

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Blount County		STREET ADDRESS, CITY, STATE, ZIP CODE 1965 Stewart Lane Louisville, TN 37777	

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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003</p> <p>Based on facility policy review, medical record review, facility investigation documentation review, and interview, the facility failed to protect the resident's right to be free from psychosocial abuse for 1 of 13 (Resident #14) sampled residents reviewed for abuse when Resident #15 entered Resident #14's room, pulled the covers off of her, tried to remove her brief, and exposed himself to Resident #14 on 8/21/2023. The facility's failure to protect the resident's right to be free from abuse resulted in actual HARM for Resident #14.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Resident Rights, dated 6/8/2020, revealed .The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation .</p> <p>Review of the facility policy titled, Abuse-Identification of Types, dated 10/4/2022, revealed .Abuse-is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse .Willful-is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Wandering into other's rooms/space .Does not want the contact to occur .Literature indicates that the most prevalent psychosocial outcomes of abuse are depression, anxiety, and posttraumatic disorder .</p> <p>Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including Dementia with Anxiety, Depression, and Chronic Kidney Disease.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #14 scored a 99 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was unable to complete the interview.</p> <p>Review of an Event Note for Resident #14 dated 8/21/2023, revealed .aide observed another resident [Resident #15] at [Resident #14's] bedside disrobing & [and] pulling at covers, other resident [Resident #15] removed from room immediately. When asked resident [Resident #14] if the other resident [Resident #15] touched her she stated yes he touched her brief .[Doctor O and Doctor P] notified .</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Doctor (Dr.) O's Progress Note for Resident #14 dated 8/21/2023, revealed .CHIEF COMPLAINT: Evaluation of patient following inappropriate behavior by other resident [Resident #15] .According to social worker, the patient [Resident #14] was asleep while a male patient [Resident #15] entered her room, disrobed, and pulled the cover off of her exposing her own brief. He reportedly touched her brief but it was intact. A hospitality aide was passing by and noticed this and was able to intervene. She [Resident #14] is upset and somewhat tearful following .On examination, she is somewhat withdrawn and tearful .appears unharmed physically .She denies any needs at present, although is clearly anxious about this event .</p> <p>Review of Dr. P's Psychiatry in Longterm Care Summary-Diagnosis-Plan for Resident #14 dated 8/21/2023, revealed .I was asked to see the patient because of an alleged assault by a peer .I asked her about worry and she said yes but she was unable to specify .She looks anxious but she says she's not anxious if someone is with her . Dr. P recommended treatment with an additional antianxiety medication and increased the dosage of her antidepressant.</p> <p>Review of Medication Administration Records for Resident #14 revealed the resident's Zoloft (antidepressant medication) was increased from 12.5 milligrams (mg) daily to 25 mg daily on 8/21/2023. Further review revealed Resident #14 received Hydroxyzine (a medication used to treat anxiety) from 8/21/2023-8/23/2023.</p> <p>Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Dementia without Behavioral Disturbance and Abnormalities of Gait and Mobility.</p> <p>Review of the admission MDS assessment dated [DATE], revealed Resident #15 scored a 3 on the BIMS test indicating the resident had severe cognitive impairment. The resident had not exhibited behaviors.</p> <p>Review of a comprehensive care plan dated 8/9/2023, revealed Resident #15 had a care plan for .at risk for complications from potential inappropriate behaviors r/t [related to] dementia .</p> <p>Review of an Event Note for Resident #15 dated 8/21/2023, revealed .aide observed resident [Resident #15] disrobbing [disrobing] and pulling at covers in another residents [Resident #14's] room. family notified @ [at] 1230 [12:30 PM] of residents [resident's] inappropriate behaviors and sent to [named hospital] for behavioral eval. [evaluation] . Dr. O and Dr. P were notified of Resident #15's behaviors.