STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445442	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Crestview	704 Dupree Road Brownsville, TN 38012

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 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** 30974 Based on policy review, medical record review, facility investigation, and interview, the facility failed to ensure effective fall interventions were in place to prevent injury, and failed to complete neuro checks for 2 of 3 (Resident #23 and #73) sampled residents reviewed for accidents. The facility's failure to implement effective fall interventions when Resident #23 fell and sustained a closed fracture (broken bone) of right distal femur (large upper bone of the leg) resulted in actual harm. The findings include: 1. Review of the facility's policy titled, Fall Risk-Fall Prevention, dated 4/20/2023, revealed Purpose: To provide a coordinated system to identify Residents at risk for falls and develop an individualized interdisciplinary plan of care to reduce the risk of falls and subsequent injury .Implement interventions, including adequate supervision, consistent with a Resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of a fall .Monitor for effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice .Residents with a BIMS [Brief Interview for Mental Status] of 13 or greater [indicates no cognitive impairment] may be educated on the use of the call light system and reminded to ask for assistance . Review of the facility's policy titled, Neurological Exam, dated 11/28/2023, revealed .Neuro assessments shall be performed for 72 hours .Neuro-checks shall be initiated when there is an unobserved fall and the residents [resident's] BIMS is less than 13 . 2. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses that included Dementia, Schizoaffective Disorder, Seizures, Mood Disorder, Anxiety, and Depression. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan dated 1/17/2023-1/17/2024, revealed .At Risk for Falls R/T [related to] self ambulatory, unsteady gait, poor safety awareness .Place call bell/light within easy reach .Provide reminders to use ambulation and transfer assist devices .Remind [named Resident #23] to call for assistance before moving from bed-to-chair and from chair-to-bed .has exhibited Wandering Behavior potential for elopement . Patient transferred to Memory Care Unit for safety and to prevent potential elopement .Redirect [named Resident #23] behavior/activity when wandering is observed .Provide orientation to facility layout and room as needed .Redirect when wandering .Monitor resident's location to ensure safety . Further review of the 1/17/2023-1/17/2024 care plan revealed, .Provide diversional activities .[Named Resident #23] is receiving antipsychotic drugs on a regular basis secondary to impulse control disorder .Remind [Named Resident #23] that BEHAVIOR is not appropriate .Remove from situation; allow time to calm down . The care plan to remind a severely cognitively impaired resident to use ambulation and transfer assist devices and remind the resident to call for assistance was inappropriate. Review of the Nurses' Note dated 4/8/2023, revealed Res. [Resident #23] alert, verbal, able to make some needs known. Ambulatory in hallway with walker. Res trying to take food from meal cart. Tried to take water from nurse's hand. Walked up on nurse twice in aggressive manner, but no threat or physical action taken. Res. was upset that 'everybody else gets medicine'. Repeatedly attempting to enter female res. room. Redirected res. [Resident #23] each time, but continues to come back to that door and trying to enter . The facility failed to follow its policy to use education on use of call lights remind to ask for assistance for residents with a BIMS score of 13 or greater and to modify interventions as necessary. The facility failed to implement effective interventions when continued redirection for wandering into other residents' room was ineffective. Review of the Nurses' Note dated 4/9/2023, revealed Res. [Resident #23] repeatedly entering female [resident's] room. Angry and aggressively approaching nurse when told not to enter room. Verbal insults to this nurse when instructed not to enter room. Review of the Nurses' Note dated 5/16/2023, revealed Res. [Resident #23] pacing most of the day with walker. Rare exit seeking noted. Repeatedly entering rooms of female res [residents] sometimes when they were in the rooms and sometimes when they were out, despite being told not to enter. Res [Resident #23] on the constant lookout for any kind of food item or drink that he can find. Trying to take other res food from tray. Repeatedly trying to get into trash can to look at it . Review of the Nurses' Note dated 8/6/2023, revealed Res. [Resident #23] continues to wander the halls, entering other res [residents] rooms at will. Unable to redirect. Res [Resident #23] continues to steal snacks, food, and drink from med cart, other residents, food cart, or any item he can find. Res [Resident #23] cannot stop this behavior. It is every day, as long as he is awake he is wandering and searching for food items. When given food or drink, he may or may not consume