STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445167	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Crossville	80 Justice St Crossville, TN 38555

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 - Minimal harm or potential for 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** 40606 Based on facility policy review, facility documentation review, medical record review, and interview the facility failed to ensure 1 resident (Resident #9) was free from physical abuse after Resident #2 struck Resident #9 in the face, of 11 residents reviewed for abuse. The findings include: Review of the facility policy titled, Abuse Prevention, dated 10/4/2022, revealed .It is the policy of this facility to prevent and prohibit all types of abuse .Identify, correct and intervene in situations in which abuse .is more likely to occur . Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Aphasia, ,Diabetes, Congestive Heart Failure, Delusional Disorder, and Major Depressive Disorder with Severe Psychotic Features. The resident was discharged from the facility on 7/31/2024. Review of quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #9 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had mild cognitive impairment, required assistance of 1-2 staff members for bed mobility, transfers, toileting, and activities of daily living (ADL). Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnosis including Rheumatoid Arthritis, Dementia, Cognitive Communication Deficit, and History of Falling. Review of a quarterly MDS assessment dated [DATE], revealed Resident #2 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment, required assistance of 1-2 staff members for bed mobility, transfers, toileting, and ADL care. Resident was frequently incontinent of bladder. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation documentation of resident-to-resident contact between Resident #9 and Resident #2 dated 2/13/2024 at 4:00 PM, revealed a Certified Nursing Assistant (CNA) was notified by Resident #9 that Resident #2 had struck him in the face, Resident #2 was not present in the room at the time. Licensed Practical Nurse (LPN) C responded and assessed Resident #9 who was found to have a reddened area to his cheek which quickly faded to a normal skin tone. LPN C ensured both residents were separated and safe. LPN C conducted interviews with both residents and found during the interview with Resident #9 that both were seated in their wheelchairs beside the bed when the contact took place. Resident #9 told LPN C that he reached for the call light on the bed and was struck by Resident #2 in the face. LPN C interviewed Resident #2, where he admitted striking Resident #9. Resident #9 was moved to another hallway and Resident #2 was placed on 1:1(1 staff to 1 resident) monitoring. Review of the nurses progress note for Resident #9 dated 2/13/2024 at 4:33 PM, revealed .This nurse notified that the resident was involved in a physical altercation between himself and his roommate [Resident #2] . The progress note revealed Resident #9 reported Resident #2 had struck him in the jaw. Review of the Psychosocial Progress Note for Resident #2 dated 2/14/2024 at 2:20 PM, revealed .SSD [Social Services Director] spoke with resident in the rehab [rehabilitation] gym .Resident appeared happy . stated he was missing his wife . Nothing was voiced by the resident about the altercation. Review of the Psychiatric Progress Note for Resident #2 dated 2/21/2024 showed .I am seeing this patient today for aggressive behaviors toward other residents, Depression, Anxiety. Depakote [medication to aid with behaviors .recently increased to 250 mg [milligram] by PCP [primary care physician] due to getting into a physical altercation with resident's roommate [Resident #9] .roommate has been moved to another room . [Resident #2] is doing well . No further behaviors were reported by staff. During an observation and interview on 8/27/2024 at 10:13 AM, LPN C stated she provided care to Resident #2 routinely. LPN C stated she responded to the residents' room (Resident #2 and Resident #9) and noted Resident #2 was already out of the room. LPN C stated she interviewed each resident post incident and stated this was an isolated incident and neither resident had issues previously, neither resident experienced any residual effects as a result of the prior altercation and no injuries were noted to either resident. LPN C stated there was slight redness to Resident #9's cheek which faded within moments. During an interview on 8/28/2024 at 11:10 AM, the Director of Nursing confirmed physical contact was made when Resident #2 struck Resident #9 in the face on 2/13/2024.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405 Based on facility policy review, medical record review, facility investigation review, personnel file review, and interview, the facility failed to protect a resident's rights to be free from misappropriation and/or exploitation when money totaling $119.49 was taken from 1 resident (Resident #7) of 11 sampled residents reviewed for misappropriation. The findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation, revised on 7/18/2023, revealed .It is the policy of this facility to identify abuse, neglect, and exploitation of residents and misappropriation of resident property .Misappropriation of resident property is the deliberate misplacement, exploitation .use of a resident's property or money without the resident's consent . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Metabolic Encephalopathy, Type 2 Diabetes Mellitus, Morbid Obesity, Acute and Chronic Respiratory Failure, Anxiety, and Quadriplegia. Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of the facility investigation documentation dated 9/5/2023, revealed Resident #7 informed the Assistant Business Office Manager (ABOM) she would not have the funds to pay her bill because someone used her debit card to purchase food at a local restaurant without the resident's permission. The ABOM instructed Resident #7 to call her bank and dispute the charges. The ABOM received a call from the resident's bank stating a police report needed to be filed to dispute the charges. The ABOM notified the facility Administrator of the alleged misappropriation. The facility started an investigation. During the facility investigation Hospitality Aide D was suspended on 9/6/2023 pending the investigation after the Hospitality Aide was identified as a possible suspect. Continued review revealed the facility substantiated the abuse and terminated Hospitality Aide D on 9/21/2023 for violation of the code of conduct. Review of a Cardholder Statement of Disputed Items dated 9/5/2023 and signed by Resident #7 on 9/6/2023 revealed the amount of $119.49 was disputed for the following reason: My Card was stolen. Review of the personnel file for Hospitality Aide D revealed the facility terminated Hospitality Aide D on 9/21/2023 for alleged violation of code of conduct. During an interview on 8/27/2024 at 9:33 AM, Resident #7 confirmed her debit card was taken by the facility Hospitality Aide without her permission with $119.49 stolen. Continued interview revealed the resident bank did reimburse her for the $119.49 after she disputed the charges. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/27/2024 at 9:57 AM, the Administrator confirmed the facility substantiated the allegation of misappropriation on Resident #7. The Administrator stated the $119.49 was reimbursed to Resident #7 by the resident's bank. The Administrator further confirmed the facility employed Hospitality Aide was responsible for the misappropriation of Resident #7's property.