</p> <p>Review of the facility's investigation documentation dated 8/21/2023 at 12:15 PM, revealed .Resident [#15] found standing at Resident [#14] bedside disrobing and pulling her [Resident #14] covers back. Staff immediately removed him [Resident #15] from the room . Resident #14 and Resident #15 were placed on one-to-one supervision until Resident #15 was transferred from the facility. Continued review revealed the following . HOSPITALITY AIDE SAW RESIDENT [#15] IN THE DAY ROOM AS SHE WENT TO THE KITCHEN AT APPROXIMATELY 12:05 PM AND SHE HEARD THE RESIDENT [#14] SAYING 'NO' AS SHE CAME BACK UP THE HALL AT 12:15 pm AND WENT INTO THE ROOM AND IMMEDIATELY TOOK RESIDENT [#15] FROM THE ROOM .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Hospitality Aide (HA) K's witness statement dated 8/21/2023 at 12:15 PM, revealed .I walked into [Resident #14's] room and saw [Resident #15] standing beside the bed with his pants and brief pulled down and he [Resident #15] was trying to remove her [Resident #14] brief she was telling him no and trying to keep him from removing the brief. I instantly pulled his pants up and removed him from her room .</p> <p>Review of Social Services Aide (SSA) N's witness statement dated 8/21/2023 at 12:40 PM, revealed .I was asked to sit with [Resident #15] after he was reportedly involved in a situation with another resident [Resident #14] where he displayed inappropriate behavior. After talking with [Resident #15] about what happened, he stated, 'I'm in trouble. I got busted going into another person's room'. Continued review revealed Resident #15 did not offer further information.</p> <p>Review of Licensed Practical Nurse (LPN) L's witness statement dated 8/21/2023 (no time), revealed . Notified by aide that she had observed [Resident #15] standing beside bed with pants and brief on ground and [Resident #14's] blanket down trying to pull off her brief. Went to Resident [Resident #14's] room to assess resident. Resident stated he [Resident #15] touched her brief .</p> <p>Review of LPN M's witness statement dated 8/21/2023 (no time), revealed .I entered [Resident #14's room] after the incident took place to assess [Resident #14] .The resident .very scared and upset .</p> <p>During a telephone interview on 7/8/2024 at 12:00 PM, HA K stated she was coming back from lunch and heard Resident #14 saying, .no .no . HA K stated she saw Resident #15 standing over Resident #14 with his pants down, with his brief on, trying to pull her brief off. HA K stated Resident #15 did not touch Resident #14, as she had intervened and immediately removed Resident #15 from Resident #14's room.</p> <p>During an interview on 7/8/2024 at 1:30 PM, LPN L stated she heard an aide (HA) say, .oh, no . The HA came out and told LPN L Resident #15 was in Resident #14's room with his pants down.</p> <p>During a second telephone interview on 7/9/2024 at 1:34 PM, HA K stated Resident #15's pants and brief were pulled down at the time of the incident. (HA K's first telephone interview stated Resident #15's brief was on when the incident occurred.)</p> <p>During a telephone interview on 7/9/2024 at 3:48 PM, LPN M stated Resident #14 was crying and was trying to pull the blanket up over her after the incident with Resident #15.</p> <p>During a second interview on 7/9/2024 at 4:15 PM, LPN L stated Resident #14 was upset and crying after the incident.</p> <p>During a telephone interview on 7/10/2024 at 10:09 AM, SSA N stated her supervisor had asked her to check on Resident #14 because Resident #15 had gone into Resident #14's room around lunch time. SSA N asked Resident #14 if she was okay. Resident #14 told SSA N, .he [Resident #15] just came in here, he stood over me and tried to pull my blanket off . and tried to take her brief off. Further interview revealed Resident #14 reported Resident #15 had taken his pants off and was trying to climb on top of her. SSA N stated HA K told her Resident #15 was standing next to Resident #14's bed with his pants down. SSA N stated HA K went into Resident #14's room and redirected Resident #15 to his room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 7/10/2024 at 1:00 PM, Dr. P stated he recommended administering an antianxiety medication and increasing Resident #14's antidepressant dose after the incident with Resident #15. Dr. P stated .I did this empirically [based on what is experienced or seen] .it wouldn't hurt to give her Hydroxyzine [antianxiety] . When asked if Resident #14's reaction was related to Resident #15 entering her room, removing his brief, and attempting to remove her brief, Dr. P stated .I would say it could be .