it, but will always attempt to take food or drink item that is left unsecured. Review of the Nurses' Note dated 8/20/2023, revealed Res [Resident #23] awake, up ambulating in hallway with walker. Going into female res [residents'] rooms. Instructed to not enter any room but his own. Res [Resident #23] verbalized understanding, reminded frequently and continued to enter other rooms. At present sitting in chair in his room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had a BIMS score of 2, which indicated severe cognitive impairment. The facility failed to follow its policy to use education on use of call lights remind to ask for assistance for residents with a BIMS score of 13 or greater and to modify interventions as necessary. Resident #23 had a BIMS of 2, which indicated severe cognitive impairment, and did not have a BIMS of greater than 13 per facility policy. The facility failed to implement effective interventions/modify when continued redirection for wandering into other residents' room was ineffective. Review of the facility's FALL RISK assessment dated [DATE], revealed a score of 18, which indicated moderate risk. Review of the facility's OCCURANCE INVESTIGATION INTERVIEW, dated 11/7/2023, revealed .FALL . WITNESSED [by Resident #71] .I heard [Named Resident #71] yell Get out of my room. [Named Resident #23] stated he fell .Resident fell on his R [right] side .He was walking with his walker .Resident told not to go in another resident room . Review of the facility's Interdisciplinary Team Occurrence Investigation Worksheet dated 11/7/2023, revealed Transferred to Hospital .No .STEPS IMPLEMENTED TO PREVENT RECURRENCE .[Named Resident #23] will be redirected to his hall and will not go into [named Resident #71's] room . Resident #23 ambulated with a walker and would attempt to enter Resident #71's room. Resident #71 often stood in her doorway and did not want anyone coming into her room. On 11/7/2023 Resident #23 attempted to enter Resident #71's room and she grabbed Resident #23's walker to turn him around causing Resident #23 to fall. Resident #23 was transferred to the hospital where he was admitted for a right femur fracture. Resident #23 had a surgical repair for the right fractured femur. Resident #23 was readmitted to the facility on [DATE]. Review of the discharge MDS assessment (with return anticipated) dated 11/7/2023, revealed Resident #23 had short term memory problems, was moderately cognitively impaired, made poor decisions, and required cues/supervision. Review of the Nurses' Note dated 11/13/2023, revealed .The resident [Resident #23] returned from hospital due to Right hip fracture .The resident received a hemiarthroplasty [partial hip replacement] and is now stable . Review of the Care Plan dated 11/20/2023, revealed .at risk for complications related to Right Femur Fracture .Call light available and answered promptly . Review of the Care Plan dated 12/15/2023, revealed .[Resident #23] At risk for mood swings related to .has diagnoses of depression and impulse disorder . Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #23 had a BIMS of 2, which indicated severe cognitive impairment, wandering behavior occurred daily, no falls were documented, and the resident received antipsychotic, antidepressant, and antiplatelet medications. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan dated 1/17/2024 - Present, revealed .At Risk for Falls R/T self ambulatory, unsteady gait, poor safety awareness .Provide patient with extra snacks b/t [between] meals to reduce/limit wandering and taking food .Place call bell/light within easy reach .Provide reminders to use ambulation and transfer assist devices .Remind [named Resident #23] to call for assistance before moving from bed-to-chair and from chair-to-bed .has exhibited Wandering Behavior at times .Memory Care Unit. Ensure all doors alarms/locks are armed to reduce the risk of [named Resident #23] leaving secure area .Redirect [named Resident #23] behavior/activity when wandering is observed .Provide orientation to facility layout and room as needed .Redirect when wandering . The facility failed to follow its policy to use education on use of call lights remind to ask for assistance for residents with a BIMS score of 13 or greater and to modify interventions as necessary. Resident #23 had a BIMS of 2, which indicated severe cognitive impairment, and did not have a BIMS of greater than 13 per facility policy. The facility failed to implement effective interventions/modify when continued redirection for wandering into other residents' room was ineffective. Review of the quarterly MDS dated [DATE], revealed Resident #23 had a BIMS of 2, which indicated severe cognitive impairment. During an interview on 4/24/2024 at 4:33 PM, CNA G was asked about Resident #23. CNA G stated, [Named Resident #23] has been in [the memory] unit a long time. He ambulated with his walker all the time and he would steal food wherever he found it. He would wander into all the residents' rooms, male and female. Now [after the fractured femur] he has to use [his] wheelchair due to lack of strength. He goes to showers and is total dependent for all ADLs [Activities of Daily Living] except eating. He would not participate in therapy, so he does not receive therapy at this time . During an interview on 4/26/24 at 10:15 AM, the Director of Rehabilitation was asked about Resident #23. Director stated, He was ambulating in [the] Memory Care unit with his walker. He was picked up post traumatic fall [with a fracture]. His dementia is worse now since [his] fall. Some get scared after a fall .used to be able to reason with to get him [Resident #23] to do things in therapy back in 2022. After his fall he [Resident #23] just would not participate in therapy or restorative .