STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445159	A. BUILDING _____ B. WING _____	07/11/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY CENTER FOR REHABILITATION AND HEALING LLC	**421 OCALA DRIVE NASHVILLE, TN 37211**

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on review of facility policy, review of a facility reported incident, medical record review, observation, review of a facility surveillance video, and interview, the facility failed to protect 2 (#316, #26) of 5 residents reviewed for physical abuse. The abuse resulted in actual Harm to Resident #316. Findings include: Review of facility policy Abuse Prevention, revised [DATE] revealed, .The facility has a zero tolerance policy for abuse .physical abuse .is prohibited .The Abuse Policy applies to anyone involved with Residents of this facility, including, but not limited to, all facility staff .Abuse .willful infliction of injury .with resulting .physical harm or mental anguish .willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Medical record review revealed Resident #316 was admitted to the facility on [DATE], was placed on Hospice [DATE] and expired on [DATE] with [DIAGNOSES REDACTED]. Medical record review of a Quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #316 was rarely/never understood and had short and long term memory problems. She had unclear speech, and rarely/never understood others. She required extensive assistance of 2 or more people for bed mobility, and transfers. She required extensive assistance of 1 person for dressing and toileting. She was totally dependent with assistance of 1 person for locomotion on and off the unit, eating and bathing; and was dependent with assistance of 2 or more people for personal hygiene. She did not require pain medications. Review of a facility reported incident dated [DATE] revealed 2 Certified Nurse Assistants (CNAs) having a verbal argument and CNA #1 threw a plate lid at CNA #2. The plate lid hit Resident #316 in the face and she was transported to the hospital for care. CNA #1 was arrested on site by the local Police Department. Review of a hospital emergency department physician's note dated [DATE] at 9:18 AM revealed, .4 cm (centimeter) laceration with area of deep puncture extending below right eye, does not involve eye .facial plastics (plastic surgeon) at bedside .will repair laceration .discussed with nephew who is point of contact at bedside who is comfortable with patient's return to .facility . Review of a computed tomography (CT) scan report dated [DATE] revealed, .The patient has a [MEDICAL CONDITION] right nasal bone at the nasomaxillary junction (right side of the bridge of the nose) with subcutaneous [MEDICAL CONDITION] (gas or air in the layer under the skin) . Review of Discharge Instructions from the hospital dated [DATE] revealed the reason for the visit was a facial laceration. [DIAGNOSES REDACTED].Assault by striking with a [MEDICATION NAME] or thrown object, initial encounter .Alzheimer's dementia without behavioral disturbance .Closed fracture of nasal bone, initial encounter . Telephone interview with an Adult Protective Services (APS) Supervisor on [DATE] at 10:56 AM revealed they substantiated the alleged abuse based on the video. Further interview revealed, The video shows the CNA throwing the plate lid and it hit the resident . Observation on [DATE] at 8:00 AM in the State Survey office of a 1 minute digital video dated [DATE] at 7:30 AM recorded by the facility and provided by APS revealed 6 residents were in a day room along with 2 CNAs (CNA #1 and CNA #2) and 1 Licensed Practical Nurse (LPN) #2. 3 residents were seated in wheelchairs at one table and 3 residents were seated in wheelchairs at another table. LPN #2 had a medication cart at one doorway of the day room and was administering medications to a male resident seated at the table by CNA #2. CNA #1 was removing breakfast items from the breakfast tray and setting up the meal for a resident by placing used condiment wrappers and straw wrappers into an upside down hard plastic plate lid resting on the table. CNA #2 was at the other table approximately ,[DATE] feet away placing clothing protectors on the 3 residents. Both CNAs were seen talking to each other, CNA #1 stopped what she was doing, faced CNA #2 and put her left hand on her hip. CNA #2 kept talking to her. CNA #1 had the empty food tray in her left hand then picked up the plate lid with her right hand and threw it forcefully in the direction of CNA #2 who was standing between 2 residents; a male resident and Resident #316. The plate lid hit Resident #316 on the right side of her face. Her head was seen moving backward then forward. CNA #2 turned her head and right shoulder to the left to avoid being hit. The plate lid rolled out of another door of the day room. LPN #1 had her back to CNA #1 at the time she threw the lid and was giving medication to the male resident seated at the table by CNA #2. LPN #2 immediately stepped between the 2 CNAs and walked CNA #1 out of the room. As she was leaving the room, CNA #1 dropped the empty food tray on the floor by the door. There was no audio on the recording. Interview with the Administrator with the Director of Nursing (DON) present on [DATE] at 12:50 PM in the DON's office stated he was notified by phone sometime between 7:00 AM and 8:00 AM on [DATE] by LPN #5 that a resident was hit by a tray or something by CNA #1. The Administrator was driving to the facility at the time and instructed the nurse to bring CNA #1 to his office and have the Social Worker (SW) and LPN #5 view the video recording from the camera in the day room. After viewing the video, the police were notified and arrested CNA #1 at the facility. Interview with LPN #2 on [DATE] at 1:35 PM in the DON's office revealed the incident occurred in the F hall day room which is the secured dementia unit. Continued interview revealed, .The techs were setting up breakfast trays and one (CNA #2) told the other one (CNA #1) about not bringing drinks to the day room and (CNA #1) was like, 'I forgot.' I was in the room and I heard (CNA #1) say 'I'm gonna do something.' (CNA #2) said 'What you gonna do?' Then I told them to cool it or something to that effect. Next thing I heard a tray drop. I separated the 2 CNAs and called the supervisor. I put (CNA #1) on A hall and kept (CNA #2) on F hall. When I went back to F hall to finish my meds, (CNA #2) said, 'You need to look at (Resident #316's) face.' When I looked at it she had a gash on her face and it was bleeding a little bit at that time . Telephone interview with LPN #5 on [DATE] at 2:26 PM revealed she was the night supervisor and the only management person in the building on [DATE]. Continued interview revealed LPN #5 stated she received a phone call from LPN #2 telling me you need to come ASAP (as soon as possible) because I have 2 CNAs who aren't getting along and I have to have 2 CNAs on the secured unit .About ,[DATE] minutes later (LPN #2) comes to get me and tells me I need to come quick because a resident is hurt. The Nurse Practitioner (NP) was there, so I grabbed her and all 3 of us are in the elevator when (LPN #2) said she thinks CNA #1 threw a tray and she saw it bounce on the floor . Continued interview revealed LPN #5 stated, .(Resident #316) doesn't speak. She was in a high back wheelchair and I saw a laceration from her inner eye to her cheek approximately ,[DATE] centimeters .we called 911 .me and the Director of Maintenance viewed the video. There was no volume only video. I could see the CNA's hand gestures and (CNA #1) put her hands on her hip .the nurse was at the med cart .(CNA #1) threw the whole tray and the lid flew in (CNA #2's) direction and it hit the resident in the face. She can't verbally respond. Her