</p> <p>During a telephone interview on 7/10/2024 at 1:33 PM, Dr. O stated he had spoken with the Director of Nursing (DON) and determined Resident #15 should be transferred due to the incident that had occurred and due to concerns for Resident #14's safety. Dr. O stated, .I think it was a Hypersexual impulse related to Dementia . Dr. O stated he saw Resident #14 after the event.I remember she was anxious above her baseline .she was pretty shook up by it .we looked at her skin for signs of injury and sexual assault .no signs . She was anxious and afraid beyond her baseline .</p> <p>During an interview on 7/10/2023 at 5:02 PM, the Executive Director (ED) stated a staff member observed Resident #15 with his brief off and reaching for a female resident's (Resident #14's) covers. The ED stated the staff member immediately intervened. The ED stated .Obviously, we [the facility] saw the potential for abuse . Resident #15 was transferred out for evaluation and Resident #14 was evaluated by Dr. O and Dr. P. I do acknowledge I saw 100% potential for abuse .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003</p> <p>Based on facility policy review, medical record review, facility investigation documentation review, and interview, the facility failed to report an allegation of abuse to the State Agency when a resident (Resident #15) exposed himself to another resident (Resident #14 of 13 residents reviewed for abuse.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Protection of Residents: Reducing the Threat of Abuse & [and] Neglect, revised 8/10/2021, revealed .This facility does not condone resident abuse and/or neglect by anyone. This includes, but is not limited to staff members, other residents .family members .or other individuals .The facility must ensure that all alleged violations involving abuse . are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Failure to do so will mean that the facility is not in compliance with the federal regulations .</p> <p>Medical record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including Dementia with Anxiety, Depression, Anemia (low blood count), and Chronic Kidney Disease.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident scored a 99 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment.</p> <p>Review of an Event Note for Resident #14 dated 8/21/2023, revealed .aide observed another resident [Resident #15] at [Resident #14's] bedside disrobing & [and] pulling at covers. other resident [Resident #15] removed from room immediately. When asked resident [Resident #14] if the other resident [Resident #15] touched her she stated yes he touched her brief .[Doctor O and Doctor P] notified of above .</p> <p>Review of Doctor (Dr.) O's Progress Note for Resident #14 dated 8/21/2023 revealed .CHIEF COMPLAINT: Evaluation of patient following inappropriate behavior by other resident [Resident #15] .According to social worker, the patient [Resident #14] was asleep while a male patient [Resident #15] entered her room, disrobed, and pulled the cover off of her exposing her own brief. He reportedly touched her brief but it was intact. A hospitality aide was passing by and noticed this and was able to intervene. She [Resident #14] is upset and somewhat tearful following .On examination, she is somewhat withdrawn and tearful .appears unharmed physically .She denies any needs at present, although is clearly anxious about this event .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Dr. P's Psychiatry in Longterm Care Summary-Diagnosis-Plan for Resident #14 dated 8/21/2023, revealed .I was asked to see the patient because of an alleged assault by a peer .I asked her about worry and she said yes but she was unable to specify .She looks anxious but she says she's not anxious if someone is with her . Dr. P recommended treatment with an additional antianxiety medication and increasing the dosage of her antidepressant.</p> <p>Medical record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Encounter for Surgical Aftercare Following Surgery on the Digestive System, Dementia without Behavioral Disturbance, and Abnormalities of Gait and Mobility.