[Resident #23] had a doctor visit with ortho [Orthopedic doctor that performs surgery on bones] and the doctor seemed pleased with his progress of getting around in his wheelchair . During an interview on 4/26/2024 at 10:30 AM, CNA H was asked about Resident #23. CNA H stated, He is used to going in the rooms of other residents and pilfering their stuff and eating their food. He knows what he is doing because he laughs and said 'I know' when you redirect him. When you ask why [are] you doing that he would say 'I don't know.' I didn't take him to [the] main dining room because he won't stay and he be [is] constantly rolling back here. He won't go all the way to [Named Resident #71's] room he turns around at the nurse station. He won't go to [Named Resident #8's] room either because she curses like a sailor. He continues going into other residents' room in his wheelchair. His sister is aware of his roaming here because she [has] seen him doing it. I stand him up with the standing lift but we can't get him to walk. When elderly persons falls, they get scared .We just try to redirect him, but he laughed [laughs]. He snatched a cookie from a female resident that was eating a cookie. She turned around and started cursing him and he gave it back. His interventions was to redirect and provide extra food/snacks . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/26/2024 at 2:41 PM, the Director of Nursing (DON) was asked, Would you expect other interventions besides being redirected for Resident #23 since he continued to wander. The DON stated, I would do other interventions if there had been an injury, or maybe MDS [coordinator] could do other interventions. He didn't mean no harm to anyone. He was just looking for food or something. He is in [a] wheelchair and still going into resident rooms . The facility's failure to ensure effective interventions were implemented resulted in an actual harm when Resident #23 sustained a fall with a right femur fracture. 3. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease, Fracture Left Femur, Acute Respiratory Failure, Diabetes, and Panic Disorder. Review of the Care plan dated 2/15/2024, revealed .At Risk For Falls R/T [related to] weakness, poor endurance, functional decline .All Staff .Place call bell/light within easy reach .Provide reminders to use ambulation and transfer assist devices .provide the Resident and/or Resident Representative with education regarding strategies to reduce the risk for falls .Remind [Named Resident #73] to call for assistance before moving from bed-to-chair and from chair-to-bed .Respond promptly to calls for assist to the toilet .Short-term memory impaired-unable to recall after 5 minutes .Re-orient to time, location, events, and activities as needed .Use cues to enhance participation in self-care .Report any decline in ability to participate/perform ADL care . The facility failed to follow its policy to use education on use of call lights remind to ask for assistance for residents with a BIMS score of 13 or greater and to modify interventions as necessary. Resident #73 had a BIMS of 12, which indicated moderate cognitive impairment, and did not have a BIMS of greater than 13 per facility policy. Review of the admission MDS dated [DATE], revealed Resident #73 had a BIMS score of 12, which indicated moderate cognitive impairment with no behaviors identified and required partial to moderate assistance with most activities of daily living (ADLs). Review of Nurse's Notes dated 2/15/2024, revealed Resident arrived to the facility by ambulance and escorted in by paramedics. She is alert and oriented [AAO] X [times] 3 upon arrival and with a lot of anxiety. She has been on the call light every 5-10 minutes. She has been very restless. She is on oxygen at 2L [liters]. She has a bruise on both eyes and 5 stitches over her right eye that can be removed on 2/18. She is still very weak, incontinent, and is a fall risk. Review of Nurse's Notes dated 2/22/2024, revealed Found resident on the floor, in her room on her left side facing the door. Unknown what resident was doing and she was unable to state what she was doing. She states she did not hit her head and there are no visible injuries but resident states her left hip hurts. While laying [lying] in bed resident cannot lay on her back or move her left leg without complaining of pain. MD [Medical Doctor] notified and order received for hip x-rays. Resident is her own RP [Responsible Party] with a BIMs of 12. Neuros not initiated . During an interview on 4/26/2024 at 2:53 PM, the DON was asked should neuro checks have been done with an unwitnessed fall and a BIMS of 12. The DON stated, Yes ma'am.