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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** 27405 Based on facility policy review, medical record review, facility investigation review, hospital record review, and interview, the facility failed to prevent a fall for 1 resident (Resident #8) of 5 residents reviewed for falls. The facility's failure resulted in actual HARM to Resident #8 when the resident was receiving care by facility staff and allowed to fall to the floor from the bed, resulting in injury. The findings include: Review of the facility policy titled, Area of Focus: Fall Management, reviewed 12/4/2023, revealed .To promote patient safety and reduce patient falls .the facility must ensure that .each resident receives adequate supervision .to prevent falls . Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Dominant Side, Diabetes, Long Term use of Anticoagulants, and Functional Quadriplegia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Continued review revealed the resident was dependent on staff for toileting, bathing, and upper and lower body dressing. Review of the comprehensive care plan dated 12/16/2023, revealed Resident #8 was dependent on staff for toileting and required 2 staff assistance with transfers. Review of a Nursing Progress Note for Resident #8 dated 4/3/2024 at 11:15 AM, revealed .Nursing staff called to room .for a resident fall. Resident was in bed being changed [provided incontinence care] by 2 CNA's [certified nursing assistants] and when rolled [to] her side towards one CNA, resident was not able to be supported and rolled out of bed onto the floor .resident on floor face down .EMS [emergency medical services] called .resident complaining of pain .resident is yelling and crying, wanting us to roll her over . complaints of neck and head hurting .also c/o [complaints of] Rt [right] arm/ shoulder and index finger hurting. Small bump and bruising noted to right forehead .EMS arrived Neck stabilized .transport to ER [emergency room] . Review of ER documentation for Resident #8 dated 4/3/2024, revealed XXX[AGE] year old .here for a fall . patient rolled out of bed at nursing home and landed on the floor .patient tells me she did hit her head but did not pass out .primary complaint of right index finger .patient notes pain to the right knee as well .Physical Exam .Right forehead purple ecchymosis [discoloration of the skin resulting from bleeding underneath] .right knee pain with palpation without effusion or swelling .x ray fingers .no acute fracture .x ray knee .no acute fractures .CT [computed tomography] scan of head and neck unremarkable . Review of the facility investigation documentation dated 4/3/2024, revealed Resident #8 stated, .[CNA A] let me fall in the floor on my face . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a facility Corrective Action Form for CNA A dated 4/3/2024, revealed .On 4/3/2024, associate provided unsatisfactory/ careless work while completing ADL [activities of daily living] care with a resident [Resident #8] while in bed. Associate did not provide proper body mechanics to meet the needs of the resident safety . Review of a weekly skin assessment for Resident #8 dated 4/8/2024, revealed .Face .L [left] eye purple bruising, L forehead fading yellow bruising (both from recent fall) . Review of a follow up Nursing Progress Note for Resident #8 dated 4/12/2024, revealed .on day of event [4/3/2024] resident returned from the ED [emergency department] .X-ray and CT scans were negative .small bruise to forehead above her left eye and also small reddened raised area to the middle of her forehead .on day after event, 4/4/2024, resident was switched to a bariatric bed . Review of a weekly skin assessment for Resident #8 dated 4/15/2024, revealed .Face .L eye purple bruising, forehead fading yellow bruising (both from recent fall) . Review of a Nurse Practitioner visit note for Resident #8 dated 4/16/2024, revealed .patient reports falling out of bed while being repositioned by staff with residual right upper extremity soreness/ weakness. X-ray of right upper extremity negative .patient reports working with occupational therapy to build strength . During an interview on 8/27/2024 at 1:13 PM, CNA A stated during Resident #8's fall on 4/3/2024 .I couldn't hold her [Resident #8] after CNA B pushed her [Resident #8] toward me, wasn't able to catch her leg in time and she [Resident #8] went through my legs . Continued interview revealed the facility implemented a corrective action plan including an assessment CNA A completed for competency and strength after Resident #8's fall. The CNA was given the option of being a hospitality Aide due to the results of the assessment. Further interview revealed CNA was transitioned to a Hospitality Aide following Resident #8's fall from bed on 4/3/2024. During an interview on 8/27/2024 at 6:49 PM, CNA B stated during Resident #8's fall on 4/3/2024 .[name of CNA A] was closest to the window and when I rolled her [Resident #8] toward [CNA A] she couldn't hold her and the resident [Resident #8] fell .after the fall they [facility leadership] moved her [CNA A] to Hospitality Aide . During an interview on 8/28/2024 at 8:54 AM, Resident #8 stated she remembered the fall, where she had injury/ bruising across her face, .and black under my eyes .I landed on my face . Continued interview revealed the resident stated CNA A let her fall, but she does feel safe with the facility staff for her transfer and toileting needs now. During an interview and facility documentation review on 8/28/2024 at 9:32 AM, the Administrator confirmed Resident #8 received an injury during the 4/3/2024 fall and confirmed CNA A received corrective action for not meeting the needs of resident safety during ADL care.