STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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 0157	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to notify the physician of use of a multipodus boot (a rigid appliance to prevent the foot from extending to prevent foot drop) and failed to notify the physician of pressure ulcer progression for one resident (#95) of fourteen residents with pressure ulcers reviewed; and failed to notify the physician of [MEDICAL CONDITION] medication recommendations for one resident (#62) of sixty-five residents reviewed. The facility's failure to notify the physician in order to obtain orders for care and treatment of [REDACTED]. The Immediate Jeopardy was effective on November 26, 2012, and is ongoing. The Regional Vice President, Director of Clinical Services, Administrator and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m. in the conference room. The findings included: Resident #95 was admitted to a Trauma Center on July 27, 2012, following an accident while burning brush in which there was an explosion. Two days later the family and friends were unable to contact the resident and a neighbor found the resident in the house, minimally responsive and lethargic. As a result of the accident the resident was a C6 quadriplegic (fracture of neck just above shoulders leaving resident unable to move from the neck down) [MEDICAL CONDITION] 15% (percent) of the body, including face, right arm, left arm, and bilateral lower extremities. Resident #95 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the discharge recommendations dated August 20, 2012, from Physical Therapy at an outside hospital, revealed, .the following anti-contracture devices were applied to patient: Multipodus boots BLEs (bilateral lower extremities) continuously when supine (lying on the back). Interview with the Director of Nursing (DON) on October 3, 2013, at 12:50 p.m., at the nurses station, revealed the resident was admitted to the facility from the hospital on October 5, 2012, with a multipodus boot in place on the left foot. Medical record review of an admission Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all Activities of Daily Living (ADL's); at risk for pressure ulcers; and had no pressure ulcers on admission. Medical record review of the Nursing Assessment Re-admitted d October 29, 2012, revealed, .Skin/Wound condition present: no.red area (coccyx).scabbed area (right lower extremity) scab area (top of right foot).red area (right forearm).Norton Score 12 (very high risk). Medical record review of the Physician's orders from admission on October 5, 2012, to discharge on May 1, 2013, revealed no order for a boot. Medical record review of the resident's chart revealed no information regarding the application of the multipodus boot, the schedule of the multipodus boot, and/or the staff responsible for monitoring the multipodus boot. Interview with the Assistant Director of Nursing (ADON) on November 5, 2013, at 7:58 a.m., in the conference room, revealed the resident had on multipodus boots from the hospital. Further interview with the ADON revealed the resident wore the multipodus boots at all times except for showers. Medical record review of the Treatment Administration Record (TAR) dated November 1-30, 2012, revealed, .open area to coccyx apply exuderm (cream to harden skin and prevent breakdown) change q (every) 3 days.weekly skin check by licensed nurse. Continued review of the November TAR revealed weekly skin assessments completed on November 9, and 16, 2012, and no other skin assessments were documented. Medical record review of a Nurse's Note dated November 26, 2012, at 10:00 a.m., revealed, .Blister noted to L (left) heel possibly caused by boot resident wears to prevent foot drop. Medical record review of a Nurse Practitioner (NP) note on November 26, 2012, revealed .Skin: normal. Medical record review of a Physician's order dated November 26, 2012, revealed, .Skin prep bilateral heels q (every) shift. Continued medical record review of a Physician's order also dated November 26, 2012, revealed, .cleanse blister to left heel. Medical record review revealed no wound measurements for the left heel documented until December 27, 2012 (thirty-one days after discovery). Medical record review of Pressure Ulcer Documentation Forms dated December 27, 2012, through January 30, 2013, revealed the resident had an unstageable left heel ulcer with the following: December 27, .length 2 cm (centimeter) width 1.5 cm.no undermining, no tunneling, no odor, no exudate.; January 3, length 1.5 cm. width 1.5 cm; January 8, length 1.5 cm. width 1 cm; January 16, length 2 cm. width 1 cm; January 23, length 1.5 cm. width .5 cm; and January 30, .length 1.5 cm. width .5 cm.no undermining, no tunneling, no odor, no exudate. Continued review revealed no documentation the physician was notified of the lack of wound progress and no new orders were obtained for the wound. Medical record review of the physician's progress notes dated January 3, 2013, revealed the statement .wounds healing nicely. Medical record review of a quarterly MDS dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all ADL's (activities of daily living); at risk for pressure ulcers; and had one Stage 1 pressure ulcer and no unstageable pressure ulcers. Medical record review of the Pressure Ulcer Documentation Form dated February 5, 2013, revealed the wound had changed to a Deep Tissue Injury (DTI) and .length 1.5 cm. width 1.5 cm.100% eschar (necrotic tissue), [MEDICAL CONDITION] present, no order change.no notification of change (to physician). Medical record review of the Pressure Ulcer Documentation form dated February 12, through March 1, 2013, revealed the wound was staged as a DTI and no wound measurements were documented or notification to the physician. Medical record review of the Pressure Ulcer Documentation Form dated March 12, 2013, revealed, .Left Heel Stage DTI.Wound Measurements length 1.7 cm, width 1.6 cm.25 % slough (necrotic tissue in process of separating), 75% eschar, [MEDICAL CONDITION] present, order change Santyl (wound debridement). (The first notification to the physician and new orders obtained for wound treatment). Medical record review of a Physician's order dated March 13, 2013, revealed, .cleanse blister to left heel with wound cleanser.apply santyl (removes necrotic tissue). Medical record review of a Pressure Ulcer Documentation Form dated March 19, 2013, revealed, .Left Heel Stage DTI.Wound Measurements Length 2 cm, Width 1.8 cm, no depth documented, no tunneling, no odor, exudates sm type ser, 100% slough, no order change.no notification of change (to physician or family). Review of the TAR for March 2013, revealed the order for skin prep bilateral heels each shift and the treatment was not documented as administered on March 2, 3, 4, 8, 11, 12, 17, 18, 21, 23, 24, 25, 27, 28, and 30, 2013, on the night shift. Continued review of the TAR for March 2013, revealed an order for [REDACTED]. Medical record review revealed no documentation of the left heel pressure ulcer after March 19, 2013, through April 3, 2013 (fifteen days). Medical record review of a IDT note dated March 21, 2013, revealed, .new bed (with) air mattress which allows more room so (resident's) feet don't touch foot board d/t (due to) Pt (patient) sliding down in bed. Medical record review of a physician progress notes [REDACTED]. Medical record review of an IDT note dated April 3, 2013, revealed, .Left heel.2.8 x 2.2 cm tx (treatment) (with) Santyl. Medical record review of a Physician's order dated April 8, 2013, revealed, [MEDICATION NAME] (antibiotic) 875-125 mg by mouth every eight hours for seven days wound. Medical record review of a Physician Order dated April 8, 2013, revealed, .Wound care consult complex. Medical record review of a Pressure Ulcer Documentation Form dated April 10, 2013, revealed .left heel 3 x 2.6 x 1 with 100% slough; left lower posterior leg upper wound 2.8 x 0.1, stage II; left lower posterior leg lower wound - 1.7 x 1.1 - stage II. Medical record review of a New Patient Medical History from the Wound Care Physician, dated April 12, 2013, revealed, .Heel Ulcers/Leg Ulcers.L heel 2.3 x 2.7 x 1.0 cm (centimeters). Medical record review of an IDT note dated April

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

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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F 0157	(continued... from page 1) 18, 2013, revealed, .Left heel.5.2 x 2.5 x 1.5 cm 100 % slough tx to area (with) Santyl. Left lower leg lower ulcer 2.4 x 1.2 x 0.1, stage II; left lower leg upper ulcer 2.0 x 1.0 x 0.1, stage II. Medical record review of a Physician Order dated May 1, 2013, revealed, .send to (hospital) for direct admit.wound debridement. Interview with the Medical Records Director on October 3, 2013, at 7:30 a.m., in the Medical Records Department, confirmed there was no documentation of wound measurements in the medical record prior to December 27, 2012. Interview with the resident's physician on October 3, 2013, at 11:35 a.m., on the A-Wing, confirmed the physician expected the facility to obtain an order with specific instructions for application and maintenance of a multipodus boot (footdrop management). Continued interview confirmed the physician expected the facility to complete weekly skin assessments with wound measurements for all pressure ulcers and notify the physician with changes. Interview with the Director of Nursing (DON) on October 3, 2013, at 12:50 p.m., at the Nurse's Station, confirmed there was no physician order for [REDACTED]. Further interview confirmed no documentation the physician and/or family were notified. Resident #62 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a Psychiatric Progress Note dated January 17, 2013, and February 4, 2103, revealed, .Recommendation :1) DC (discontinue) [MEDICATION NAME] non-use > (greater than) 30 days.2) DC [MEDICATION NAME] 10 mg po 2 x day.3) [MEDICATION NAME] 5 mg po 2 x day. Medical record review of the Comprehensive Non-Psychiatric Progress Note dated March 4, 2013, revealed, .Recommendation-1) DC [MEDICATION NAME] non-use >30 days.2) DC [MEDICATION NAME] po 10 mg 2 x day.3) [MEDICATION NAME] 5 mg po 2 x day.Informed consent for GDR (Gradual Dose Reduction) to [MEDICATION NAME], DC [MEDICATION NAME] NP (Nurse Practitioner) spoke with daughter. Medical record review of the physician orders dated March 15, 2013, revealed the [MEDICATION NAME] 10 mg twice a day was discontinued, [MEDICATION NAME] 25 mg prn was discontinued, and [MEDICATION NAME] 5 mg bid was ordered (three months after the initial recommendation). Interview with Licensed Practical Nurse #1 on October 3, 2013, at 9:40 a.m., in the TV lounge, confirmed there was no documentation the physician was notified of the [MEDICAL CONDITION] medication recommendations initiated January 2013, and continued in February 2013. Further interview confirmed the physician was not notified of the [MEDICAL CONDITION] medication recommendations until after March 4, 2013. .
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F 0157

(continued... from page 2)
IDT note dated April 3, 2013, revealed, .Left heel.2.8 x 2.2 cm tx (treatment) (with) Santyl. Medical record review of a Physician's order dated April 8, 2013, revealed, [MEDICATION NAME] (antibiotic) 875-125 mg by mouth every eight hours for seven days wound. Medical record review of a Physician Order dated April 8, 2013, revealed, .Wound care consult complex. Medical record review of a Pressure Ulcer Documentation Form dated April 10, 2013, revealed .left heel 3 x 2.6 x 1 with 100% slough; left lower posterior leg upper wound 2.8 x 0.1, stage II; left lower posterior leg lower wound - 1.7 x 1.1 - stage II. Medical record review of a New Patient Medical History from the Wound Care Physician, dated April 12, 2013, revealed, .Heel Ulcers/Leg Ulcers.L heel 2.3 x 2.7 x 1.0 cm (centimeters). Medical record review of an IDT note dated April 18, 2013, revealed, .Left heel.5.2 x 2.5 x 1.5 cm 100 % slough tx to area (with) Santyl. Left lower leg lower ulcer 2.4 x 1.2 x 0.1, stage II; left lower leg upper ulcer 2.0 x 1.0 x 0.1, stage II. Medical record review of a Physician Order dated May 1, 2013, revealed, .send to (hospital) for direct admit.wound debridement. Interview with the Medical Records Director on October 3, 2013, at 7:30 a.m., in the Medical Records Department, confirmed there was no documentation of wound measurements in the medical record prior to December 27, 2012. Interview with the resident's physician on October 3, 2013, at 11:35 a.m., on the A-Wing, confirmed the physician expected the facility to obtain an order with specific instructions for application and maintenance of a multipodus boot (footdrop management). Continued interview confirmed the physician expected the facility to complete weekly skin assessments with wound measurements for all pressure ulcers and notify the physician with changes. Interview with the Director of Nursing (DON) on October 3, 2013, at 12:50 p.m., at the Nurse's Station, confirmed there was no physician order for [REDACTED]. Further interview confirmed no documentation the physician and/or family were notified. Resident #62 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a Psychiatric Progress Note dated January 17, 2013, and February 4, 2103, revealed, .Recommendation :1) DC (discontinue) [MEDICATION NAME] non-use > (greater than) 30 days.2) DC [MEDICATION
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F 0170

Send and promptly deliver unopened mail to residents.

Based on interview, the facility failed to deliver mail to the residents for one of six days mail was delivered to the facility. The findings included: Interview with resident #32 (Resident Council President) on October 2, 2013, at 3:30 p.m., in the resident's room, revealed the mail was not delivered to the residents on Saturdays. Continued interview revealed the office staff were responsible for delivering the mail but did not work on weekends. Interview with the Activities Director on October 2, 2013, at 9:15 a.m., in the Activities Office, confirmed mail was not delivered to the residents on Saturdays.
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F 0170

Send and promptly deliver unopened mail to residents.

