 at 2:20 PM, in the conference room, revealed .we knew she was a 2 person assist by the care guide and by looking at her .she was obese, not active, non-verbal, just needed assistance with everything . Interview with Registered Nurse (RN) #4 on 3/20/19 at 2:50 PM, on the 400 Hall, revealed CNA care guides are updated daily and printed and left in a folder at the nurse's station daily for the CNAs which clearly document the level of assitance Resident #9 required. Interview with the Director of Nursing (DON) and the Administrator, on 3/19/19 at 4:05 PM, in the DON's office, confirmed Resident #9 required 2 person assistance with bed mobility, Resident #9 sustained multiple rib fractures, and the facility failed to provide the required 2 person assistance which resulted in a fall and actual harm to Resident #9. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In summary, Resident #9 had been assessed as requiring the assistance of 2 staff members for bed mobility. Resident #9's MDS assessment, Care Plan, and CNA Care Guide all documented Resident #9 needed the assistance of 2 staff members for bed mobility. During interviews conducted with multiple CNAs during the survey, all were aware of the level of assistance Resident #9 required. Interviews confirmed other CNAs were available and nearby when CNA #1 assisted Resident #9, and interviews confirmed CNA #1 only asked for help after Resident #9 had already fallen from the bed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39705 Based on facility policy review, observation, and interview, the facility failed to follow contact isolation precautions for 1 resident (#87) of 1 resident observed for isolation precautions of 9 halls observed for infection control. The findings include: Review of the facility's policy Contact Precautions, undated, revealed .Wear gloves when entering the room . Wear a gown . Medical record review revealed Resident #87 was admitted to the facility on [DATE] with diagnoses including Intervertebral Disc Degeneration, Muscle Weakness, and Difficulty in Walking. Medical record review of an Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #87 had a Brief Interview for Mental Status (BIMS) score of 3 indicating the resident was severely cognitively impaired. Continued review revealed the resident was always incontinent of urine and required the extensive assistance of 2 staff for bed mobility, toileting and personal hygiene. Medical record review of a Physician Telephone Order dated 3/14/19 revealed .contact isolation . Continued review revealed Resident #87 had a diagnosis of Urinary Tract Infection with possible anitbiotic resistant organism. Medical record review of Resident #87's current comprehensive care plan updated 3/18/19 revealed . Interventions .Follow facility isolation policy . Observation on 3/19/19 at 8:19 AM, on the 800 hall, revealed Hydration Aide #1 entering Resident #87's room wearing a gown not properly secured at the waist and ungloved. Continued observation revealed Hydration Aide #1 touched the resident's bed to raise the head of the bed, touched Resident #87 to assist the resident with repositioning in bed, touched the blinds, and sat on the chair. Interview with Registered Nurse (RN) #1 on 3/19/19 at 2:28 PM, at the long term care nurse's station, revealed Resident #87 is on contact isolation precautions. Continued interview revealed .I try to watch them [Hydration Aides] because they don't always gown and glove up . Observation on 3/20/19 at 12:20 PM, on the 800 hall, revealed Certified Nursing Assistant (CNA) #1 sitting on a chair inside Resident #87's room with a gown not properly secured at the waist and her arms resting on the resident's bedside table, holding her gloves in one hand. Observation and interview with the Assistant Director of Nursing on 3/20/19 at 12:22 PM, on the 800 hall, confirmed CNA #1 had not properly donned (put on) a gown and gloves prior to entering and while inside a contact isolation room. Continued interview confirmed the facility failed to follow the contact isolation policy.