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

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

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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) head went back and forward and she can't move her arms very well, she's very, very weak Medical record review of the (MONTH) (YEAR) Medication Administration Record [REDACTED]. Give ,[DATE] tablet (2XXX,[DATE].5 mg) by mouth every 4 hours as needed for pain. Continued review revealed Resident #316 received a dose of pain medication on [DATE], [DATE], and [DATE]. In summary, upon medical record review, observation and interview, the facility failed to protect Resident #316 from physical abuse resulting in actual Harm when CNA #1 injured the resident by throwing a plate lid in her direction on [DATE]. Medical record review revealed Resident #26 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Quarterly MDS dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating he was cognitively intact with a resident mood interview indicating moods occurring ,[DATE] days and no behaviors documented. Continued review revealed Resident #26 was independent with eating requiring set-up only by 1 staff person. Further review revealed the resident's mobility was independent with set up by 1 staff person in his electric wheelchair. Review of the facility investigation dated [DATE] revealed Resident #26 made derogatory remarks and racial slurs to Dietary Aide #3 after she brought him the wrong food order from the alternative food menu. Continued review revealed when the resident persisted with the derogatory remarks and racial slurs Dietary Aide #3, with her closed fist, punched Resident #26 on the left side of his face. Continued review revealed the Unit Manager immediately removed Dietary Aide #3 from the situation and placed her in a room, took her statement, and terminated her employment in the facility. Continued review of the facility investigation revealed video footage from a surveillance camera (from the facility's investigation) in the main dining room and a written statement from LPN #7. The written statement revealed on [DATE] at 7:47 PM Resident #26 and Dietary Aide #3 appeared to be arguing with Dietary Aide #3 aggressively finger pointing in the resident's face. At 7:51 PM, the same evening, the Dietary Aide #3 struck Resident #26 with a closed fist to the left side of his face and left the main dining room. Medical record review of the Nurse's Notes dated [DATE] revealed the resident's left ear was reddened and ordered pain medication was given as requested by the resident. Continued review revealed the resident felt safe and unthreatened. Telephone interview with an Adult Protective Services counselor on [DATE] at 10:01 AM revealed Resident #26 ordered food from the alternative food menu for dinner. Continued interview revealed Dietary Aide #3 delivered the food to Resident #26. Further interview revealed upon receipt of the food Resident #26 told Dietary Aide #3 it was not what he ordered and began yelling the derogatory remarks and racial slurs at the teh Dietary Aide #3. As the yelling persisted Dietary Aide #3 hit Resident #26 with her closed fist on the left side of his face. Continued interview revealed the Unit Manager immediately removed Dietary Aide #3 from the situation and placed her in a room, took her statement, and terminated her. Interview with the DON on [DATE] at 10:40 AM in the DON's office confirmed Dietary Aide #3 did physically abuse Resident #26 after he made racial slurs and called her names. Continued interview confirmed as a facility employee Dietary Aide #3 represented the facility and did deliberately punch the resident with her closed fist instead of initially walking away from the situation. Further interview confirmed the facility failed to prevent physical abuse to Resident #26.
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** > Based on review of facility policy, medical record review, observation and interview, the facility failed to change a soiled dressing Percutaneous Inserted Central Catheter (PICC) (a line that goes into your arm and runs all the way to a large vein near the heart for long term intravenous therapy) as ordered for 1 (#1) of 7 residents reviewed. Findings include: Review of facility policy IV Tubing and Dressing Changes dated 10/1/07 revealed .PICC line dressings will be changed weekly . Medical record review revealed Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Physician order [REDACTED].change PICC line dressing 24-48 hours after insertion of line if dressing is soiled and then every 7 days . Observation on 7/10/18 at 9:50 AM in Resident #1's room revealed an old soiled transparent dressing, covering the PICC line of the upper left arm with a date of 6/20/18. Observation and interview with the Unit Manager on 7/10/18 at 9:52 AM in Resident #1's room confirmed the transparent dressing was dated 6/20/18 to Resident #1's PICC line. Further interview revealed the Unit Manger stated I see it and nodded her head in agreement that the facility failed to change the soiled dressing weekly as ordered.