Based on interview, the facility failed to deliver mail to the residents for one of six days mail was delivered to the facility. The findings included: Interview with resident #32 (Resident Council President) on October 2, 2013, at 3:30 p.m., in the resident's room, revealed the mail was not delivered to the residents on Saturdays. Continued interview revealed the office staff were responsible for delivering the mail but did not work on weekends. Interview with the Activities Director on October 2, 2013, at 9:15 a.m., in the Activities Office, confirmed mail was not delivered to the residents on Saturdays.
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F 0221

Keep each resident free from physical restraints, unless needed for medical treatment.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on facility policy review, medical record review, and interview, the facility failed to keep one resident (#42) free of a restraint of sixty-five residents reviewed. The findings included: Review of facility policy, Use of Restraints, revealed Patients will be assessed for the use of restraints.during the nursing assessment process.If the device cannot be easily removed by the patient and/or restricts freedom of movement, the Restraint Evaluation/reduction will be completed: Prior to the application of the restraint.re-assessed monthly for three months. Interview with the Director of Nurses (DON) at 2:50 p.m., on October 2, 2013, in the conference room confirmed the Use of Restraint policy was the only policy in use at the facility. Interview confirmed the policy did not indicate the following: Individuals who would be required to give written consent before restraint application; a Medical [DIAGNOSES REDACTED]. Resident #42 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of two quarterly Minimum Data Sets (MDS) dated [DATE], and May 25,
2013, revealed the resident was moderately impaired for daily decision making; required extensive assistance with bed mobility, transfers, and locomotion on unit; and required total dependence for locomotion off unit and toilet use. Medical record review of facility falls reports revealed the resident had a fall on March 3, 2013, at 5:00 a.m., and a second fall on the same day at 12:15 p.m. Record review revealed when the physician was contacted to report the second fall, the physician gave an order to apply a restraint device called an activity tray to the resident's wheelchair. Review of the physician's orders [REDACTED]. Interview with Licensed Practical Nurse (LPN) #1 on October 30, 2013, at 2:00 p.m., in the conference room, confirmed the activity tray was attached to the resident's wheelchair at both sides and prevented the resident from standing and exiting the wheelchair. Continued interview revealed the activity tray was removed due to the resident being observed attempting to scoot down under the tray. Continued interview confirmed the following: The nursing assessment process was not followed prior to the restraint application on March 3, 2013; the restraint was not care planned; a monthly reassessment was not done in April 2013; the date the restraint was removed (prior to May 17, 2013, when the re-assessment stated no longer in use) could not be determined from the medical record.

F 0221	**Keep each resident free from physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to keep one resident (#42) free of a restraint of sixty-five residents reviewed. The findings included: Review of facility policy, Use of Restraints, revealed Patients will be assessed for the use of restraints.during the nursing assessment process.If the device cannot be easily removed by the patient and/or restricts freedom of movement, the Restraint Evaluation/reduction will be completed: Prior to the application of the restraint.re-assessed monthly for three months. Interview with the Director of Nurses (DON) at 2:50 p.m., on October 2, 2013, in the conference room confirmed the Use of Restraint policy was the only policy in use at the facility. Interview confirmed the policy did not indicate the following: Individuals who would be required to give written consent before restraint application; a Medical [DIAGNOSES REDACTED]. Resident #42 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of two quarterly Minimum Data Sets (MDS) dated [DATE], and May 25, 2013, revealed the resident was moderately impaired for daily decision making; required extensive assistance with bed mobility, transfers, and locomotion on unit; and required total dependence for locomotion off unit and toilet use. Medical record review of facility falls reports revealed the resident had a fall on March 3, 2013, at 5:00 a.m., and a second fall on the same day at 12:15 p.m. Record review revealed when the physician was contacted to report the second fall, the physician gave an order to apply a restraint device called an activity tray to the resident's wheelchair. Review of the physician's orders [REDACTED]. Interview with Licensed Practical Nurse (LPN) #1 on October 30, 2013, at 2:00 p.m., in the conference room, confirmed the activity tray was attached to the resident's wheelchair at both sides and prevented the resident from standing and exiting the wheelchair. Continued interview revealed the activity tray was removed due to the resident being observed attempting to scoot down under the tray. Continued interview confirmed the following: The nursing assessment process was not followed prior to the restraint application on March 3, 2013; the restraint was not care planned; a monthly reassessment was not done in April 2013; the date the restraint was removed (prior to May 17, 2013, when

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F 0221	(continued... from page 3) the re-assessment stated no longer in use) could not be determined from the medical record.

F 0224

Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on medical record review, review of facility policy, review of facility investigations, and interview, the facility failed to prevent misappropriation of controlled substances for thirteen residents (#10, #72, #79, #87, #71, #47, #116, #66, #39, #118, #100, #69, and #91) of forty-three residents receiving controlled substances. The facility's failure to follow a systematic approach for receipt and destruction of narcotics placed all residents receiving narcotics at risk for drug diversion and misappropriation of narcotics. The facility's failure to follow policy and procedure and have a systematic approach for receipt and destruction of narcotics constitutes Substandard Quality of Care. The findings included: Resident #10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated July 2013 revealed orders for [MEDICATION NAME]/[MEDICATION NAME] (pain medication) 10/500 mg (milligram) every six hours as needed for pain. Review of the Controlled Drug Records dated July 2013, provided by the facility, revealed seventeen [MEDICATION NAME]/[MEDICATION NAME] 10/500 mg were removed from the facility and not administered to the resident. Resident #72 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated July 2013 revealed orders for [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg every six hours as needed for pain. Review of the Controlled Drug Records dated July 2013, provided by the facility, revealed two [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg were removed from the facility and not administered to the resident. Resident #79 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated July and August 2013 revealed orders for a [MEDICATION NAME] Patch (pain medication) 50 mcg (micrograms) 72 hour [MEDICATION NAME] every three days, [MEDICATION NAME]-[MEDICATION NAME] (pain medication) 10-325 mg every six hours as needed for pain and [MEDICATION NAME] (pain medication) 15 mg every twelve hours as needed for pain. Review of the Controlled Drug Records dated June 2013 through August 2013, provided by the facility, revealed four [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, eight [MEDICATION NAME] 15 mg, and fifty-three [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg were removed from the facility and not administered to the resident. Resident #87 was admitted to the facility on [DATE], and readmitted [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated June 2013, July 2013, and August 2013, revealed orders for [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg every six hours as needed for pain. Review of the Controlled Drug Records dated July 2013, provided by the facility, revealed seventy-six [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg were removed from the facility and not administered to the resident. Resident #71 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review the Physician's Recapitulation Orders dated June 2013 through August 2013 revealed orders for [MEDICATION NAME] (pain medication) 5 mg as needed for pain every four hours. Review of the Controlled Drug Records from June 10, 2013 through August 21, 2013, provided by the facility, revealed 248 of the [MEDICATION NAME] 5 mg were removed from the facility and not administered to the resident. Resident #47 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated June 2013 and July 2013 revealed orders for [MEDICATION NAME] (antianxiety) 0.5 mg every six hours for Anxiety and [MEDICATION NAME] 5mg every four hours as needed for pain. Review of the Controlled Drug Records dated June 2013 and July 2013, provided by the facility, revealed eighteen [MEDICATION NAME] 0.5 mg and seventeen [MEDICATION NAME]/[MEDICATION NAME] 10/650 mg were removed from the facility and not administered to the resident. Resident #116 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated August 8, 2013, revealed orders for [MEDICATION NAME] (pain medication) 50 mg every six hours for pain. Review of the Controlled Drug Record dated August 2013, provided by the facility, revealed thirty [MEDICATION NAME] 50 mg had been removed from the facility and not administered to the resident. Resident #66 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated July 30, 2013, revealed orders for [MEDICATION NAME] (pain medication) 5/325 mg every four hours as needed for pain. Review of the Controlled Drug Record dated July 2013, provided by the facility, revealed four [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg were removed from the facility and not administered to the resident. Resident #39 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated June 2013 and July 30, 2013, revealed orders for [MEDICATION NAME]-[MEDICATION NAME] 7.5/500 mg every six hours as needed for pain. Review of the Controlled Drug Record dated June through July 2013, provided by the facility, revealed eighteen [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg were removed from the facility and not administered to the resident. Resident #118 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated June 2013 and July 30, 2013, revealed orders for [MEDICATION NAME]-[MEDICATION NAME] 7.5/500 mg every four hours as needed for pain. Review of the Controlled Drug Record dated June through July 2013, provided by the facility, revealed four [MEDICATION NAME]-[MEDICATION NAME] 7.5/500 mg were removed from the facility and not administered to the resident. Resident #100 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated June 2013, July 2013, and August 2013, revealed orders for [MEDICATION NAME]-[MEDICATION NAME] 10/500 mg every six hours as needed for pain. Review of the Controlled Drug Record dated June through August 2013, provided by the facility, revealed twenty-three [MEDICATION NAME]-[MEDICATION NAME] 10/500 mg were removed from the facility and not administered to the resident. Resident #69 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated June 2013 revealed orders for [MEDICATION NAME]-[MEDICATION NAME] 7.5/325 mg every six hours as needed for pain. Review of the Controlled Drug Record dated June 2013, provided by the facility, revealed eight [MEDICATION NAME]-[MEDICATION NAME] 7.5/325 mg were removed from the facility and not administered to the resident. Resident #91 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Physician's Recapitulation Orders dated June 2013 revealed orders for [MEDICATION NAME] 20 mg two tablets four times a day for pain. Review of the Controlled Drug Record dated June 2013 revealed 30 [MEDICATION NAME] 20 mg were removed from the facility and not administered to the resident. Review of facility policy, Abuse Prohibition, dated October 1, 2008, revealed .Misappropriation of resident property is defined as the deliberate.wrongful.use of a resident's belongings.the Administrator.shall take all necessary corrective actions depending on the investigation. Review of the facility's policy Management of Controlled Drugs revised October 1, 2012, revealed, .Storage: Two licensed nurses are required to document placement of controlled drugs into inventory.Destruction: Two licensed professionals are required to destroy and document destruction of controlled drugs.Centers will use the 'controlled Substances Book' a bound books system from which the pages cannot be removed, for ongoing tracking of all controlled drugs on each medication cart.Storage and Maintenance of Controlled Drugs.Two licensed nursing staff are required to immediately log the received medication into the 'Controlled Substances Book'.One licensed nursing staff will log the required information for each entry and sign the entry.The second licensed nursing staff will witness the documentation and sign the entry.To store drugs awaiting destruction.Perform count of drugs to be stored. Count to be done by DON or designee and licensed nursing staff.Signatures of two licensed nursing staff are required.document on Index Page date drug removed, by whom and highlight 'off' the Index Page.Two licensed nursing staff must sign the highlighted removed drug entry line on the Index Page.Document the disposition to storage in the bound destruction book located in the storage area.Signatures of two licensed nursing staff are required. Review of the facility investigation revealed Licensed Practical Nurse (LPN) #4 reported on August 27, 2013, LPN #4 had been taking the residents' discontinued medications and signing as needed (prn) medications as administered to residents, but keeping the medications. Further review revealed the facility investigated all residents who received narcotics (pain medications) to determine all residents who had been victims of the misappropriation of pain medications. Further review revealed the facility investigated the medication diversion and no residents had been found to have experienced uncontrolled pain. Review of a facility e-mail from the Consultant Pharmacist dated September 9, 2013, revealed a nurse was diverting controlled substances by several different methods in order to avoid detection. The nurse was diverting by taking the entire card and declining the inventory sheet upon delivery by the courier; taking the balance of the card and inventory sheet on medications when a new sheet had arrived from the pharmacy; and had also documented giving PRN pain medications to several residents (11) and not actually administering the pain medications. The pharmacist recommendations were two nurses must sign for delivery from courier; two nurses must sign to zero out a sheet from shift change reports; two nurses must

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**
NAME OF PROVIDER OF SUPPLIER **WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **32 MEMORIAL DRIVE** **WINCHESTER, TN 37398**	

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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F 0224	(continued... from page 4) count and verify discontinued meds to be destroyed; and, facility will begin using hard bound books for declining inventory sheets. Interview with the Administrator on September 24, 2013, at 10:38 a.m., in the Conference Room, confirmed the facility had completed pain assessments on the residents and determined no resident had been without medications or had been in pain. Continued interview confirmed the facility had not reimbursed the residents for the misappropriation of the medications. Interview with the DON on September 24, 2013, from 2:11 p.m., until 3:00 p.m., in the Conference Room, confirmed the facility had not followed the policy dated October 1, 2012, and had only required one licensed nurse to sign for controlled substances from the courier, destroy the empty narcotic cards, and remove the narcotic count sheets from the Controlled Substance Card Count Sheet. The facility's failure to follow policy and procedure for receipt and destruction of narcotics enabled LPN #4 to divert narcotics for personal use from residents living in the facility. C/O #

