STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445236	A. BUILDING _____ B. WING _____	06/14/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF COLUMBIA	841 W. JAMES CAMPBELL BLVD. COLUMBIA, TN 38401

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** Based on policy review, medical record review, and interview, the facility failed to implement written care plan interventions related to falls for 1 of 5 (Resident #57) sampled residents. The facility failed to implement Resident #57's fall interventions. The failure to implement and follow the care plan interventions resulted in actual Harm when Resident #57 fell and sustained a nasal fracture, head injury with a possible subdural hematoma (a collection of blood between the brain cover and the brain), a laceration to the forehead that required suture repair and skin tears to the right hand and the right cheek. The findings included: 1. Review of the facility's undated Fall Management policy documented, .to promote patient safety and reduce patient falls by proactively identifying, care planning and monitoring of patients' fall indicators .comprehensive assessment of a patient, the facility must ensure that patients receive treatment and care .the comprehensive person-centered care plan, and the patient's choice .remains as free of accident hazards as is possible and each patient receives adequate supervision and assistance devices to prevent accidents .Avoidable Accident: means that an accident occurred because the facility failed to: 1. Identify environmental hazards and individual patient risk of an accident, including the need for supervision .2. Evaluate/analyze the hazards and risks .3. Implement interventions, including supervision, consistent with a patient's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident; and/or 4. Monitor the effectiveness of the interventions and modify the interventions as necessary . 2. Medical record review revealed Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Fall Risk Evaluation forms revealed Resident #57 was a high risk for falls with a score on 3/8/18 of 26, 4/3/18 of 22, 4/8/18 of 24 and 4/17/18 of 24. High risk for falls was a score of 10 or higher. The admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #57 had a Brief Interview of Mental Status (BIMS) score of 01 which indicated Resident #57 was severely cognitively impaired, required total staff assistance with transfers and extensive assistance with walking. Resident #57 had 1 fall with no injury and 2 falls with injury. Medical record review of the care plan dated 12/11/17 with revisions documented, .Problems .Potential for falls .4/3/18 Encourage resident to push chair up next to the table when sitting in dining room chairs .4/9/18 Remove resident from table after meals as allowed .4/17/18 Re-educate staff to escort pt. (patient) to recliner when sleepy . 3. Review of a facility Incident Follow-up & (and) Recommendation form dated 4/3/18 documented the following: a. 4:30 PM Summary .found resident laying on the floor on her right side in the dining room between the dining chair and the table . b. Recommendations .when resident sits in dining room chair scoot it up to the table due to falling asleep in chairs and refusing to go to bed and not staying in one position for much longer than 15-20 mins (minutes) at a time . c. Follow-Up: Staff intervention of pushing resident up close to the table has proven to be ineffective. Resident pushes self away & crosses legs .See new intervention 4/9/18 . 4. Review of a facility Incident Follow-up & (and) Recommendation form dated 4/9/18 documented the following: a. 8:35 AM Summary .Resident fell asleep @ (at) dining table after breakfast and fell onto floor on knees and staff gently lowered her on to ground . b. Recommendations .To remove resident from table after meals as allowed . c. Follow Up: On 4/17/18 staff failed to follow new intervention & subsequent fall happened see follow up for 4/17/18 . 5. Review of a facility Incident Follow-up & (and) Recommendation form dated 4/17/18 documented the following: a. 4:50 AM Pt (patient) found on floor, sitting on buttocks in front of dining table. Skin tears to top of R right) hand and (R) cheek, small laceration to forehead. Blood noted to L (left) side of head and skin tears & swollen nose . b. Recommendations .Re-educate staff to escort pt to recliner in dayroom rather than less stable chair when sleepy . Review of the hospital emergency room Report dated 4/17/18 documented, .Triage Note .PT fell IN DINING ROOM (At Nursing Home) AND HIT A CHAIR .SKIN TEARS NOTED TO RIGHT HAND. EMS (Emergency Medical Services) REPORTS HEAD WOUND AS A PUNCTURE TYPE WOUND . Skin: Laceration (2.8 cm (centimeters) laceration right forehead-gaping and actively bleeding. 