</p> <p>Review of the Admission MDS assessment dated [DATE] revealed Resident #15 scored a 3 on the BIMS test indicating the resident had severe cognitive impairment. The resident had not exhibited behaviors.</p> <p>Review of an Event Note for Resident #15 dated 8/21/2023, revealed .aide observed resident [Resident #15] disrobbing [disrobing] and pulling at covers in another residents [Resident #14] room. family notified @ [at] 1230 [12:30 PM] of residents inappropriate behaviors and sent to [named hospital] for behavioral eval. [evaluation] . Dr. O and Dr. P were notified of Resident #15's behaviors.</p> <p>Review of the facility's investigation documentation dated 8/21/2023 at 12:15 PM, revealed .Resident [#15] found standing at Resident [#14] bedside disrobing and pulling her [Resident #14] covers back. Staff immediately removed him [Resident #15] from the room . Resident #14 and Resident #15 were placed on one-to-one supervision until Resident #15 was transferred from the facility Continued review revealed the following . HOSPITALITY AIDE SAW RESIDENT [#15] IN THE DAY ROOM AS SHE WENT TO THE KITCHEN AT APPROXIMATELY 12:05 PM AND SHE HEARD THE RESIDENT [#14] SAYING 'NO' AS SHE CAME BACK UP THE HALL AT 12:15 pm AND WENT INTO THE ROOM AND IMMEDIATELY TOOK RESIDENT [#15] FROM THE ROOM .</p> <p>Review of Hospitality Aide (HA) K's witness statement dated 8/21/2023 at 12:15 PM, revealed .I walked into [Resident #14's] room and saw [Resident #15] standing beside the bed with his pants and brief pulled down and he [Resident #15] was trying to remove her [Resident #14] brief she was telling him no and trying to keep him from removing the brief. I instantly pulled his pants up and removed him from her room .</p> <p>Review of Social Services Aide (SSA) N's witness statement dated 8/21/2023 at 12:40 PM, revealed .I was asked to sit with [Resident #15] after he was reportedly involved in a situation with another resident [Resident #14] where he displayed inappropriate behavior. After talking with [Resident #15] about what happened, he stated, 'I'm in trouble. I got busted going into another person's room'. Continued review revealed Resident #15 did not offer further information .</p> <p>Review of Licensed Practical Nurse (LPN) L's witness statement dated 8/21/2023 (no time) revealed . Notified by aide that she had observed [Resident #15] standing beside bed with pants & brief on ground & [Resident #14's] blanket down trying to pull off her brief. Went to residents room [Resident #14] to assess resident. Resident stated he [Resident #15] touched her brief .</p> <p>Review of LPN M's witness statement dated 8/21/2023 (no time) revealed .I entered [Resident #14's room] after the incident took place to assess [Resident #14] .The resident .very scared and upset .</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 7/8/2024 at 12:00 PM, HA K stated she was coming back from lunch and heard Resident #14 saying .no .no . HA K stated she saw Resident #15 standing over Resident #14 with his pants down, with his brief on, trying to pull her brief off. HA K stated Resident #15 did not touch Resident #14, as she had intervened and immediately removed Resident #15 from Resident #14's room.</p> <p>During an interview on 7/8/2024 at 1:30 PM, LPN L stated she heard an aide (HA) say .oh, no . The HA came out and told LPN L Resident #15 was in Resident #14's room with his pants down. Resident #15 was moved to a different location and orders were received to transfer Resident #15 for evaluation.</p> <p>During a second telephone interview on 7/9/2024 at 1:34 PM, HA K stated Resident #15's pants and brief were pulled down at the time of the incident. (HA K's first telephone interview stated Resident #15's brief was on when the incident occurred.)</p> <p>During a telephone interview on 7/9/2024 at 3:48 PM, LPN M stated Resident #14 was crying and was trying to pull the blanket up over her after the incident with Resident #15.</p> <p>During a a second interview on 7/9/2024 at 4:15 PM, LPN L stated Resident #14 was upset and crying a little bit after the incident.