F 0224

Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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F 0224	(continued... from page 5) determine all residents who had been victims of the misappropriation of pain medications. Further review revealed the facility investigated the medication diversion and no residents had been found to have experienced uncontrolled pain. Review of a facility e-mail from the Consultant Pharmacist dated September 9, 2013, revealed a nurse was diverting controlled substances by several different methods in order to avoid detection. The nurse was diverting by taking the entire card and declining the inventory sheet upon delivery by the courier; taking the balance of the card and inventory sheet on medications when a new sheet had arrived from the pharmacy; and had also documented giving PRN pain medications to several residents (11) and not actually administering the pain medications. The pharmacist recommendations were two nurses must sign for delivery from courier; two nurses must sign to zero out a sheet from shift change reports; two nurses must count and verify discontinued meds to be destroyed; and, facility will begin using hard bound books for declining inventory sheets. Interview with the Administrator on September 24, 2013, at 10:38 a.m., in the Conference Room, confirmed the facility had completed pain assessments on the residents and determined no resident had been without medications or had been in pain. Continued interview confirmed the facility had not reimbursed the residents for the misappropriation of the medications. Interview with the DON on September 24, 2013, from 2:11 p.m., until 3:00 p.m., in the Conference Room, confirmed the facility had not followed the policy dated October 1, 2012, and had only required one licensed nurse to sign for controlled substances from the courier, destroy the empty narcotic cards, and remove the narcotic count sheets from the Controlled Substance Card Count Sheet. The facility's failure to follow policy and procedure for receipt and destruction of narcotics enabled LPN #4 to divert narcotics for personal use from residents living in the facility. C/O #
F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility investigation, observation, review of facility policy, and interview, the facility failed to follow policy and procedures for a sexual abuse investigation for two residents (#77, #42) and failed to investigate an attempted removal of a pain patch for one resident (#33) of sixty-five residents reviewed. The findings included: Resident #77 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; required no assistance with transfers, walking in room, walking in corridor, and/or locomotion on unit; and needed limited assistance with dressing. Medical record review of the Care Plan dated July 10, 2013, revealed, .inappropriate sexual behaviors towards others at times.explain behavior not acceptable.may be unable to stay at the facility.alert and oriented at times.self care deficit cognitive impairment.ambulated with a rolling walker. Review of a facility investigation dated August 2, 2013, revealed Licensed Practical Nurse (LPN) #8 was called to resident #77's room where other staff members had gathered and were unable to open the door. The LPN was able to open the door enough to view resident #77 holding a wheelchair against the door. The LPN was able to gain entrance and found resident #77 had no bottoms on and resident #42 was lying on the bed in a fetal position with only a shirt and a brief on, with the pants and shoes on the floor. Resident #42 was placed in the wheelchair and taken to his/her room. The physician and the families of the residents were notified. The residents were kept separated and were monitored by the staff until both were transferred for further evaluation. Medical record review of a hospital discharge record dated August 3, 2013, revealed, .transfer from a psych (psychiatric) ward as he/she has only Dementia which was not considered as an acute psy (psychiatric) issue and does not belong on acute psy unit. Review of a facility investigation dated August 8, 2013, revealed, .Suspected Sexual Altercation. Medical record review of a nursing assessment dated [DATE], revealed, .Decision Making: modified impaired-poor, supervision required.Behavioral symptoms: none of the above (socially inappropriate not marked). Medical record review of a Physician Telephone Order dated August 8, 2013, revealed, Flutamide 250 mg (milligram) Capsule by mouth every 12 hours everyday po (by mouth) BID (twice daily) increased libido (Flutamide was a medication ordered to decrease the resident's libido). Medical record review of an Interdisciplinary Department Note (IDT) dated August 15, 2013, revealed, .return from Geropsych Unit for inappropriate behavior.from August 2, 2013 through August 8, 2013, no issues have been noted.alert with confusion. Medical record review of a physician progress notes [REDACTED]. Medical record review of a physician progress notes [REDACTED]. Medical record review revealed no Psychiatric Notes since admission for sexually inappropriate behaviors. Observation on September 26, 2013, at 9:50 a.m., in the front lobby revealed resident #77 sitting in a chair and talking to visitors and residents. Observation on October 1, 2013, at 8:35 a.m., in resident #77's room revealed the resident lying on the bed watching television. Observation on October 1, 2013, at 5:20 p.m., in the dining room revealed resident #77 sitting at a table with three female residents eating supper. Resident #42 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; required extensive assistance with bed mobility, transfers, and locomotion on unit; and required total dependence for locomotion off unit and toilet use. Medical record review of a Triage from the hospital dated August 2, 2013, revealed, .Chief Complaint: 'tried to have sex with me.touch along my vagina with his hand'.denied penetration by penis. Medical record review of Emergency Department records dated August 2, 2013, revealed, .Stated Complaint Alleged Assault.Police Department has been notified.Course of Treatment no evidence of sexual assault noted on this exam.Primary Impression: alleged sexual assault-unfounded. Review of facility policy, Abuse Prohibition, dated October 1, 2008, revealed, .Facilities shall prohibit abuse.for all residents.prevention of occurrences.investigations of incidents and allegations.the Administrator.shall conduct an immediate and thorough investigation which shall focus on.causative factors; interventions to prevent further injury.assign a representative from social services or designee to monitor the resident's feelings concerning the incident.The Administrator shall take all necessary corrective actions depending on the results of the investigation. Observation on September 26, 2013, at 10:10 a.m., in the physical therapy room revealed resident #42 participating in physical therapy, alert, and talking to staff. Observation on October 1, 2013, at 8:36 a.m., in resident #42's room, revealed the resident lying on the bed asleep. Observation on October 1, 2013, at 4:30 p.m., in front of the nurses' station, revealed resident #42 self-propelling in the wheelchair. Interview with the Administrator on October 1, 2013, in the Administrator's office confirmed there were no causative factors, interventions, or corrective actions included in the investigation for the sexual altercation between residents #77 and #42. Continued interview confirmed the facility had failed to follow the policy and procedure for investigating allegations of resident to resident sexual abuse. Resident #33 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was cognitively intact; required extensive assistance with all Activities of Daily Living (ADL's); and had frequent pain that limited daily activities and made it hard to sleep at night. Review of a facility concern dated July 25, 2013, at 10:00 a.m., written by the Director of Nursing (DON) revealed, .Resident asked to speak with me regarding an employee.resident stated that he/she felt an employee had attempted to remove his/her pain patch.employee suspended pending outcome of the investigation. Interview with the resident on October 3, 2013, at 10:00 a.m., in the resident's room, revealed the resident woke up a few months ago and a Certified Nurse Aide (CNA) was messing with my pain patch. Continued interview revealed the resident reported the incident to the DON and the resident never saw the employee again. Interview with the DON on October 3, 2013, at 2:30 p.m., in the Administrator's office confirmed CNA #8 had been terminated due to an alleged attempt to remove a pain patch from resident #33. Interview with the Administrator on October 3, 2013, at 2:35 p.m., in the Administrator's office, confirmed the facility had failed to investigate and report to the appropriate State Agency the attempted removal of a pain patch from a sleeping resident. C/O # , #
F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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Medical record review of the Care Plan dated July 10, 2013, revealed, .inappropriate sexual behaviors towards others at times.explain behavior not acceptable.may be unable to stay at the facility.alert and oriented at times.self care deficit cognitive impairment.ambulated with a rolling walker. Review of a facility investigation dated August 2, 2013, revealed Licensed Practical Nurse (LPN) #8 was called to resident #77's room where other staff members had gathered and were unable to open the door. The LPN was able to open the door enough to view resident #77 holding a wheelchair against the door. The LPN was able to gain entrance and found resident #77 had no bottoms on and resident #42 was lying on the bed in a fetal position with only a shirt and a brief on, with the pants and shoes on the floor. Resident #42 was placed in the wheelchair and taken to his/her room. The physician and the families of the residents were notified. The residents were kept separated and were monitored by the staff until both were transferred for further evaluation. Medical record review of a hospital discharge record dated August 3, 2013, revealed, .transfer from a psych (psychiatric) ward as he/she has only Dementia which was not considered as an acute psy (psychiatric) issue and does not belong on acute psy unit. Review of a facility investigation dated August 8, 2013, revealed, .Suspected Sexual Altercation. Medical record review of a nursing assessment dated [DATE], revealed, .Decision Making: modified impaired-poor, supervision required.Behavioral symptoms: none of the above (socially inappropriate not marked). Medical record review of a Physician Telephone Order dated August 8, 2013, revealed, Flutamide 250 mg (milligram) Capsule by mouth every 12 hours everyday po (by mouth) BID (twice daily) increased libido (Flutamide was a medication ordered to decrease the resident's libido). Medical record review of an Interdisciplinary Department Note (IDT) dated August 15, 2013, revealed, .return from Geropsych Unit for inappropriate behavior.from August 2, 2013 through August 8, 2013, no issues have been noted.alert with confusion. Medical record review of a physician progress notes [REDACTED]. Medical record review of a physician progress notes [REDACTED]. Medical record review revealed no Psychiatric Notes since admission for sexually inappropriate behaviors. Observation on September 26, 2013, at 9:50 a.m., in the front lobby revealed resident #77 sitting in a chair and talking to visitors and residents. Observation on October 1, 2013, at 8:35 a.m., in resident #77's room revealed the resident lying on the bed watching television. Observation on October 1, 2013, at 5:20 p.m., in the dining room revealed resident #77 sitting at a table with three female residents eating supper. Resident #42 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; required extensive assistance with bed mobility, transfers, and locomotion on unit; and required total dependence for locomotion off unit and toilet use. Medical record review of a Triage from the hospital dated August 2, 2013, revealed, .Chief Complaint: 'tried to have sex with me.touch along my vagina with his hand'.denied penetration by penis. Medical record review of Emergency Department records dated August 2, 2013, revealed, .Stated Complaint Alleged Assault.Police Department has been notified.Course of Treatment no evidence of sexual assault noted on this exam.Primary Impression: alleged sexual assault-unfounded. Review of facility policy, Abuse Prohibition, dated October 1, 2008, revealed, .Facilities shall prohibit abuse.for all residents.prevention of occurrences.investigations of incidents and allegations.the Administrator.shall conduct an immediate and thorough investigation which shall focus on.causative factors; interventions to prevent further injury.assign a representative from social services or designee to monitor the resident's feelings concerning the incident.The Administrator shall take all necessary corrective actions depending on the results of the investigation. Observation on September 26, 2013, at 10:10 a.m., in the physical therapy room revealed resident #42 participating in physical therapy, alert, and talking to staff. Observation on October 1, 2013, at 8:36 a.m., in resident #42's room, revealed the resident lying on the bed asleep. Observation on October 1, 2013, at 4:30 p.m., in front of the nurses' station, revealed resident #42 self-propelling in the wheelchair. Interview with the Administrator on October 1, 2013, in the Administrator's office confirmed there were no causative factors, interventions, or corrective actions included in the investigation for the sexual altercation between residents #77 and #42. Continued interview confirmed the facility had failed to follow the policy and procedure for investigating allegations of resident to resident sexual abuse. Resident #33 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was cognitively intact; required extensive assistance with all Activities of Daily Living (ADL's); and had frequent pain that limited daily activities and made it hard to sleep at night. Review of a facility concern dated July 25, 2013, at 10:00 a.m., written by the Director of Nursing (DON) revealed, .Resident asked to speak with me regarding an employee.resident stated that he/she felt an employee had attempted to remove his/her pain patch.employee suspended pending outcome of the investigation. Interview with the resident on October 3, 2013, at 10:00 a.m., in the resident's room, revealed the resident woke up a few months ago and a Certified Nurse Aide (CNA) was messing with my pain patch. Continued interview revealed the resident reported the incident to the DON and the resident never saw the employee again. Interview with the DON on October 3, 2013, at 2:30 p.m., in the Administrator's office confirmed CNA #8 had been terminated due to an alleged attempt to remove a pain patch from resident #33. Interview with the Administrator on October 3, 2013, at 2:35 p.m., in the Administrator's office, confirmed the facility had failed to investigate and report to the appropriate State Agency the attempted removal of a pain patch from a sleeping resident. C/O # , #
F 0226	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, review of facility customer concern, and interview, the facility failed to follow policies for investigation of misappropriation of resident funds for one resident (#10) of fifty-one residents reviewed. The findings included: Resident #10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the admission Minimum Data Set (MDS) dated [DATE], revealed, .cognitively intact, very important to choose own clothes.have a place to lock your things to keep them safe.required extensive assistance in transfers and toileting. Review of a Nursing assessment dated [DATE], revealed the resident was alert to person, place, time, and situation. Medical record review of a Care Plan dated June 20, 2013, revealed the resident had a self care deficit in ADL's (Activities of Daily Living) due to decreased balance and pain; required assistance with toileting; and was at risk for falls. Review of facility policy, Abuse Prohibition, dated October 1, 2008, revealed, .the employee alleged to have committed the act of abuse shall be immediately removed from duty, pending investigation. Review of facility Customer Concern revealed on July 7, 2013, (Sunday) resident #10 reported to Licensed Practical Nurse (LPN) #1 a Certified Nurse Aide (CNA) was going through the resident's belongings when the resident woke up I had $92.00 and only $2.00 was left. Review of a police report dated July 7, 2013, revealed an officer responded to the facility to take a report of missing money from resident #10. The resident named CNA #2 to the officer as the accused. Review of CNA #2's payroll record revealed CNA #2 worked July 8, 2013, 6:53 a.m. to 3:03 p.m., and July 9, 2013, 6:53 a.m. to 8:00 a.m. Review of CNA #2's employee file revealed the employee was suspended on July 9, 2013 (two days after the incident was reported). Review of a Petty Cash Account Reimbursement Request dated July 12, 2013, revealed the resident was reimbursed the missing $90.00. Interview with the Administrator on September 23, 2013, at 2:30 p.m., in the conference room confirmed the alleged employee worked July 8, 2013, (7.33 hours) and July 9, 2013, (1 hour). Further interview confirmed the facility had failed to remove the CNA from duty pending the investigation. C/O #
F 0226	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, review of facility customer concern, and interview, the facility

