STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445112	A. Building B. Wing	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trevecca Center for Rehabilitation and Healing LLC	329 Murfreesboro Rd Nashville, TN 37210

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 - Minimal harm or potential for 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 facility policy review, medical record review, observation, and interview, the facility failed to follow the comprehensive care plan for 1 of 59 (Resident #92) sampled residents reviewed. The findings include: Review of the facility policy titled, Care Plans Comprehensive dated 5/18/2023, revealed, .developed and implemented for each resident .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Review of the facility policy titled, Lifting Machine Using Mechanical dated 5/19/2023 revealed, .to establish the general principles of safe lifting using a mechanical lifting device .At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift . Review of the medical record revealed Resident #92 was admitted to the facility on [DATE] with diagnoses which included Metabolic Encephalopathy, Supraventricular Tachycardia, and Primary Generalized (Osteo) Arthritis. Review of the comprehensive care plan for Resident #92 dated 5/18/2021 and revised 12/28/2021, revealed, .requires assist with activities of daily living .Total Dependent x2 Staff (Mechanical Lift) for Transfers for Safety . During an observation and interview on 6/12/2023 at 3:24 PM, Certified Nursing Assistant (CNA) #9 was observed coming out of Resident #92's room with a mechanical lift. CNA #9 stated she had transferred Resident #92 using the mechanical lift without another CNA because she could not find anyone to help her with the transfer. CNA #9 confirmed staff was required to use two people for all mechanical lift transfers. During an interview on 6/12/2023 at 3:31 PM, Unit Manager #1 stated for resident safety, staff is required to use two person assist for all mechanical lift use. Unit Manager #1 reviewed Resident #92's [NAME] and confirmed she was care planned to use two person assist for mechanical lift.

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