</p> <p>During a telephone interview on 7/10/2024 at 10:09 AM, SSA N stated her supervisor had asked her to check on Resident #14 because Resident #15 had gone into Resident #14's room around lunch time. SSA N asked Resident #14 if she was okay. Resident #14 (had severe cognitive impairment) told SSA N .he [Resident #15] just came in here, he stood over me and tried to pull my blanket off . and tried to take her brief off. Further interview revealed Resident #14 reported Resident #15 had taken his pants off and was trying to climb on top of her. SSA N stated HA K told her Resident #15 was standing next to Resident #14's bed with his pants down. SSA N stated HA K went into Resident #14's room and redirected Resident #15 to his room. SSA N stated she was asked to sit at the nurses' station with Resident #15 until an ambulance arrived to transport him to the hospital. Continued interview revealed Resident #15 told SSA N he was in trouble because he had wandered into another resident's room.</p> <p>During an interview on 7/10/2023 at 5:02 PM, the Executive Director (ED) stated a staff member observed Resident #15 with his brief off and reaching for a female resident's (Resident #14's) covers. The ED stated the staff member immediately intervened. The ED stated .Obviously, we saw the potential for abuse . He stated because of the potential for abuse, the facility conducted a full investigation, Resident #15 was transferred out for evaluation, and Resident #14 was evaluated by Dr. O and Dr. P. The ED stated .I'll be honest with you .looking back on this I should have reported this .I do acknowledge I saw 100% potential for abuse .If I could go back to that date, I would have reported it .</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40606</p> <p>Based on review of the Resident Assessment Instrument (RAI) Manual 3.0, medical record review, and interview the facility failed to accurately complete a discharge Minimum Data Set (MDS) assessment for 1 resident (Resident #24) of 3 residents reviewed for falls.</p> <p>The findings include:</p> <p>Review of the RAI Manual 3.0 dated 10/2023, revealed .The MDS is completed on all residents in Medicare or Medicaid certified facilities .Sections A-Q contain the clinical data items used to assess residents in the nursing facility .Assure that the information found in the resident's most current assessment .report changes in the resident's status that may affect the accuracy of this information .J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment .Review nursing home incident reports and medical record . for falls and level of injury .</p> <p>Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including Fracture of the Right Leg, Muscle Weakness, and Lack of Coordination.</p> <p>Review of the comprehensive care plan revised 8/11/2023, for Resident #24 revealed, .Resident is at risk for falls .</p> <p>Review of the Nurse's Notes for Resident #24 dated 8/11/2023, revealed, .Resident observed in floor next to bed on her bottom. Resident was leaning with back against the side of bed .</p> <p>Review of the facility's fall investigation for Resident #24 dated 8/11/2023, revealed, .Resident observed in floor . assisted to the bathroom New Interventions .toileting program .</p> <p>Review of a discharge MDS assessment for Resident #24 dated 8/16/2023, revealed, . Any falls since Admission/Entry or Reentry or Prior Assessment .0 [no] .</p> <p>During an interview on 7/10/2024 at 10:26 AM, the MDS Coordinator Registered Nurse K and the MDS Coordinator Licensed Practical Nurse L confirmed Resident #24 had a fall on 8/11/2023, the fall was not captured on the discharge MDS assessment dated [DATE], and the assessment was inaccurate.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50407</p> <p>Based on facility policy review, medical record review and interviews the facility failed to provide scheduled showers for 3 dependent residents (Resident #12, #8, and #22) of 10 residents reviewed for Activities of Daily Living (ADLs).</p> <p>The findings include:</p> <p>Review of the facility policy titled, Activities of Daily Living (ADLs), revised 2/2024, revealed .The resident will receive assistance as needed to complete activities of daily living (ADLs) .Quality of care is fundamental .the facility must ensure that residents receive treatment .care .in accordance with professional standards of practice .hygiene .bathing .grooming .a resident who is unable to carry out activities of daily living receives . services to maintain good .personal hygiene .</p> <p>Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Epilepsy, Vascular Dementia, and Urinary Incontinence.