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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F 0226	(continued... from page 7) failed to follow policies for investigation of misappropriation of resident funds for one resident (#10) of fifty-one residents reviewed. The findings included: Resident #10 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the admission Minimum Data Set (MDS) dated [DATE], revealed, .cognitively intact, very important to choose own clothes.have a place to lock your things to keep them safe.required extensive assistance in transfers and toileting. Review of a Nursing assessment dated [DATE], revealed the resident was alert to person, place, time, and situation. Medical record review of a Care Plan dated June 20, 2013, revealed the resident had a self care deficit in ADL's (Activities of Daily Living) due to decreased balance and pain; required assistance with toileting; and was at risk for falls. Review of facility policy, Abuse Prohibition, dated October 1, 2008, revealed, .the employee alleged to have committed the act of abuse shall be immediately removed from duty, pending investigation. Review of facility Customer Concern revealed on July 7, 2013, (Sunday) resident #10 reported to Licensed Practical Nurse (LPN) #1 a Certified Nurse Aide (CNA) was going through the resident's belongings when the resident woke up I had $92.00 and only $2.00 was left. Review of a police report dated July 7, 2013, revealed an officer responded to the facility to take a report of missing money from resident #10. The resident named CNA #2 to the officer as the accused. Review of CNA #2's payroll record revealed CNA #2 worked July 8, 2013, 6:53 a.m. to 3:03 p.m., and July 9, 2013, 6:53 a.m. to 8:00 a.m. Review of CNA #2's employee file revealed the employee was suspended on July 9, 2013 (two days after the incident was reported). Review of a Petty Cash Account Reimbursement Request dated July 12, 2013, revealed the resident was reimbursed the missing $90.00. Interview with the Administrator on September 23, 2013, at 2:30 p.m., in the conference room confirmed the alleged employee worked July 8, 2013, (7.33 hours) and July 9, 2013, (1 hour). Further interview confirmed the facility had failed to remove the CNA from duty pending the investigation. C/O #
F 0241	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, facility policy review, and interview, the facility failed to request and obtain permission prior to entering a resident's room for two residents (#29, #28) of fifty-one residents reviewed. The findings included: Resident #29 was readmitted to the facility on December, 2, 2011, with diagnoses including [MEDICAL CONDITION] Disorder, [MEDICAL CONDITION], Paranoid [MEDICAL CONDITION], Episodic Mood Disorder, Anxiety Disorder, and [MEDICAL CONDITION] Disorder. Medical record review of the Quarterly Minimum Data Set, dated dated dated [DATE], revealed resident #29 was cognitively intact, could make self understood, understood others, and had adequate hearing and vision. Observation on September 30, 2013, at 4:15 p.m., revealed resident #29 was in the resident's room with the door closed. Further observation revealed Certified Nurse Aide (CNA) #10 knocked on the closed door and entered the room without obtaining the resident's permission. Further observation revealed a housekeeper knocked on the closed door at 4:20 p.m., entered the resident's room, and proceeded to go to the trash can without asking the resident's permission. Resident #28 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Annual Minimum Data Set, dated dated dated [DATE], revealed resident #28 was moderately cognitively impaired, could make self understood, understood others, and had adequate hearing and vision. Observation on October 1, 2013, at 3:20 p.m., revealed resident #28 was awake, in the bed, and the door to the room was closed. Further observation revealed CNA #9 entered the resident's room without knocking on the closed door or asking the resident's permission to enter the room. Further observation revealed housekeeper #1 entered the resident's room and went to the resident's bathroom without asking the resident's permission. Review of facility policy, Treatment: Consideration and Respect, effective date June 1, 1996, revision date September 1, 2013, revealed, .1.6 Respect patient's private space and property. 1.6.2 Knock on doors and request permission to enter. Interview with CNA #9 on October 1, 2013, at 3:25 p.m., in resident #28's room, confirmed the CNA and housekeeper had failed to knock on the closed door, announce their presence, and obtain the resident's permission prior to entering the room.
F 0241	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, facility policy review, and interview, the facility failed to request and obtain permission prior to entering a resident's room for two residents (#29, #28) of fifty-one residents reviewed. The findings included: Resident #29 was readmitted to the facility on December, 2, 2011, with diagnoses including [MEDICAL CONDITION] Disorder, [MEDICAL CONDITION], Paranoid [MEDICAL CONDITION], Episodic Mood Disorder, Anxiety Disorder, and [MEDICAL CONDITION] Disorder. Medical record review of the Quarterly Minimum Data Set, dated dated dated [DATE], revealed resident #29 was cognitively intact, could make self understood, understood others, and had adequate hearing and vision. Observation on September 30, 2013, at 4:15 p.m., revealed resident #29 was in the resident's room with the door closed. Further observation revealed Certified Nurse Aide (CNA) #10 knocked on the closed door and entered the room without obtaining the resident's permission. Further observation revealed a housekeeper knocked on the closed door at 4:20 p.m., entered the resident's room, and proceeded to go to the trash can without asking the resident's permission. Resident #28 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Annual Minimum Data Set, dated dated dated [DATE], revealed resident #28 was moderately cognitively impaired, could make self understood, understood others, and had adequate hearing and vision. Observation on October 1, 2013, at 3:20 p.m., revealed resident #28 was awake, in the bed, and the door to the room was closed. Further observation revealed CNA #9 entered the resident's room without knocking on the closed door or asking the resident's permission to enter the room. Further observation revealed housekeeper #1 entered the resident's room and went to the resident's bathroom without asking the resident's permission. Review of facility policy, Treatment: Consideration and Respect, effective date June 1, 1996, revision date September 1, 2013, revealed, .1.6 Respect patient's private space and property. 1.6.2 Knock on doors and request permission to enter. Interview with CNA #9 on October 1, 2013, at 3:25 p.m., in resident #28's room, confirmed the CNA and housekeeper had failed to knock on the closed door, announce their presence, and obtain the resident's permission prior to entering the room.
F 0250	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility investigation, review of facility policy, and interview, the facility failed to provide social services for two residents (#77, #42) of sixty-five residents reviewed. The findings included: Resident #77 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; required no assistance with transfers, walking in room, walking in corridor, and/or locomotion on unit; and needed limited assistance with dressing. Medical record review of the Care Plan dated July 10, 2013, revealed, .inappropriate sexual behaviors towards others at times.explain behavior not acceptable.may be unable to stay at the facility.alert and oriented at times.self care deficit cognitive impairment.ambulated with a rolling walker. Review of a facility investigation dated August 2, 2013, revealed Licensed Practical Nurse (LPN) #8 was called to resident #77's room where other staff members had gathered and were unable to open the door. The LPN was able to open the door enough to view resident #77 holding a wheelchair against the door. The LPN was able to gain entrance to find resident #77 had no bottoms on and resident #42 was lying on the bed in a fetal position with only a shirt and a brief on, with the pants and shoes on the floor. Resident #42 was placed in the wheelchair and taken to his/her room. The physician and the families of the residents were notified. The residents were kept separated and were monitored by the staff until both were transferred for further evaluation. Medical record review of a hospital discharge record dated August 3, 2013, revealed, .transfer from a psych (psychiatric) ward as he/she has only Dementia which was not considered as an acute psy (psychiatric) issue and does not belong on acute psy unit. Review of a facility investigation dated August 8, 2013, revealed, .Suspected Sexual

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F 0250	(continued... from page 8) Altercation. Medical record review of a Physician Telephone Order dated August 8, 2013, revealed, Flutamide 250 mg (milligram) Capsule by mouth every 12 hours everyday po (by mouth) BID (twice daily) increased libido (Flutamide was a medication ordered to decrease the resident's libido). Medical record review of an Interdisciplinary Department Note (IDT) note dated August 15, 2013, revealed, .return from Geropsych Unit for inappropriate behavior.from August 2, 2013, through August 8, 2013, no issues have been noted.alert with confusion. Medical record review of a physician progress notes [REDACTED]. Medical record review revealed no Psychiatric Notes since admission for sexually inappropriate behaviors. Resident #42 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; required extensive assistance with bed mobility, transfers, and locomotion on unit; and required total dependence for locomotion off unit and toilet use. Medical record review of a Triage from the hospital dated August 2, 2013, revealed, .Chief Complaint: 'tried to have sex with me.touch along my vagina with his hand'.denied penetration by penis. Medical record review of an Emergency Department record dated August 2, 2013, revealed, .Stated Complaint Alleged Assault.Police Department has been notified.Course of Treatment no evidence of sexual assault noted on this exam.Primary Impression: alleged sexual assault-unfounded. Review of facility policy, Abuse Prohibition, dated October 1, 2008, revealed, .Facilities shall prohibit abuse.for all residents.prevention of occurrences.investigations of incidents and allegations.the Administrator.shall conduct an immediate and thorough investigation which shall focus on.causative factors; interventions to prevent further injury.assign a representative from social services or designee to monitor the resident's feelings concerning the incident.The Administrator shall take all necessary corrective actions depending on the results of the investigation. Interview with the Social Service (SS) Director on October 1, 2013, at 8:46 a.m., in the SS office revealed the Social Worker had not followed up with the families or residents since the sexual altercation. Interview revealed the Social Worker had no involvement with the situation. Interview with the Administrator on October 1, 2013, in the Administrator's office, confirmed the facility had failed to provide medically related social services to two residents and families after a sexual altercation at the facility. C/O #
F 0250	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility investigation, review of facility policy, and interview, the facility failed to provide social services for two residents (#77, #42) of sixty-five residents reviewed. The findings included: Resident #77 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; required no assistance with transfers, walking in room, walking in corridor, and/or locomotion on unit; and needed limited assistance with dressing. Medical record review of the Care Plan dated July 10, 2013, revealed, .inappropriate sexual behaviors towards others at times.explain behavior not acceptable.may be unable to stay at the facility.alert and oriented at times.self care deficit cognitive impairment.ambulated with a rolling walker. Review of a facility investigation dated August 2, 2013, revealed Licensed Practical Nurse (LPN) #8 was called to resident #77's room where other staff members had gathered and were unable to open the door. The LPN was able to open the door enough to view resident #77 holding a wheelchair against the door. The LPN was able to gain entrance to find resident #77 had no bottoms on and resident #42 was lying on the bed in a fetal position with only a shirt and a brief on, with the pants and shoes on the floor. Resident #42 was placed in the wheelchair and taken to his/her room. The physician and the families of the residents were notified. The residents were kept separated and were monitored by the staff until both were transferred for further evaluation. Medical record review of a hospital discharge record dated August 3, 2013, revealed, .transfer from a psych (psychiatric) ward as he/she has only Dementia which was not considered as an acute psy (psychiatric) issue and does not belong on acute psy unit. Review of a facility investigation dated August 8, 2013, revealed, .Suspected Sexual Altercation. Medical record review of a Physician Telephone Order dated August 8, 2013, revealed, Flutamide 250 mg (milligram) Capsule by mouth every 12 hours everyday po (by mouth) BID (twice daily) increased libido (Flutamide was a medication ordered to decrease the resident's libido). Medical record review of an Interdisciplinary Department Note (IDT) note dated August 15, 2013, revealed, .return from Geropsych Unit for inappropriate behavior.from August 2, 2013, through August 8, 2013, no issues have been noted.alert with confusion. Medical record review of a physician progress notes [REDACTED]. Medical record review revealed no Psychiatric Notes since admission for sexually inappropriate behaviors. Resident #42 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; required extensive assistance with bed mobility, transfers, and locomotion on unit; and required total dependence for locomotion off unit and toilet use. Medical record review of a Triage from the hospital dated August 2, 2013, revealed, .Chief Complaint: 'tried to have sex with me.touch along my vagina with his hand'.denied penetration by penis. Medical record review of an Emergency Department record dated August 2, 2013, revealed, .Stated Complaint Alleged Assault.Police Department has been notified.Course of Treatment no evidence of sexual assault noted on this exam.Primary Impression: alleged sexual assault-unfounded. Review of facility policy, Abuse Prohibition, dated October 1, 2008, revealed, .Facilities shall prohibit abuse.for all residents.prevention of occurrences.investigations of incidents and allegations.the Administrator.shall conduct an immediate and thorough investigation which shall focus on.causative factors; interventions to prevent further injury.assign a representative from social services or designee to monitor the resident's feelings concerning the incident.The Administrator shall take all necessary corrective actions depending on the results of the investigation. Interview with the Social Service (SS) Director on October 1, 2013, at 8:46 a.m., in the SS office revealed the Social Worker had not followed up with the families or residents since the sexual altercation. Interview revealed the Social Worker had no involvement with the situation. Interview with the Administrator on October 1, 2013, in the Administrator's office, confirmed the facility had failed to provide medically related social services to two residents and families after a sexual altercation at the facility. C/O #
F 0278	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and observation, and facility policy review, the facility failed to complete an accurate assessment for pressure ulcers for one resident, (#95) of fourteen residents with pressure ulcers reviewed; and failed to accurately assess the dental status for one resident (#28) of sixty-five residents reviewed. The facility's failure to assess the skin status and the multipodus boot placement resulted in the development of an unstageable pressure ulcer resulting in an amputation below the knee, placed resident #95 in Immediate Jeopardy (a situation in which the provider's non-compliance has caused or likely to cause serious injury, harm, impairment, or death). The Immediate Jeopardy was effective on November 26, 2012, and is ongoing. The Regional Vice President, Diretor of Clinical Services, Administrator and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m. in the conference room. The facility provided and acceptable Allegation of Compliance on November 22, 2013, and a revisit on November 26, 2013, revealed the corrective actions implemented on November 25, 2013, removed the Immediate Jeopardy. Noncompliance for F-278 continues at an D level citation. The findings included: Resident #95 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the admission nursing assessment dated [DATE], revealed the resident had an open area on the left knee, open/abrasion on the right lower extremity, reddened area to the scrotum, sore/scabbed area to the coccyx, reddened right lower extremity, and a reddened area on the right side. Medical record review of the Interim Care Plan dated October 5, 2012, revealed, .potential for pain related to wounds.alteration in skin integrity r/t (related to) Burn.report new open areas. Medical record review of a Nurse's Notes dated October 5, 2012, at 3:45 p.m., revealed, .skin pink warm, multiple red areas D/T (due to)[MEDICAL CONDITION] total Norton plus score of 11 (indicates very high risk). Medical record review of a physician's orders [REDACTED]. Medical record review of the Treatment Administration Record (TAR) dated October 5-31, 2012, revealed, .open area to coccyx apply exuderm change q (every) 3 days (start date October 9, 2012). Medical record review of the admission Minimum Data Set (MDS) dated [DATE],