2 cm superficial laceration right maxillary face) .Other bruising and soft tissue swelling nasal bridge .Number of Stitches 4 Discharge (back to nursing home) .Diagnosis 2.8 centimeter laceration repair right forehead; superficial laceration right maxillary face; nasal fracture; fall with head injury .possible left subacute subdural hematoma . The facility staff failed to follow Resident #57's care plan interventions and on 4/17/18 Resident #57 fell and sustained a nasal fracture, head injury with a possible subdural hematoma (a collection of blood between the brain cover and the brain), a laceration to the forehead that required suture repair and skin tears to the right hand and the right cheek. Interview with the Director of Nursing (DON) on 6/13/18 at 10:34 AM, in the DON office, the DON was asked about Resident #57's falls and interventions. The DON stated, .4/3/18 the intervention was push (Resident #57) up to the table and this was ineffective .4/9/18 it was ineffective to push her up to the table because she pushes herself back so the intervention was to remove her from the dining room to the recliner in the day room .4/17/18 staff were not informed of the change in interventions .we started a new intervention binder so the staff reads and knows . The DON was then asked how staff knew about interventions prior to the incident on 4/17/18. The DON stated, .verbally passed down . Interview with the Director of Nursing (DON) on 6/14/18 at 1:11 PM, in the DON's office, the DON was asked what fall interventions were in place for Resident #57. The DON stated, .on the 4/17/18 fall .the staff did not implement the interventions .didn't look at the new interventions for fall . The DON confirmed that staff should be aware and implement new interventions for falls. The facility staff failed to implement a new fall intervention for Resident #57. Resident #57 fell on [DATE] and sustained a nasal fracture, head injury with a possible subdural hematoma (a collection of blood between the brain cover and the brain), a laceration to the forehead that required suture repair and skin tears to the right hand and the right cheek.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate**

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) **supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to prevent accidents related to falls for 1 of 5 (Resident #57) sampled residents when new fall interventions were not implemented which resulted in actual harm to Resident #57 when Resident #57 fell and sustained a nasal fracture, head injury with a possible subdural hematoma (a collection of blood between the brain cover and the brain), a laceration to the forehead that required suture repair and skin tears to the right hand and the right cheek. The findings included: 1. Review of the facility's undated Fall Management policy documented, .to promote patient safety and reduce patient falls by proactively identifying, care planning and monitoring of patients' fall indicators .comprehensive assessment of a patient, the facility must ensure that patients receive treatment and care .the comprehensive person-centered care plan, and the patient's choice .remains as free of accident hazards as is possible and each patient receives adequate supervision and assistance devices to prevent accidents .Avoidable Accident: means that an accident occurred because the facility failed to .Evaluate/analyze the hazards and risks .implement interventions, including supervision .Monitor the effectiveness of the interventions and modify the interventions as necessary . 2. Medical record review revealed Resident #57 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 01, which indicated Resident #57 had severe cognitive impairment, required total staff assistance with transfers, extensive assistance walking and had 1 fall with no injury and 2 falls with injury. The care plan dated 12/11/17 with revisions documented, .Problems .Potential for falls .4/3/18 Encourage resident to push chair up next to the table when sitting in dining room chairs .4/9/18 Remove resident from table after meals as allowed .4/17/18 Re-educate staff to escort pt. (patient) to recliner when sleepy . Review of the Fall Risk Evaluation forms (an assessment completed on admission and quarterly by nursing staff to assess the resident's potential to fall) revealed Resident #57 was a high risk for falls (more likely to fall) with a score on 3/8/18 of 26, 4/3/18 of 22, 4/8/18 of 24 and on 4/17/18 of 24. High risk for falls was a score of 10 or higher. 3. Review of a facility Incident Follow-up & (and) Recommendation form dated 4/3/18 documented the following: a. 4:30 PM Summary .found resident laying on the floor on her right side in the dining room between the dining chair and the table . b. Recommendations .when resident sits in dining room chair scoot it up to the table due to falling asleep in chairs and refusing to go to bed and not staying in one position for much longer than 15-20 mins (minutes) at a time . c. Follow-Up: Staff intervention of pushing resident up close to the table has proven to be ineffective. Resident pushes self away & crosses legs .See new intervention 4/9/18 . 4. Review of a facility Incident Follow-up & (and) Recommendation form dated 4/9/18 documented the following: a. 8:35 AM Summary .Resident fell asleep @ (at) dining table after breakfast and fell on to floor on knees and staff gently lowered her on to ground . b. Recommendations .To remove resident from table after meals as allowed . c. Follow Up: On 4/17/18 staff failed to follow new intervention & subsequent fall happened see follow up for 4/17/18 . 5. Review of a facility Incident Follow-up & (and) Recommendation form dated 4/17/18 documented the following: a. 4:50 AM Pt (patient) found on floor, sitting on buttocks in front of dining table. Skin tears to top of R (right) hand and (R) cheek, small laceration to forehead. Blood noted to L (left) side of head and skin tears & swollen nose . b. Recommendations .Re-educate staff to escort pt to recliner in dayroom rather than less stable chair when sleepy . Review of an emergency room Report dated 4/17/18 documented, .Triage Note .PT (patient) fell IN DINING ROOM AND HIT A CHAIR .SKIN TEARS NOTED TO RIGHT HAND. EMS (Emergency Medical Services) REPORTS HEAD WOUND AS A PUNCTURE TYPE WOUND .Skin: Laceration (2.8 cm (centimeters) laceration right forehead-gaping and actively bleeding. 