</p> <p>Review of a comprehensive care plan for Resident #12 dated 1/26/2022, revealed the resident was care planned for ADL assistance and required assistance of 1-2 staff for bathing.</p> <p>Review of a quarterly [NAME] Data Set (MDS) assessment dated [DATE], revealed Resident #12 was rarely/never understood which indicated the resident had severe cognitive impairment.</p> <p>Review of the facility ADL documentation for Resident #12 dated 9/1/2023 -9/30/2023, revealed the resident received a shower on 9/8/2023, 9/20/2023, and 9/29/2023. This was a total of 3 showers provided to the resident of 13 scheduled showers during the month of 9/2023.</p> <p>During an interview on 7/10/2024 at 10:21 AM, CNA Q stated she cared for Resident #12 routinely, the resident's shower days were on Monday, Wednesday, and Friday. If the resident did not receive a shower, the resident was provided a bed bath.The CNA also stated when the facility had staff call-ins, she was not always able to document bathing.</p> <p>Medical record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of Earlobe, Type 2 Diabetes Mellitus, and Age-Related Osteoporosis.</p> <p>Review of a quarterly 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. Further review revealed the resident required moderate assistance with activities of daily living.</p> <p>Review of a comprehensive care plan for Resident #8 dated 12/4/2023, revealed the resident was care planned for ADL self-care performance due to limited mobility and .totally dependent on .associates to provide bath/shower .</p> <p>Review of the facility ADL documentation for Resident #8 dated 1/1/2024 - 1/31/2024, revealed the resident received a shower on 1/4/2024, 1/24/2024, and 1/31/2024. This was a total of 3 showers provided to the resident of 15 scheduled showers.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445520	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Blount County		STREET ADDRESS, CITY, STATE, ZIP CODE 1965 Stewart Lane Louisville, TN 37777	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility ADL documentation for Resident #8 dated 2/1/2024 - 2/29/2024, revealed the resident received a shower on 2/9/2024, 2/13/2024, 2/15/2024, 2/20/2024, 2/27/2024, and 2/29/2024. This was a total of 6 showers provided to the resident of 12 scheduled showers.</p> <p>Review of the facility ADL documentation for Resident #8 dated 3/1/2024 - 3/31/2024, revealed the resident received a shower on 3/9/2024, 3/14/2024, 3/16/2024, and 3/19/2024. This was a total of 4 showers provided to the resident of 13 scheduled showers.</p> <p>During an interview on 7/7/2024 at 2:30 PM, Resident #8 stated a few months ago she had not received scheduled showers. The resident's son reported it to the facility and she started receiving the scheduled showers. The resident also stated when she did not receive a shower staff provided a sponge bath or bed bath.</p> <p>Medical record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Metabolic Encephalopathy, Dementia, Malignant Neoplasm of the Lung, and Cellulitis. The resident was discharged on [DATE].</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #22 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact and was dependent with bathing.</p> <p>Review of a comprehensive care plan for Resident #22 dated 9/1/2023, revealed the resident required ADL assistance.</p> <p>Review of the facility ADL documentation for Resident #22, dated 9/1/2023 - 9/30/2023, revealed the resident received a shower on 9/19/2023 and 9/21/2023. This was a total of 2 showers provided to the resident of 13 scheduled showers.</p> <p>Review of the facility ADL documentation for Resident #22 dated 10/1/2023 - 10/31/2023, revealed Resident #22 received a shower on 10/5/2023. This was a total of 1 shower provided to the resident of 5 scheduled showers.</p> <p>Review of the facility grievance log for 9/2023 and 10/2023 revealed no concerns regarding bathing/showers for Resident #22.</p> <p>During an interview on 7/9/2024 at 10:44 AM, NP II stated she had not observed any unkempt residents. No residents had voiced concerns regarding bathing.</p> <p>During an interview on 7/10/2024 at 4:15 PM, the Director of Nursing (DON) stated it was her expectation for residents to receive 3 scheduled showers per week. Residents are scheduled for showers on Monday, Wednesday, Friday or Tuesday, Thursday, Saturday depending on room number. The DON reviewed Resident #12, #8, and #22's ADL bathing records and confirmed the residents had not received the scheduled showers.</p>		

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Blount County		STREET ADDRESS, CITY, STATE, ZIP CODE 1965 Stewart Lane Louisville, TN 37777	
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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>50407</p> <p>Based on facility policy review, observations, and interviews the facility failed to post accurate nursing staff information to reflect daily staffing levels on 2 of 4 days reviewed for staffing and failed to maintain the posted daily nurse staffing data for a minimum of 18 months.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Staffing, dated 6/12/2024, revealed .The facility maintains adequate staff on each shift to meet residents' needs, posts daily staffing data .The facility must post the following information .Facility name .The current date .The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift .Registered nurses .Licensed practical nurses or licensed vocational nurses .Certified nurse aides .Resident census . Posting requirements .The facility must post the nurse staffing data .on a daily basis at the beginning of each shift .The facility maintains the posted daily nurse staffing data for a minimum of 18 months .</p> <p>During an observation on 7/10/2024 at 5:15 AM, the posted daily staffing data dated 7/9/2024, revealed night shift staff (11:00 PM-7:00 AM) included 1 Registered Nurse (RN), 2 Licensed Practical Nurses (LPNS), and 8.5 Certified Nursing Assistants (CNAs).</p> <p>During observations on 7/10/2024 from 5:20 AM to 7:00 AM, revealed there was 1 RN, 2 LPNs, and 7 CNAs present in the facility. The following staff were observed working on the 200 hallway: CNA A, CNA B, and LPN C. The following staff were observed working on the 100 hallway: CNA D, CNA E, CNA F, and LPN G. The following staff were observed working on the 300 hallway: CNA H, CNA I, and RN J.</p> <p>During an interview on 7/10/2024 at 6:30 AM, CNA E stated 1 CNA had called in for the 7/9/2024 night shift and 1 CNA left at 3:00 AM.</p> <p>During an interview on 7/10/2024 at 6:50 AM, the Director of Nursing (DON) confirmed the 7/9/2024 night shift posting included the hours from 11:00 PM to 7:00 AM. The DON stated 8.5 CNAs were scheduled for the 7/9/2024 night shift and a CNA had called in. The DON confirmed there were 7.5 CNAs working 7/9/2024 night shift and the daily staff posting in the facility entryway had not been updated to reflect the actual number of CNAs working. The DON confirmed the daily staff posting that was posted in the facility entry way every morning included the staffing plan of what staff were scheduled and was not updated throughout the day to reflect staffing changes or call ins. The DON stated there was no designated person responsible for updating the daily staff posting in the facility once it was posted in the morning and .I've never been told I had to update it .</p> <p>During an observation on 7/10/2024 at 8:00 AM, the posted daily staffing data dated 7/10/2024, revealed day shift staff included 1 RN, 7 LPNs, and 10.5 CNAs.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Blount County		STREET ADDRESS, CITY, STATE, ZIP CODE 1965 Stewart Lane Louisville, TN 37777	

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observations on 7/10/2024 from 8:15 AM to 8:45 AM revealed 2 RNs, 6 LPNs, and 10 CNAs present in the facility. The following staff were observed working on the 200 hallway: RN HH, LPN S, LPN T, LPN V, CNA X, CNA Y, and CNA FF. The following staff were observed working on the 100 hallway: LPN V, LPN W, LPN L, CNA BB, CNA Q, and CNA CC. The following staff were observed working on the 300 hallway: RN GG, CNA Z, and CNA AA. The following staff were observed performing restorative therapy services: CNA DD and CNA EE.</p> <p>Observations from 7/7/2024-7/10/2024 revealed the facility posted the daily staffing data on a dry erase board and the facility did not keep a record of the daily staffing data.</p> <p>During an interview on 7/10/2024 at 9:39 AM, the DON confirmed the daily staffing data posted 7/10/2024 was inaccurate, the facility posted staffing data daily on a dry erase board, the facility did not keep a copy of the daily staff posting data, and the data had not been maintained for 18 months.</p>