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F 0278	(continued... from page 9) revealed the resident was moderately impaired for daily decision making; totally dependent for all Activities of Daily Living (ADL's); at risk for pressure ulcers; and had no pressure ulcers on admission. Medical record review revealed the resident was admitted to the hospital October 24-29, 2012, for Altered Mental Status, Urinary Tract Infection, and for treatment of [REDACTED]. Medical record review of the Nursing Assessment Re-admitted d October 29, 2012, revealed, .Skin/Wound condition present: no.red area (coccyx).scabbed area (right lower extremity) scab area (top of right foot).red area (right forearm).(no areas on heels noted).Norton Scale 12 (very high risk). Medical record review of the Care Plan dated October 30, 2012, revealed, .potential for pain related to wounds.alteration in skin integrity r/t Burn.report new open areas.10/30/12 coccyx shearing. Medical record review of the Care Plan dated October 31, 2012, revealed, .Skin (with) Stage II on coccyx. Medical record review of the TAR dated November 1-30, 2012, revealed, .open area to coccyx apply exuderm change q (every) 3 days. Record review of the TAR revealed a start date of October 9, 2012, for this treatment order. Medical record review of a Nurse's Note dated November 26, 2012, at 10:00 a.m., revealed, .Blister noted to L (left) heel. Medical record review of a physician's orders [REDACTED]. Medical record review of an Interdisciplinary Progress Note (IDT) dated December 11, 2012, revealed, .open area to coccyx. and no documentation of the left heel. Medical record review of an IDT note dated December 18, 2012, revealed, .wound care to L heel.area to coccyx healed. Medical record review of the TAR dated December 1-31, 2012, revealed, .open area to coccyx apply exuderm change q (every) 3 days.(start date October 9, 2012).Cleanse blister to left heel.start date 11/26/2012. Medical record review of a Pressure Ulcer Documentation Form dated December 27, 2012, revealed, .Left Heel Stage U (unstageable). Medical record review of an IDT note dated December 28, 2012, revealed, .wound care to L heel. Medical record review of a Pressure Ulcer Documentation Form dated January 3, 2013, revealed .Left Heel Stage U. Medical record review of a Pressure Ulcer Documentation Form dated January 8, 2013, revealed, .Left Heel Stage U. Medical record review of the Care Plan dated January 10, 2013, revealed .Alteration in skin integrity r/t: foot ulcer (left heel) shearing to coccyx.date initiated: 10/29/12.Revision on: 1/10/2013. Medical record review of a quarterly MDS dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all ADL's; at risk for pressure ulcers; had one Stage One pressure ulcer; and no unstageable pressure ulcers. Interview with MDS nurse #1 on October 3, 2013, at 8:00 a.m., in the MDS office, confirmed the MDS dated [DATE], and January 2013, did not include an accurate assessment of the resident's pressure ulcers. Validation of the Credible Allegation of Compliance was accomplished on-site November 26, 2013, through medical record review, review of facility documents, observations and interviews with nursing and administrative staff. The facility provided evidence of in-service training with sign-in sheets for all nursing staff related to pressure ulcer prevention and skin assessments. Medical record review revealed resident #95 had been discharged from the facility on May 6, 2013. Medical record review and observations of residents #73 and #114 (in-house residents with pressure ulcers) confirmed the facility had conducted comprehensive skin assessments by the new Wound Care Nurse, treatments and interventions were in place, and preventative interventions were current on certified nursing assistant kardexs. Interview with the new Wound Care Nurse on November 26, 2013, at the facility, and review of facility documentation confirmed the Wound Care Nurse had completed comprehensive skin assessments on all residents currently in the facility, and had reviewed treatments currently in place. Continued interview confirmed the new Wound Care Nurse had completed, and submitted a Pressure Ulcer Report log to the New Director of Nursing. Further interview with the Wound Care Nurse confirmed the nurse had completed in-service training to all licensed and certified nursing staff related to skin assessments and reporting of changes. Interviews conducted with licensed and certified nursing staff on November 26, 2013, confirmed the staff were able to verbalize skin assessment and reporting policies. Interview with the Minimum Data Set (MDS) Coordinators revealed they were provided the Pressure Ulcer Reports weekly, and had completed an audit for pressure ulcers comprephensive assessment needs. Review of the Treatment Administration Records confirmed the facility had conducted an audit and were monitoring all residents with current pressure ulcers. Interviews conducted on November 26, 2013, with the Administrator and Regional Vice-President of Clinical Operations confirmed the facility had conducted a Quality Assurance Meeting which included discussion of pressure ulcer prevention, treatment and policy review with the new Medical Director. The facility will remain out of compliance at a Scope and Severity level D a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy, until it provides an acceptable plan of correction. C/O # Resident #28 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], and the Annual MDS dated [DATE], revealed the resident was moderately impaired cognitively and had no dental issues. Medical record review of the Medical Nutritional Therapy Quarterly Assessments signed by the Registered Dietitian, dated November 1, 2012, and January 29, 2013, and the Medical Nutritional Therapy Annual Assessment signed by the Registered Dietitian and dated August 14, 2013, revealed, .Oral/Dental: no pain, not edentulous, partial lower dentures, chewing ability WNL (within normal limits). Medical record review of the Nursing Readmission assessment dated [DATE]; and the Nursing Quarterly Assessments dated October 20, 2012, and April 30, 2013, revealed, .1. Oral Problems: None.Teeth: upper right/left and lower right/left: Fair.Lower Dentures. Medical record review of the Dental Progress Note dated January 6, 2012, revealed, .Prosthesis: Upper.Other: No lower jaw for dentures. Observation on September 30, 2013, at 1:08 p.m., revealed the resident was in the dining room. Further observation revealed the resident picked up a hamburger patty on two occasions with a hand and sucked or attempted to bite on the patty and placed the patty back on the hamburger bun. Further observation at 1:18 p.m., revealed a facility staff member asked the resident if the resident needed assistance or wanted something else to eat. Further observation revealed the resident refused the assistance and the alternative food. Further observation revealed none of the hamburger patty was consumed. Interview with the resident, in the resident's room, on October 1, 2013, at 7:58 a.m., and at 3:20 p.m., revealed the resident had lost the lower dentures in another facility and was having problems chewing food. Further interview revealed the resident could not recall if had told anyone in the facility of having difficulty chewing the food. Further interview and observation revealed the resident had a full upper denture in place. Further interview confirmed the resident was not able to chew the hamburger on September 30, 2013. Interview with the resident's direct care Certified Nurse Aide #9 on October 1, 2013, at 3:20 p.m., in the resident's room, revealed the resident .has real teeth that I know of.I never knew (resident) had false teeth. Interview with MDS Coordinator #2 on October 1, 2013, at 4:14 p.m., in the MDS office, confirmed the facility failed to accurately assess the resident's dental status.
F 0278	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and observation, and facility policy review, the facility failed to complete an accurate assessment for pressure ulcers for one resident, (#95) of fourteen residents with pressure ulcers reviewed; and failed to accurately assess the dental status for one resident (#28) of sixty-five residents reviewed. The facility's failure to assess the skin status and the multipodus boot placement resulted in the development of an unstageable pressure ulcer resulting in an amputation below the knee, placed resident #95 in Immediate Jeopardy (a situation in which the provider's non-compliance has caused or likely to cause serious injury, harm, impairment, or death). The Immediate Jeopardy was effective on November 26, 2012, and is ongoing. The Regional Vice President, Diretor of Clinical Services, Administrator and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m. in the conference room. The facility provided and acceptable Allegation of Compliance on November 22, 2013, and a revisit on November 26, 2013, revealed the corrective actions implemented on November 25, 2013, removed the Immediate Jeopardy. Noncompliance for F-278 continues at an D level citation. The findings included: Resident #95 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the admission nursing assessment dated [DATE], revealed the resident had an open area on the left knee, open/abrasion on the right lower extremity, reddened area to the scrotum, sore/scabbed area to the coccyx, reddened right lower extremity, and a reddened area on the right side. Medical record review of the Interim Care Plan dated October 5, 2012, revealed, .potential for pain related to wounds.alteration in skin integrity r/t (related to) Burn.report new open areas. Medical record review of a Nurse's Notes dated October 5, 2012, at 3:45 p.m., revealed, .skin pink warm, multiple red areas D/T (due to)[MEDICAL CONDITION] total Norton plus score of 11 (indicates very high risk). Medical record review of a physician's orders [REDACTED]. Medical record review of the Treatment Administration Record (TAR) dated October 5-31, 2012, revealed, .open area to coccyx apply exuderm change q

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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 0278

(continued... from page 10)
(every) 3 days (start date October 9, 2012). Medical record review of the admission Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all Activities of Daily Living (ADL's); at risk for pressure ulcers; and had no pressure ulcers on admission. Medical record review revealed the resident was admitted to the hospital October 24-29, 2012, for Altered Mental Status, Urinary Tract Infection, and for treatment of [REDACTED]. Medical record review of the Nursing Assessment Re-admitted d October 29, 2012, revealed, .Skin/Wound condition present: no.red area (coccyx).scabbed area (right lower extremity) scab area (top of right foot).red area (right forearm).(no areas on heels noted).Norton Scale 12 (very high risk). Medical record review of the Care Plan dated October 30, 2012, revealed, .potential for pain related to wounds.alteration in skin integrity r/t Burn.report new open areas.10/30/12 coccyx shearing. Medical record review of the Care Plan dated October 31, 2012, revealed, .Skin (with) Stage II on coccyx. Medical record review of the TAR dated November 1-30, 2012, revealed, .open area to coccyx apply exuderm change q (every) 3 days. Record review of the TAR revealed a start date of October 9, 2012, for this treatment order. Medical record review of a Nurse's Note dated November 26, 2012, at 10:00 a.m., revealed, .Blister noted to L (left) heel. Medical record review of a physician's orders [REDACTED]. Medical record review of an Interdisciplinary Progress Note (IDT) dated December 11, 2012, revealed, .open area to coccyx. and no documentation of the left heel. Medical record review of an IDT note dated December 18, 2012, revealed, .wound care to L heel.area to coccyx healed. Medical record review of the TAR dated December 1-31, 2012, revealed, .open area to coccyx apply exuderm change q (every) 3 days.(start date October 9, 2012).Cleanse blister to left heel.start date 11/26/2012. Medical record review of a Pressure Ulcer Documentation Form dated December 27, 2012, revealed, .Left Heel Stage U (unstageable). Medical record review of an IDT note dated December 28, 2012, revealed, .wound care to L heel. Medical record review of a Pressure Ulcer Documentation Form dated January 3, 2013, revealed .Left Heel Stage U. Medical record review of a Pressure Ulcer Documentation Form dated January 8, 2013, revealed, .Left Heel Stage U. Medical record review of the Care Plan dated January 10, 2013, revealed .Alteration in skin integrity r/t: foot ulcer (left heel) shearing to coccyx.date initiated: 10/29/12.Revision on: 1/10/2013. Medical record review of a quarterly MDS dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all ADL's; at risk for pressure ulcers; had one Stage One pressure ulcer; and no unstageable pressure ulcers. Interview with MDS nurse #1 on October 3, 2013, at 8:00 a.m., in the MDS office, confirmed the MDS dated [DATE], and January 2013, did not include an accurate assessment of the resident's pressure ulcers. Validation of the Credible Allegation of Compliance was accomplished on-site November 26, 2013, through medical record review, review of facility documents, observations and interviews with nursing and administrative staff. The facility provided evidence of in-service training with sign-in sheets for all nursing staff related to pressure ulcer prevention and skin assessments. Medical record review revealed resident #95 had been discharged from the facility on May 6, 2013. Medical record review and observations of residents #73 and #114 (in-house residents with pressure ulcers) confirmed the facility had conducted comprehensive skin assessments by the new Wound Care Nurse, treatments and interventions were in place, and preventative interventions were current on certified nursing assistant kardexs. Interview with the new Wound Care Nurse on November 26, 2013, at the facility, and review of facility documentation confirmed the Wound Care Nurse had completed comprehensive skin assessments on all residents currently in the facility, and had reviewed treatments currently in place. Continued interview confirmed the new Wound Care Nurse had completed, and submitted a Pressure Ulcer Report log to the New Director of Nursing. Further interview with the Wound Care Nurse confirmed the nurse had completed in-service training to all licensed and certified nursing staff related to skin assessments and reporting of changes. Interviews conducted with licensed and certified nursing staff on November 26, 2013, confirmed the staff were able to verbalize skin assessment and reporting policies. Interview with the Minimum Data Set (MDS) Coordinators revealed they were provided the Pressure Ulcer Reports weekly, and had completed an audit for pressure ulcers comprerehensive assessment needs. Review of the Treatment Administration Records confirmed the facility had conducted an audit and were monitoring all residents with current pressure ulcers. Interviews conducted on November 26, 2013, with the Administrator and Regional Vice-President of Clinical Operations confirmed the facility had conducted a Quality Assurance Meeting which included discussion of pressure ulcer prevention, treatment and policy review with the new Medical Director. The facility will remain out of compliance at a Scope and Severity level D a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy, until it provides an acceptable plan of correction. C/O #

Resident #28 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], and the Annual MDS dated [DATE], revealed the resident was moderately impaired cognitively and had no dental issues. Medical record review of the Medical Nutritional Therapy Quarterly Assessments signed by the Registered Dietitian, dated November 1, 2012, and January 29, 2013, and the Medical Nutritional Therapy Annual Assessment signed by the Registered Dietitian and dated August 14, 2013, revealed, .Oral/Dental: no pain, not edentulous, partial lower dentures, chewing ability WNL (within normal limits). Medical record review of the Nursing Readmission assessment dated [DATE]; and the Nursing Quarterly Assessments dated October 20, 2012, and April 30, 2013, revealed, .1. Oral Problems: None.Teeth: upper right/left and lower right/left: Fair.Lower Dentures. Medical record review of the Dental Progress Note dated January 6, 2012, revealed, .Prosthesis: Upper.Other: No lower jaw for dentures. Observation on September 30, 2013, at 1:08 p.m., revealed the resident was in the dining room. Further observation revealed the resident picked up a hamburger patty on two occasions with a hand and sucked or attempted to bite on the patty and placed the patty back on the hamburger bun. Further observation at 1:18 p.m., revealed a facility staff member asked the resident if the resident needed assistance or wanted something else to eat. Further observation revealed the resident refused the assistance and the alternative food. Further observation revealed none of the hamburger patty was consumed. Interview with the resident, in the resident's room, on October 1, 2013, at 7:58 a.m., and at 3:20 p.m., revealed the resident had lost the lower dentures in another facility and was having problems chewing food. Further interview revealed the resident could not recall if had told anyone in the facility of having difficulty chewing the food. Further interview and observation revealed the resident had a full upper denture in place. Further interview confirmed the resident was not able to chew the hamburger on September 30, 2013. Interview with the resident's direct care Certified Nurse Aide #9 on October 1, 2013, at 3:20 p.m., in the resident's room, revealed the resident .has real teeth that I know of.I never knew (resident) had false teeth. Interview with MDS Coordinator #2 on October 1, 2013, at 4:14 p.m., in the MDS office, confirmed the facility failed to accurately assess the resident's dental status.

F 0280

Allow the resident the right to participate in the planning or revision of the resident's care plan.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, review of facility documentation, observation, review of facility policy, and interview, the facility failed to revise the care plan following falls to include interventions for the staff to implement to prevent future falls for nine residents (#35, #73, #62, #120, #26, #93, #100, #52, #119) of twenty-two residents reviewed with falls; failed to revise the care plan addressing pressure ulcers for staff to implement care plans for four (#35, #73, #114, #79) of fourteen residents reviewed with pressure ulcers; and failed to revise the care plan with interventions for staff to implement after a sexual altercation for two residents (#77, #42) of sixty-five residents reviewed. The facility's failure to address interventions on the care plan for pressure ulcers for three residents (#35, #73, and #114) resulted in staff unfamiliar with the care to be provided placing residents in Immediate Jeopardy (a situation in which the provider's non-compliance has caused or likely to cause serious injury, harm, impairment, or death). The failure of the facility to revise the care plans addessing falls with new interventions resulted in a [MEDICAL CONDITION] for one resident (#35) and a fractured clavicle for one resident (#73) placing the residents in Immediate Jeopardy. The Immediate Jeopardy was effective on November 26, 2012, and is ongoing. The Regional Vice President, Director of Clinical Services, Administrator and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m. in the conference room. The findings included: Resident #35 was admitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Minimum
Data Set (MDS) dated [DATE], revealed a Brief Mental Status score of 14, indicating no cognitive impairment. Medical record review of the Fall Risk Evaluation completed on admission and at quarterly reviews on March 8, and June 8, 2013, revealed the resident was high risk for falls. Medical record review of facility falls reports and Care Plans (from December 2012 through October 2013) revealed the resident had a history of [REDACTED]. January 12, 2013, at 4:20 a.m., fell on the way to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER **WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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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F 0280	(continued... from page 11) the bathroom and Safety alarm was care planned; January 15, 2013, no fall report provided for review and no new interventions care planned; March 6, 2013 at 7:50 a.m., fall report revealed fell on the way to the bathroom, new interventions care planned; March 21, 2013, at 7:20 a.m., fall report was not completed, no new interventions care planned; April 1, 2013, at 11:55 p.m., fall report revealed resident on the way to the bathroom, the Care Plan recorded a new intervention for a scoop mattress; May 21, 2013, at 4:15 p.m., fall report revealed this was a witnessed fall, no new interventions were implemented; May 25, 2013, at 7:25 a.m., fall report revealed a CNA heard the safety alarm, saw the bathroom emergency call light blinking, and found the resident in the bathroom on the floor with bruises, a skin tear to the left arm. Review of the Care Plan revealed no new interventions were implemented; July 19, 2013, at 8:20 a.m., fall report was not initiated until October 1, 2013, by the DON, during the annual survey, no investigation done. Review revealed the resident was found on the floor and old skin tear re-opened. Review of the Care Plan revealed, 7/19/13 fall.Intervention 7/19/13 Reacher/grabber. August 12, 2013, at 3:40 a.m., fall report revealed To resident room to answer call light, resident sitting in floor beside the bed.noted abrasion to right cheek and resident c/o (complained of) pain to right hip. Medical record review of a History and Physical on admission to the hospital on August 12, 2013, revealed, .Assessment and Plan: fall with right intertrochanteric (hip) fracture.still alert.wants surgery. Medical record review of the an Interdisciplinary Progress Note dated August 19, 2013, revealed on this date the resident returned from the hospital following the surgery of the right hip. Medical record review of the Re-admission nursing assessment dated [DATE], revealed the resident returned from a hospitalization due to a Urinary Tract Infection. Medical record review of the Fall Risk Evaluation dated October 7, 2013, revealed a score of 13, high risk for falls. Review of facility documentation revealed the resident fell in the bathroom at 4:32 a.m., on October 9, 2013. Review of the resident's Care Plan revealed the resident did not have the individualized interventions previously put into place resumed on re-admission. Interview with the Director of Nurses (DON) in the conference room at 1:00 p.m., on October 28, 2013, confirmed previous individualized interventions were not resumed when the resident returned to the facility October 7, 2013. Interview confirmed the Interdisciplinary Team did not complete an investigate and develop new appoaches after the October 9, 2013, fall. Medical record review of the Nursing Assessment completed for the readmission on August 19, 2013, revealed the resident did not have a pressure ulcer. Medical record review of the weekly skin checks recorded on the treatment record revealed the resident's skin was intact on August 20, 2013. Medical record review of the Skin Integrity Report, initiated for a right heel pressure ulcer, indicated the pressure ulcer was identified on August 25, 2013, and intially staged and measured on August 30, 2013, as a Deep Tissue Injury measuring 3 cm (centimeters) Legnth, 4 cm Width, and undetermined Depth due to the skin intact with Appearance.deep purple. Medical record review of the physician's orders [REDACTED]. Observation of the resident at intervals on October 1, 2013, from 7:45 a.m., until 10:30 a.m., revealed the resident remained in the bed with the right heel pressure ulcer resting on the bed. Interview on October 2, 2013, at 9:00 a.m., in the resident's room with certified nurse aide (CNA) #9 revealed the CNA had cared for the resident during the previous two weeks. Interview included a review of the resident's Kardex/Care Card (provided for the CNA staff) and revealed the Kardex did not indicate the resident had a pressure ulcer of the right heel. Interview confirmed the CNA had not been told the resident had a pressure ulcer of the right heel and had not been given any instructions to maintain the right heel off of the bed. Interview by telephone on October 3, 2013, at 9:45 a.m., with the Registered Dietician (RD) revealed the RD had worked at the facility until September 20, 2013. Interview revealed the nursing home staff had not alerted the RD to the resident's pressure ulcer, and the RD verified nutritional interventions were not developed to address the right heel pressure ulcer. Interview and concurrent review of the Skin Integrity Report, with the Unit Manager/Wound Care Nurse in the conference room at 10:30 a.m., on October 2, 2013, confirmed the following: the right heel pressure ulcer had been identified on August 25, 2013, but the pressure ulcer had not been assessed until August 30, 2013; on August 30, 2013, the pressure wound was assessed as unstageable due to deep tissue injury; and the pressure ulcer measurements did not change until the resident was admitted to the hospital on October 1, 2013, after 7:00 p.m. Interview continued and the Unit Manager stated from the time the right heel ulcer was identified on August 25, 2013, it was to be floated off of the bed. Continued interview confirmed floating the heels off of the bed had not been placed on the CNA's Kardex or added to the Care Plan as a new intervention. Interview with the Director of Nurses at 11:00 a.m., on October 3, 2013, adjacent to the conference room, confirmed the resident did not have a pressure ulcer on admission to the facility; had developed a right heel pressure ulcer in the facility; the resident's Care Plan and Kardex did not include interventions to address the presence of a pressure ulcer. Resident #73 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the quarterly MDS (Minimum Data Set) dated January 9, 2013, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 2 (severe cognitive impairment). Further review of the MDS, revealed the resident was dependent on staff for bed mobility, transfers, bathing, dressing, toilet use and personal hygiene. Medical record review of the care plan updated January 11, 2013, revealed resident #73 was care planned for at risk for falls. Medical record review of the Change of Condition Documentation, revealed resident #73 had falls/incidents documented on December 8, 2012, December 24, 2012, January 12, 2013 and January 13, 2013. Further review of the care plan, revealed no new interventions to address the resident's falls on December 8, 2012, December 24, 2012, January 12, 2013 and January 13, 2013. Review of the facility's policy titled Falls Management, effective on September 15, 2001, and revised on June 1, 2013, revealed, .If patient falls.Update care plan to reflect new interventions. Review of the facility's policy titled Falls Delivery Process, with revision date of June 1, 2013, revealed, .Implement immediate interventions after the fall.Complete Condition of Change Document.Update care plan with new interventions as appropriate. Interview with the ADON (Assistant Director of Nursing) on October 3, 2013, at 8:15 a.m., in the Admission's office, confirmed the facility had failed to revise the Care Plan to reflect new interventions to address the resident's falls. Medical record review of the quarterly MDS dated [DATE], revealed the resident was assessed with [REDACTED]. Medical record review of the wound management documentation, revealed a suspected deep tissue injury pressure ulcer had been identified on June 27, 2013, on the side of the left great toe and on the side of the left lateral foot. Medical record review of the Care Plan dated July 12, 2011 and revised August 1, 2013, revealed Resident #73 was care planned for the potential for complications due to skin breakdown. Review of the facility's policy titled, 14.6 Skin Integrity Management revised October 1, 2010, revealed .develop comprehensive, interdisciplinary plan of care.adjust plan of care, as indicated. Interview with the DON (Director of Nursing) and the Wound Care Nurse on October 30, 2013, at 10:15 a.m., in the dining room, confirmed the facility had failed to revise the care plan to reflect new intervention to address the suspected deep tissue injury pressure ulcers located on the side of the left great toe and on the side of the left lateral foot at the time the pressure areas were identified on June 27, 2013. Resident #114 was admitted to the facility from the hospital on September 14, 2013, with [DIAGNOSES REDACTED]. Medical record review of the Minimum Data Set (MDS) with a reference date of September 21, 2013, revealed cognitive skills severely impaired, required two person assistance for bed mobility, always incontinent of urine, bowel continence not rated (had a rectal tube in place from admission), with one Stage 1 pressure ulcer and two Unstageable pressure ulcers. Medical record review of the Plan of Care developed on September 26, 2013, with additional information and interventions added through October 31, 2013 revealed the problem of Impaired Skin Integrity did not include the Stage I pressure ulcer assessed by the MDS and did not include the developement on October 1, 2013, of the sacral/coccyx pressure ulcer until October 16, 2013, when the sacral/coccyx ulcer had progressed to requiring a [MEDICATION NAME] agent. Review of the Plan of Care revealed the rectal tube was mentioned within the problem of Self Care Deficit, .Resident has a rectal tube with past medical history of [REDACTED]. Medical record review of the Wound Care physician's orders [REDACTED]. Do not use gerichair - may (increase) sacral wound. Medical record review of the Wound Care physician's orders [REDACTED]. Observation and interview at 1:50 p.m., on October 31, 2013, in the resident's room with the Wound Care Nurse, assisted by the Director of Nurses (DON), revealed the coccyx ulcer was not dressed. Observation revealed a dark area immediately to the right of the ulcer on the right buttock. Interview with the Wound Care Nurse revealed the area observed on the right buttock was not there when the coccyx pressure ulcer was measured two days earlier and stated the dark area was a deep tissue injury. Interview continued and the Wound Care Nurse stated the coccyx wound was larger than when measured on October 29, 2013. Interview continued and the Wound Care Nurse verified there wasn't a dressing on the coccyx ulcer when the pressure ulcer was measured on October 29, 2013. Interview continued and the Wound Care Nurse and the DON stated the dressing was not staying adhered to the pressure ulcer because of moisture from the urinary incontinence. Interview verified the resident had worn an incontinent brief from admission to the present time. Interview with the Wound Care Physician, at the nursing station, on November 4, 2013, at 10:50 a.m., revealed, .I will look at the wound (referring to the coccyx and right buttock) .Yes, the dressing needs to stay on the sacrum at all times. Interview at the nursing station, with Unit Manager on October 31, 2013, at 11:00 a.m., revealed the facility did not have

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0280

(continued... from page 12)
the manufacturer's instructions for the rectal tube the resident had in place. Interview revealed the original date the rectal tube had been placed in the resident's rectal vault at the hospital had not been determined. Interview verified a plan of care for the rectal tube had not been developed. Interview with the Director of Nurses on November 4, 2013, at 1:30 p.m., in the conference room, confirmed an intervention had not been developed to address the problem identified on October 31, 2013, of non-adherence of the dressing to the sacral/coccyx pressure ulcer. Interview with the Wound Care Nurse on November 4, 2013, at 4:00 p.m., at the nursing station, confirmed the plan of care did not include an intervention for the Stage I pressure ulcer of the right buttock assessed on the MDS September 21, 2013, and treated with the Duoderm the first two weeks the resident was in the facility. Interview continued and verified on October 1, 2013, physician's orders [REDACTED]. of care. Interview confirmed the wound care treatment ordered by the Wound Care Physician on October 9, 2013, were not added to the resident's plan of care. Resident #79 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the nursing admission assessment dated [DATE], revealed the resident had a blanchable red area on the coccyx measuring 1.3 cm (centimeters) x 1.5 cm. Medical record review of the Pressure Ulcer Documentation Form dated March 19, 2013, revealed a wound was discovered on the coccyx which as a Stage 3 pressure ulcer measuring 3 cm (centimeters) x 1.5 cm x 0.2 cm, with 25% (percent) granulation and 50% slough. Medical record review of treatment records from admission through March 19, 2013, revealed documentation the resident's skin was intact when assessed weekly. Continued review of the form dated May 7, 2013, revealed the wound increased to a stage 4, measuring 6.5 cm x 4 cm x 1.5 cm with tunneling (open track from wound into tissue). Review of a physician's progress note dated May 8, 2013, revealed, .pulse lavage saline to wound. Santyl (wound debrider) to coccyx wound when dressing. Start KCI wound vac (potassium chloride [DEVICE]) 125 mg (milligrams) intermittent every other day trial. Medical record review of a hospital History and Physical dated May 23, 2013, revealed the resident underwent [REDACTED]. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was dependent for transfers, bathing, dressing, grooming; had a Foley catheter; was incontinent of bowel; required two person assistance for transfers and Activities of Daily Living (ADLs); and had one stage 4 pressure ulcer and one unstageable pressure ulcer. Medical record review of a hospital admitted d September 9, 2013, revealed the resident underwent [REDACTED]. Review of the care plan initiated on January 16, 2013, and revised on September 20, 2013, revealed no documentation of the use of a suprapubic catheter or care of the catheter. Continued review of the care plan revealed no documentation of specific care for the sacral decubitus but stated .continue with care. Interview with the DON on October 3, 2013, at 1:40 p.m., in the nurses' station, confirmed the care plan did not reflect the resident's suprapubic catheter and its specific care nor did it reflect the wound care of the resident's decubitus.

Resident # 62 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had short and long term memory problems; required extensive assistance of one person physical assistance for transfers, walk in corridor, dressing, personal hygiene and bathing; required extensive assistance of two plus person physical assistance for bed mobility and toilet use; was continent of bowel and bladder; and had no falls. Review of facility documentation revealed the resident had a fall from the bed with no injury on January 13, 2013, at 5:00 a.m. Review of the facility fall report revealed the resident had a fall from the bed with a laceration, was sent to the emergency roiagnom on [DATE], at 3:30 p.m. Medical record review of the Resident Fall Evaluation revealed the resident experienced two falls on January 13, 2013. Review of the facility fall report revealed the resident had a fall from the bed with no injury on January 20, 2013, at 10:00 p.m., and was sent to the emergency room due to complaints of a headache. Medical record review of the Resident Fall Evaluation revealed no documentation of a fall evaluation after the fall on January 20, 2013. Medical record review of the Nursing Note dated January 21, 2013, at 2:00 a.m., revealed there resident was readmitted to the facility from the hospital. Review of the Care Plan initiated on February 28, 2010, and updated on December 4, 2012, revealed a problem for Risk for falls related to: unstable health condition, unsteady gait, history of falls.Goal: No significant injury with the target date of February 10, 2013. Further review revealed no additional interventions following the two falls on January 13, 2013, or for the fall on January 20, 2013. Review of the facility's policy titled Falls Management Policy dated September 15, 2001 and revised on June 1, 2013, revealed .communicate patient's fall risk status to caregivers.develop individualized plan of care.review and revise care plan regularly.If the patient falls: Perform Neurological Assessment for unwitnessed falls and witnessed falls with head injury.Complete the Change of Condition Note.Patient Fall Investigation Form.Update care plan to reflect new interventions.Document.Effectiveness of interventions.Conduct Interdisciplinary Team meeting within 72 hours of fall.The Administrator and Director of Nursing will conduct a post fall review. Further review revealed Refer to Falls Care Delivery Process. Review of the Falls Care Delivery Process , revised on June 1, 2013, revealed Response to a Patient Fall.Evaluate and monitor patient for 72 hours after the fall. Perform Neurological Assessments for all unwitnessed falls and witnessed falls with head injury. Complete change of condition note.Review patient's medical record and assessments to identify any causes that may have contributed to the fall.Investigate fall circumstances.Review [MEDICATION NAME]/Extrinsic Fall Risk Factors to implement new interventions or remove environmental risk factors to prevent future falls.Implement immediate interventions after the fall.Update care plan with new interventions as appropriate.Communicate interventions to staff.Conduct Interdisciplinary Team meeting within 72 hours of patient fall to perform the following: Review and complete.investigation form.Determine need for additional action/interventions. Add additional interventions to.care plan as indicated by investigation.Communicate information to staff and care plan team.The Director of Nursing (or designee) will: Complete the follow-up recommendations within five working days. Review for completion. Observations on October 2, 2013, at 1:15 p.m., and October 3, 2013, at 7:45 a.m., revealed the resident in bed with a pad alarm attached, the call light within reach, and a locked wheel chair beside the bed. Interview with the Medical Records Director on October 3, 2013, at 11:00 a.m., in the conference room, confirmed the Care Plan initiated on February 28, 2010, and updated on December 4, 2012, was the only Care Plan used during January 2013 and was effective through the goal date on February 10, 2013. Interview on October 3, 2013, at 1:55 p.m. in the business office, with the Administrator and Director of Nursing, confirmed the Care Plan following the falls on January 13, 2013, 5:00 a.m. and 3:30 p.m., and on January 20, 2013, had not been updated with new interventions. Further interview confirmed the facility failed to follow their policy to revise the Care Plans after falls. Resident #120 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Review of facility falls report revealed the resident had five falls on the following dates: February 25, 2013, March 3, 12 and 22, 2013, and April 10, 2013. Medical record review of the care plan with the initial date of February 6, 2013, revealed a focus of Risk for falls related to: unstable health condition. Further review revealed the approaches initiated on February 6, 2013, of Have commonly used articles within easy reach. Resident to wear non-slip footwear. Further review of the care plan revealed an undated approach of Encourage use of call light for assistance with transferring needs. Further review of the care plan revealed the facility failed to include new interventions after the falls on February 25, 2013, March 3, 2013, and April 10, 2013. Interview on November 5, 2013, at 3:15 p.m., in the Administrator's office, with the Administrator, Director of Clinical Services, and the Director of Nursing confirmed the facility failed to revise the care plan with new interventions after the falls on February 25, 2013, March 3, 12 and 22, 2013, and April 10, 2013. Resident #26 was initially admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the facility documentation revealed the resident had five falls on the following dates: July 4, 2013, at 8:45 a.m., and 9:00 a.m.; July 8, 2013; October 3, 2013, and October 19, 2013. Medical record review of the care plan with the initial date of June 7, 2013, revealed a focus of Risk for falls related to: unsteady gait Further review revealed the approaches initiated on June 7, 2013, of Have commonly used articles within easy reach. Resident to wear non-slip footwear. Encourage resident to use handrails or assistive devices properly. Further review of the care plan revealed the facility failed to include new interventions after both falls on July 4, 2013; July 8, 2013, and on October 4, 2013. Interview with the Director of Nursing, Administrator, Director of Clinical Services, and the Regional Vice President, on November 6, 2013, at 10:35 a.m., in the conference room confirmed the facility failed to revise the care plan to include any new interventions after both falls on July 4, 2013; July 8, 2013, and on October 4, 2013.

Resident #93 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly MDS
(Minimal Data Set) dated April 16, 2013, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 4 indicating severe cognitive impairment. Further review of the MDS, revealed the resident was totally dependent for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. Medical record review of the facility's fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE** **WINCHESTER, TN 37398**

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 0280

(continued... from page 13)
report, revealed resident #93 had falls/incidents documented on January 23, 2013, February 11, 2013, February 13, 2013, February 15, 2013, and February 25, 2013. Medical record review of the Care Plan updated January 31, 2013, April 16, 2013 and April 22, 2013, revealed resident #93 was care planned as being at risk for falls r/t (related to) unstable health condition. Further review of the Care Plan, revealed no new interventions had been added to address the resident's falls on February 11, 2013, February 13, 2013, February 15, 2013, and February 25, 2013. Interview with the DON (Director of Nursing) on November 5, 2013, at 12:20 p.m., in the conference room, confirmed the facility failed to revise the Care Plan to reflect new interventions to address the resident's falls occurring on February 11, 2013, February 13, 2013, February 15, 2013, and February 25, 2013. Resident #100 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of an annual MDS (Minimal Data Set) dated February 25, 2013, revealed the resident was dependent for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. Further review of the MDS revealed, the resident had a BIMS (Brief Interview for Mental Status) score of 15 (no cognitive impairment). Medical record review of a quarterly MDS dated [DATE], revealed the resident required extensive assistance for bed mobility and transfers, required limited assistance from for locomotion and was totally dependent for dressing, toilet use, personal hygiene and bathing. Further review of the MDS revealed, the resident had a BIMS score of 7 indicating severe cognitive impairment. Medical record review of the facility's fall reports, revealed Resident #100 had falls/incidents documented on February 18, 2013, February 21, 2013, February 23, 2013, April 5, 2013, April 20, 2013, and May 2, 2013. Medical record review of the Care Plan updated February 18, 2013, February 19, 2013, April 26, 2013, and July 31, 2013, revealed resident #100 was care planned for at risk for falls related to bilateral aka (above knee amputation), unstable health condition, pain, and decreased safety awareness. Further review of the care plan, revealed no new interventions to address the resident's falls on February 21, 2013, and May 2, 2013. Interview with the DON (Director of Nursing) on November 6, 2013, at 8:30 a.m., in the business office, confirmed the facility failed to revise the Care Plan to reflect new interventions to address the resident's falls occurring on February 21, 2013 and May 2, 2013.

Resident #52 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS)
dated [DATE], revealed the resident had short and long term memory problems; had impaired decision-making; required assistance of one person for bathing, dressing, and grooming; required assistance with transfers; was incontinent of bowel and bladder; and had a fall since the last assessment. Medical record review of the physician's orders [REDACTED]. Medical record review of the facility fall report dated July 3, 2013, which was incorrect, revealed the resident had a fall in the past 30 days, and had no issues contributing to falls. Medical record review of Interdisciplinary Team Progress Notes revealed an entry dated August 8, 2013, .reviewed d/t (due to) recent fall on August 4, 2013. Pt. was trying to transfer self from w/c (wheelchair) to another chair and fell in floor. Pt re-educated to ask for assistance before transferring. This is an inappropriate inv\tervention considering the resident had long and short term memory deficits as well as impaired decision-making. Review of a facility fall report dated June 4, 2013 (incorrect date), revealed the resident was attempting to ambulate independently in the solarium from the wheelchair to another chair. Continued review of the docu

F 0280

Allow the resident the right to participate in the planning or revision of the resident's care plan.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, review of facility documentation, observation, review of facility policy, and interview, the facility failed to revise the care plan following falls to include interventions for the staff to implement to prevent future falls for nine residents (#35, #73, #62, #120, #26, #93, #100, #52, #119) of twenty-two residents reviewed with falls; failed to revise the care plan addressing pressure ulcers for staff to implement care plans for four (#35, #73, #114, #79) of fourteen residents reviewed with pressure ulcers; and failed to revise the care plan with interventions for staff to implement after a sexual altercation for two residents (#77, #42) of sixty-five residents reviewed. The facility's failure to address interventions on the care plan for pressure ulcers for three residents (#35, #73, and #114) resulted in staff unfamiliar with the care to be provided placing residents in Immediate Jeopardy (a situation in which the provider's non-compliance has caused or likely to cause serious injury, harm, impairment, or death). The failure of the facility to revise the care plans addessing falls with new interventions resulted in a [MEDICAL CONDITION] for one resident (#35) and a fractured clavicle for one resident (#73) placing the residents in Immediate Jeopardy. The Immediate Jeopardy was effective on November 26, 2012, and is ongoing. The Regional Vice President, Director of Clinical Services, Administrator and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m. in the conference room. The findings included: Resident #35 was admitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Minimum
Data Set (MDS) dated [DATE], revealed a Brief Mental Status score of 14, indicating no cognitive impairment. Medical record review of the Fall Risk Evaluation completed on admission and at quarterly reviews on March 8, and June 8, 2013, revealed the resident was high risk for falls. Medical record review of facility falls reports and Care Plans (from December 2012 through October 2013) revealed the resident had a history of [REDACTED]. January 12, 2013, at 4:20 a.m., fell on the way to the bathroom and Safety alarm was care planned; January 15, 2013, no fall report provided for review and no new interventions care planned; March 6, 2013 at 7:50 a.m., fall report revealed fell on the way to the bathroom, new interventions care planned; March 21, 2013, at 7:20 a.m., fall report was not completed, no new interventions care planned; April 1, 2013, at 11:55 p.m., fall report revealed resident on the way to the bathroom, the Care Plan recorded a new intervention for a scoop mattress; May 21, 2013, at 4:15 p.m., fall report revealed this was a witnessed fall, no new interventions were implemented; May 25, 2013, at 7:25 a.m., fall report revealed a CNA heard the safety alarm, saw the bathroom emergency call light blinking, and found the resident in the bathroom on the floor with bruises, a skin tear to the left arm. Review of the Care Plan revealed no new interventions were implemented; July 19, 2013, at 8:20 a.m., fall report was not initiated until October 1, 2013, by the DON, during the annual survey, no investigation done. Review revealed the resident was found on the floor and old skin tear re-opened. Review of the Care Plan revealed, 7/19/13 fall.Intervention 7/19/13 Reacher/grabber. August 12, 2013, at 3:40 a.m., fall report revealed To resident room to answer call light, resident sitting in floor beside the bed.noted abrasion to right cheek and resident c/o (complained of) pain to right hip. Medical record review of a History and Physical on admission to the hospital on August 12, 2013, revealed, .Assessment and Plan: fall with right intertrochanteric (hip) fracture.still alert.wants surgery. Medical record review of the an Interdisciplinary Progress Note dated August 19, 2013, revealed on this date the resident returned from the hospital following the surgery of the right hip. Medical record review of the Re-admission nursing assessment dated [DATE], revealed the resident returned from a hospitalization due to a Urinary Tract Infection. Medical record review of the Fall Risk Evaluation dated October 7, 2013, revealed a score of 13, high risk for falls. Review of facility documentation revealed the resident fell in the bathroom at 4:32 a.m., on October 9, 2013. Review of the resident's Care Plan revealed the resident did not have the individualized interventions previously put into place resumed on re-admission. Interview with the Director of Nurses (DON) in the conference room at 1:00 p.m., on October 28, 2013, confirmed previous individualized interventions were not resumed when the resident returned to the facility October 7, 2013. Interview confirmed the Interdisciplinary Team did not complete an investigate and develop new appoaches after the October 9, 2013, fall. Medical record review of the Nursing Assessment completed for the readmission on August 19, 2013, revealed the resident did not have a pressure ulcer. Medical record review of the weekly skin checks recorded on the treatment record revealed the resident's skin was intact on August 20, 2013. Medical record review of the Skin Integrity Report, initiated for a right heel pressure ulcer, indicated the pressure ulcer was identified on August 25, 2013, and intially staged and measured on August 30, 2013, as a Deep Tissue Injury measuring 3 cm (centimeters) Legnth, 4 cm Width, and undetermined Depth due to the skin intact with Appearance.deep purple. Medical record review of the physician's orders [REDACTED]. Observation of the resident at intervals on October 1, 2013, from 7:45 a.m., until 10:30 a.m., revealed the resident remained in the bed with the right heel pressure ulcer resting on the bed. Interview on October 2, 2013, at 9:00 a.m., in the resident's room with certified nurse aide (CNA) #9 revealed the CNA had cared for the resident during the previous two weeks. Interview included a review of the resident's Kardex/Care Card (provided for the CNA staff) and revealed the Kardex did not indicate the resident had a pressure ulcer of the right heel. Interview confirmed the CNA had not been told the resident had a pressure ulcer of the right heel and had not been given any instructions to maintain the right heel off of the bed. Interview by telephone on October 3, 2013, at 9:45 a.m., with the Registered Dietician (RD) revealed the RD had worked at the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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F 0280	(continued... from page 14) until September 20, 2013. Interview revealed the nursing home staff had not alerted the RD to the resident's pressure ulcer, and the RD verified nutritional interventions were not developed to address the right heel pressure ulcer. Interview and concurrent review of the Skin Integrity Report, with the Unit Manager/Wound Care Nurse in the conference room at 10:30 a.m., on October 2, 2013, confirmed the following: the right heel pressure ulcer had been identified on August 25, 2013, but the pressure ulcer had not been assessed until August 30, 2013; on August 30, 2013, the pressure wound was assessed as unstageable due to deep tissue injury; and the pressure ulcer measurements did not change until the resident was admitted to the hospital on October 1, 2013, after 7:00 p.m. Interview continued and the Unit Manager stated from the time the right heel ulcer was identified on August 25, 2013, it was to be floated off of the bed. Continued interview confirmed floating the heels off of the bed had not been placed on the CNA's Kardex or added to the Care Plan as a new intervention. Interview with the Director of Nurses at 11:00 a.m., on October 3, 2013, adjacent to the conference room, confirmed the resident did not have a pressure ulcer on admission to the facility; had developed a right heel pressure ulcer in the facility; the resident's Care Plan and Kardex did not include interventions to address the presence of a pressure ulcer. Resident #73 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the quarterly MDS (Minimum Data Set) dated January 9, 2013, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 2 (severe cognitive impairment). Further review of the MDS, revealed the resident was dependent on staff for bed mobility, transfers, bathing, dressing, toilet use and personal hygiene. Medical record review of the care plan updated January 11, 2013, revealed resident #73 was care planned for at risk for falls. Medical record review of the Change of Condition Documentation, revealed resident #73 had falls/incidents documented on December 8, 2012, December 24, 2012, January 12, 2013 and January 13, 2013. Further review of the care plan, revealed no new interventions to address the resident's falls on December 8, 2012, December 24, 2012, January 12, 2013 and January 13, 2013. Review of the facility's policy titled Falls Management, effective on September 15, 2001, and revised on June 1, 2013, revealed, .If patient falls.Update care plan to reflect new interventions. Review of the facility's policy titled Falls Delivery Process, with revision date of June 1, 2013, revealed, .Implement immediate interventions after the fall.Complete Condition of Change Document.Update care plan with new interventions as appropriate. Interview with the ADON (Assistant Director of Nursing) on October 3, 2013, at 8:15 a.m., in the Admission's office, confirmed the facility had failed to revise the Care Plan to reflect new interventions to address the resident's falls. Medical record review of the quarterly MDS dated [DATE], revealed the resident was assessed with [REDACTED]. Medical record review of the wound management documentation, revealed a suspected deep tissue injury pressure ulcer had been identified on June 27, 2013, on the side of the left great toe and on the side of the left lateral foot. Medical record review of the Care Plan dated July 12, 2011 and revised August 1, 2013, revealed Resident #73 was care planned for the potential for complications due to skin breakdown. Review of the facility's policy titled, 14.6 Skin Integrity Management revised October 1, 2010, revealed .develop comprehensive, interdisciplinary plan of care.adjust plan of care, as indicated. Interview with the DON (Director of Nursing) and the Wound Care Nurse on October 30, 2013, at 10:15 a.m., in the dining room, confirmed the facility had failed to revise the care plan to reflect new intervention to address the suspected deep tissue injury pressure ulcers located on the side of the left great toe and on the side of the left lateral foot at the time the pressure areas were identified on June 27, 2013. Resident #114 was admitted to the facility from the hospital on September 14, 2013, with [DIAGNOSES REDACTED]. Medical record review of the Minimum Data Set (MDS) with a reference date of September 21, 2013, revealed cognitive skills severely impaired, required two person assistance for bed mobility, always incontinent of urine, bowel continence not rated (had a rectal tube in place from admission), with one Stage 1 pressure ulcer and two Unstageable pressure ulcers. Medical record review of the Plan of Care developed on September 26, 2013, with additional information and interventions added through October 31, 2013 revealed the problem of Impaired Skin Integrity did not include the Stage I pressure ulcer assessed by the MDS and did not include the developement on October 1, 2013, of the sacral/coccyx pressure ulcer until October 16, 2013, when the sacral/coccyx ulcer had progressed to requiring a [MEDICATION NAME] agent. Review of the Plan of Care revealed the rectal tube was mentioned within the problem of Self Care Deficit, .Resident has a rectal tube with past medical history of [REDACTED]. Medical record review of the Wound Care physician's orders [REDACTED]. Do not use gerichair - may (increase) sacral wound. Medical record review of the Wound Care physician's orders [REDACTED]. Observation and interview at 1:50 p.m., on October 31, 2013, in the resident's room with the Wound Care Nurse, assisted by the Director of Nurses (DON), revealed the coccyx ulcer was not dressed. Observation revealed a dark area immediately to the right of the ulcer on the right buttock. Interview with the Wound Care Nurse revealed the area observed on the right buttock was not there when the coccyx pressure ulcer was measured two days earlier and stated the dark area was a deep tissue injury. Interview continued and the Wound Care Nurse stated the coccyx wound was larger than when measured on October 29, 2013. Interview continued and the Wound Care Nurse verified there wasn't a dressing on the coccyx ulcer when the pressure ulcer was measured on October 29, 2013. Interview continued and the Wound Care Nurse and the DON stated the dressing was not staying adhered to the pressure ulcer because of moisture from the urinary incontinence. Interview verified the resident had worn an incontinent brief from admission to the present time. Interview with the Wound Care Physician, at the nursing station, on November 4, 2013, at 10:50 a.m., revealed, .I will look at the wound (referring to the coccyx and right buttock) .Yes, the dressing needs to stay on the sacrum at all times. Interview at the nursing station, with Unit Manager on October 31, 2013, at 11:00 a.m., revealed the facility did not have the manufacturer's instructions for the rectal tube the resident had in place. Interview revealed the original date the rectal tube had been placed in the resident's rectal vault at the hospital had not been determined. Interview verified a plan of care for the rectal tube had not been developed. Interview with the Director of Nurses on November 4, 2013, at 1:30 p.m., in the conference room, confirmed an intervention had not been developed to address the problem identified on October 31, 2013, of non-adherence of the dressing to the sacral/coccyx pressure ulcer. Interview with the Wound Care Nurse on November 4, 2013, at 4:00 p.m., at the nursing station, confirmed the plan of care did not include an intervention for the Stage I pressure ulcer of the right buttock assessed on the MDS September 21, 2013, and treated with the Duoderm the first two weeks the resident was in the facility. Interview continued and verified on October 1, 2013, physician's orders [REDACTED]. of care. