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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445390 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/12/2025 |
| NAME OF PROVIDER OR SUPPLIER Pickett Care and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 129 Hillcrest Drive Byrdstown, TN 38549 | |
| 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) | | |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to provide timely notification to the Power of Attorney and/or resident representative for 1 Resident (Resident #2) of a significant change in condition of 3 residents reviewed for notification, when Resident #2 had a significant mental status change which required a onetime injection of an antipsychotic medication.</p> <p>The findings include:</p> <p>Review of a facility policy titled, Notification of Change of Condition, revised 9/15/2023, revealed .to ensure appropriate individuals are notified of changes in condition .the facility must inform the resident, consult with the resident's physician; and notify consistent with his or her authority, the resident representative(s) when there is significant change in the resident's physical, mental, or psychosocial status .A need to alter treatment significantly .</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Metabolic Encephalopathy, Idiopathic Gout, Diabetes Mellitus, Protein-Calorie Malnutrition, Dementia without Behavioral Disturbance, Anxiety Disorder, Urinary Tract Infection, Dysphagia, and Depressive Episodes.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. No behaviors were noted during the assessment period.</p> <p>Review of the Nurse's Note for Resident #2 dated 10/25/2024 at 8:00 PM, revealed .Elder is up in hallway trying to enter other resident rooms stating, 'This is my room and I'm going in it.' Redirection from CNA [Certified Nursing Assistant] [CNA F] (1 on 1 with another elder) unsuccessful. Elder kicking and hitting at CNA [F] and trying to run her over with walker. CNA [G] then tries to deescalate situation and calm elder, elder also attempting to hit, kick and run over [CNA G] at this time. LPN [Licensed Practical Nurse] [LPN H] stated to this nurse when I entered into the nurses' station '[Medical Director] ordered a verbal one-time injection of Haldol r/t [related to] elders' behaviors.' This nurse and all staff fearful of elders' behavior towards staff and other elders. [LPN E] pulled Haldol injection to administer to elder. Elder being monitored by CNA [F] from 1 on 1 in elder's room .</p> <p>(continued on next page)</p> | | |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the Nurse's Note for Resident #2 dated 10/26/2024 at 7:41 AM, revealed .Elder's son notified of last night's events. Son verbalized understanding with no questions at this time .</p> <p>During an interview on 2/10/2025 at 1:15 PM, the Director of Nursing (DON) stated .[Resident #2] did have an episode on 10/25/2024, with increased agitation, unable to be redirected, going into other resident rooms and attempting to remove the cover off one resident and attempting to remove other resident belongs .[the Medical Director] was in the facility and gave a onetime order for Haldol [antipsychotic medication] 5 mg [milligram] IM [intramuscular]. However, the family was not notified until the follow morning. With any significant change my [DON] expectation is that the family is notified as soon as the resident is safe. In this circumstance, if at all possible, I would have expected the family to be notified prior to the Haldol injection or as soon as possible after the injection which was not done .</p> |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on facility policy review, facility investigation review, medical record review, and interview, the facility failed to prevent misappropriation of property for 1 resident (Resident #9) of 6 residents reviewed for misappropriation of resident property.</p> <p>The facility was cited at F-602 at a Scope and Severity of D and was cited as past non-compliance. Noncompliance began on 4/10/2024, was corrected and ended on 4/12/2024. The facility is not required to submit a Plan of Correction for F-602.</p> <p>The findings include:</p> <p>Review of a facility policy titled, Abuse, Neglect and Misappropriation of Property, revised 9/15/2023, revealed .it is the organization's intention to prevent the occurrence of abuse . misappropriation of resident property .Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent .</p> <p>Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including Acute Kidney Failure, Nondisplaced Articular Fracture of Right Femur Methicillin Resistant Staphylococcus Aureus Infection, Osteopetrosis, Extended Spectrum Beta Lactamase (ESBL), Depressive Disorder, Anxiety Disorder, Chronic Obstructive Pulmonary Disease, and Acute Respiratory Disease.</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #9 scored 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</p> <p>Review of the Medication Administration Record (MAR) for Resident #9 dated 4/1/2024-4/30/2024, revealed Lasix 80 mg twice daily for edema, the medication was documented as administered as ordered.</p> <p>Review of the Physician's Note for Resident #9 dated 4/10/2024, revealed .asked to see and evaluate patient after a member of the nursing staff had taken some of the patient's Lasix out of her medication drawer. As far as the patient is aware however, she has not missed any medication doses. She takes this for peripheral edema. She denies any increased edema, dyspnea, or other complaints related to this. Upon chart review there is no history of CHF [congestive heart failure] but she does have a h/o [history of] neurogenic bladder and this intermittent edema may be nephrogenic in etiology .Peripheral edema appears euvolemic [having a normal amount of fluid in the body] at this time without any obvious adverse effects from the medication incident described .</p> <p>Review of a facility investigation dated 4/10/2024, revealed Resident #9 stated that as far as she knew she had never missed any doses of medication. Licensed Practical Nurse (LPN) C was suspended pending the investigation of alleged misappropriation of medication (Lasix). Resident #9 experienced no adverse effects per assessments. The facility substantiated the incident. The staff member was terminated</p> <p>(continued on next page)</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 2/5/2025 at 8:33 PM, LPN C stated .I was working several 12 hour and 16 shifts, there was a card of Lasix on in the bottom drawer [of the medication cart] the name had been torn off. I knew with no name we could not return it to the pharmacy without a name. My judgement was clouded, my father had been sick and lost his insurance he had suffered from CHF [congestive heart failure], he was getting blisters from all the fluid retention. I took two of the Lasix pills out of the card and put them in my pocket I put the card in my purse to dispose of later take it up front to the box that goes back to pharmacy .some pills were already missing from the card and there were some left on the card but I couldn't go through with it my conscience was eating at me .the nurse on the other hall was a newer nurse and she asked me to help her with a fall while I was helping her she asked me if I had anything for cramps or tampons, I told her yes in my purse. She went to look and that is when she saw the card [medication card containing the Lasix] that was somewhere around 1:00 or 2:00 AM [on 4/10/2024], That is when I guess she called whoever I didn't know she had seen it until the investigation. I did not leave the building with the card I put it in the shred box after I realized we couldn't get reimbursed because the name was torn off .I put the 2 pills in the sharp's container. I never left with any of the medication I just couldn't do it .</p> <p>During an interview on 2/5/2025 at 9:15 AM, the DON stated .[LPN D] called me around 5:00 AM [on 4/10/2024], and reported that she saw a pill card .in LPN C's bag [DON] notified the Administrator, and we came to the facility unannounced around 6:00 AM and spoke with LPN D. Requested her to do a witness statement as to what she saw then we approached [LPN C] and asked her. She [LPN C] originally denied the allegation .we [the Administrator and the DON] checked the shred it box. We found the pill card and the name label detached from the pill card in the shred box .we again ask [asked] LPN C about the medication, at that time she did state she had taken the card from the medication cart removed two of the pills for her dad she put the card in her purse .We checked the nurse's station where she was working including the shred it box and found the pill card minus the top part containing resident and medication information. We went through the shred it box to see if I could find the label and did not find it there. We then checked a different nurse's station she had worked on previously a couple of nights before and found the top of the medication card containing medication and resident information in that shred box. We then asked her about it that is when she said she had taken it and was going to use it for her dad. We suspended her during the investigation notified the pharmacy requested the medication replacement notified the Elder and her Spouse, and the MD [Medical Doctor] from what I gathered from what she [LPN C] told us is that she had removed the medication card containing the 80 mg Lasix removed 2 pills and then returned the card to the facility for disposal .I did count from the delivery date of 3/24/2024 to 4/10/2024 to see if it matched and the card was 2 pills off .we did substantiate misappropriation of resident property .she was terminated on 4/12/2024 .</p> <p>During an interview on 2/5/2025 at 10:08 AM, LPN D stated .I was working 3:00 AM to 7:00 AM. I went over to speak with [LPN C], she had gotten some tarot cards and told me they were cute to go look at them they are in my purse. I opened her purse, and I saw the pill card [medication card containing the Lasix]. I called the [Administrator] around 5:00 AM, my call did not go through the Administrator called me back at 5:12 AM. I Had another call from the Administrator at 5:40 AM, he was in route I think he got to the facility about 6:00 AM .</p> <p>During an interview on 2/6/2025 at 1:00 PM, the Medical Director stated .I saw [Resident #9] and assessed her, there was no physical evidence of any harm or any kind of distress. She reported not being aware of missing any of her medications. There was no evidence of any psychosocial changes in her behavior or any harm .</p> <p>(continued on next page)</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The surveyor validated on site facility interventions and plan of correction as follows:</p> <p>Review of a facility investigation dated 4/10/2024, revealed the allegation was reported to the Nurse Licensure Board. Resident #9 stated that as far as she knew she had never missed medication when needed. No staff or residents reported any concerns of misappropriation. Licensed Practical Nurse (LPN) C, Alleged Perpetrator (AP) was suspended following the allegation of the misappropriation of medication. Residents with a BIMS score of 8 or above were interviewed with no concerns. Residents with a BIMS score of 7 or below had complete head to toe physical assessments completed with no concerns. Staff working with the alleged perpetrator LPN C for the previous 30 days were interviewed with no concerns. Resident #9 was care planned previously for non-compliance with physician's orders. Resident #9 experienced no adverse effects per assessments. MD assessed and interviewed Resident #9. The facility substantiated the incident. The staff member was terminated. Staff educated and tested on misappropriation. Nursing staff and Medication Technician educated on medication disposal and drug diversion. Ongoing audits were initiated to mitigate misappropriation.</p> <p>On 2/12/2025 the surveyor reviewed the signed verification audits for each medication cart, 1 Registered Nurse interview and 1 Licensed Practical Nurse interview confirming completion of audit on 4/10/2025.</p> <p>On 2/12/2025 the surveyor reviewed the signed verification audit Medication Administration Record Card Audit , 1 Registered Nurse interview and 1 Licensed Practical Nurse interview confirming completion of audit on 4/10/2025. Reviewed signed verification audits for 4/10/2024-6/7/2024.</p> <p>On 2/12/2025 reviewed Pharmacy Delivery Manifests for affected resident validating delivery of resident's Lasix 80 mg on 3/1/2024, 3/24/2024, and 4/10/2024 60 count delivery manifests were signed by the nurse receiving the medications.</p> <p>On 2/12/2025 the surveyor reviewed the facility pharmacy statement validating the facility was billed for 18 80 mg Lasix for the affected resident. Interview with the DON confirmed 1 Lasix had been identified as unaccountable but to keep the medication card as evidence the facility had replace all 18 80 mg Lasix.</p> <p>On 2/12/2025 the surveyor reviewed the medical record confirming documentation of Resident notification. Reviewed the Physician's progress note dated 4/11/2024.</p> <p>On 2/12/2025 the surveyor reviewed the facility's submission form to the Tennessee Board of Nursing dated 4/10/2024. Interview with the Administrator validated communication with the Board or receipt and of completion of investigation.</p> <p>On 2/12/2024 the surveyor reviewed the facility self-report validating notification to the law enforcement, APS and the Ombudsman.</p> <p>On 2/12/2025 the surveyor reviewed the signed MAR card audit for all residents. , 1 Registered Nurse interview and 1 Licensed Practical Nurse interview confirming completion of audit on 4/10/2025.</p> <p>On 2/12/2025 the surveyor Reviewed skin assessments and resident interview compared to resident roster.</p> <p>(continued on next page)</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 2/12/2025 the surveyor reviewed education for the abuse policy with emphasis on misappropriation of property completed on 4/11/2024. Staff signatures were compared to staff roster. Interviews conducted with 2 Registered Nurses, 2 Licensed Practical Nurses, 5 Certified Nursing Assistances 2 Activity Personnel, 2 Dietary Personnel, 2 Housekeeping Personnel, and 1 Therapy Personnel. All interviewed staff were knowledgeable of the abuse policy and misappropriation of property 100% of staff educated.</p> <p>On 2/12/2025 the surveyor reviewed education provided to all nursing staff and Qualified Medication Aide (QMA) validated with attendance signatures, staff roster and interview with 1 QMA, 2 RN, and 2 LPNs. Interviewed staff knowledgeable of disposal of medications when and where.</p> <p>On 2/12/2025 the surveyor reviewed the pharmacy refill audits conducted Monday-Friday dated 4/12/2024-2/10/2025. Validated with interview with the DON.</p> <p>On 2/12/2025 the surveyor reviewed the signed MAR Card Audits for 4/10/2024-6/7/2024.</p> <p>On 2/12/2025 the surveyor reviewed Ad Hoc minutes for 4/11/2024 for content and attendance.</p> <p>On 2/12/2025 the surveyor reviewed Ad Hoc minutes for 4/18/2024, 4/26/2024, 5/3/2024, 5/3/2024, 5/10/2024, 5/17/2024, 5/24/2024, 5/31/2024, and 6/7/2024 for content and attendance.</p> <p>On 2/12/2025 the surveyor interviewed 2 family representatives with attention to concerns for abuse or neglect, resident rights, resident protection, notification of changes in condition, administration, staffing, nursing services, medication administration, access to clinical services, or unresolved grievances with no concerns identified.</p> <p>During an interview on 2/12/2025 AT 11:55 the DON stated .education is provided to new hires during orientation, I call if an employee is on leave, vacation, or leave, otherwise the education is provided prior to their next shift.</p> <p>The facility was cited F-602 as past non-compliance and surveyor verified and validated the corrective actions on site on 2/12/2025. The facility is not required to submit a Plan of Correction.</p> | | |