2 cm superficial laceration right maxillary face) .Other bruising and soft tissue swelling nasal bridge .Number of Stitches 4 Discharge .Diagnosis 2.8 centimeter laceration repair right forehead; superficial laceration right maxillary face; nasal fracture; fall with head injury .possible left subacute subdural hematoma . Observations on 6/13/18 at 7:34 AM revealed Resident #57 sitting in the day room in a recliner with nonskid footwear noted. Resident #57's wc had anti-tippers in place. Observations on 6/14/18 at 7:47 AM revealed Resident #57 in the dining room, sitting in a wc at the dining table with her eyes closed. Facility staff was assisting the resident to a couch in the dayroom. Interview with Director of Nursing (DON) on 6/14/18 at 1:11 PM, in the DON's office, the DON was asked what interventions were in place for Resident #57. The DON stated, .on the 4/17/18 fall .the staff did not implement the interventions because they did not know what the new intervention was . The DON was asked if it was acceptable for staff members to not implement new interventions for falls. The DON stated, .of course not . Interview with the Executive Director (ED) on 6/14/18 at 2:41 PM, in the ED office, the ED was asked to provide some examples of what the facility had implemented to decrease the number of falls and how oversight is provided for the clinical operations. The ED stated, .the DON will investigate the falls immediately, we are going to beef that back up and make sure it is being done . The facility failed to implement effective fall interventions for Resident #57. On 4/17/18 Resident #57 fell , sustained a head injury which required laceration repair, and [MEDICAL CONDITION] nasal bone and septum which resulted in actual Harm.
F 0867 **Level of harm -** Actual harm **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on policy review, medical record review, observation and interview, the facility's Quality Assessment and Assurance Committee (QAA) failed to have an effective, ongoing quality program that identified, developed, implemented and monitored appropriate plans of action for falls. The QAA committee's failure to ensure an effective fall prevention system (an effective process to reduce patient falls) resulted in actual Harm for Resident #57. The QAA failed to ensure new interventions were implemented which resulted in actual harm to Resident #57 when she fell and sustained a nasal fracture, head injury with a possible subdural hematoma (a collection of blood between the brain cover and the brain), a laceration to the forehead that required suture repair and skin tears to the right hand and the right cheek. The findings included: 1. The QAA Committee failed to ensure the facility's fall prevention program was effective and the fall management policy

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F 0867 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) was implemented. The QAA committee failed to effectively track, trend and monitor the effectiveness of the fall prevention program. Refer to F656 and F689. The deficient practice of F656, F689 and F867 is a repeat deficient practice for failure to ensure the services were provided in accordance with each resident's written plan of care. The facility was cited F656, F689 and F867 on the recertification survey on 4/29/15 and on 5/24/17. 2. Interview with the DON on 6/13/18 at 2:00 PM, in the Conference Room, the DON was asked if it was appropriate for a Resident with a BIMS of 01 to be able to tell the staff what had caused the fall. The DON stated, .we had a meeting last night to go over falls and we determined that some of the interventions that had been put in place for the falls were not appropriate . Interview with Director of Nursing (DON) on 6/14/18 at 1:11 PM, in the DON's office, the DON was asked what fall interventions were in place for Resident #57. The DON stated, .on the 4/17/18 fall .the staff did not implement the interventions .the staff didn't look at the new interventions for fall . The DON confirmed that the staff should be aware of new interventions for falls. Interview with the Executive Director (ED) on 6/14/18 at 2:41 PM, in the ED office, the ED was asked to provide some examples of what the facility had implemented to decrease the number of falls. The ED stated, .We had PI (Performance Improvement) last night to help develop new interventions and things we could do to help decrease the number of falls .purchased some recliners .added a full time Activities Assistant . The ED was asked how oversight is provided for the clinical operations. The ED stated, .we are doing fall huddles team, the number of falls has trended down with the Activity person back there (on the memory care unit) and house wide the number of falls have gone down .the DON will investigate the falls immediately, we are going to beef that back up and make sure it is being done . The ED was asked if the Medical Director was involved in the QA process. The ED stated, .He goes over every report and he is involved in the monthly meeting. We go over each incident report with him and discuss in the monthly PI meeting due to the IJ (Immediate Jeopardy) and Harm before . The failure of the QAA to implement new fall interventions for a resident with severe cognitive abilities resulted in actual Harm to Resident #57 when she fell and sustained a nasal fracture, head injury with a possible subdural hematoma (a collection of blood between the brain cover and the brain), a laceration to the forehead that required suture repair and skin tears to the right hand and the right cheek.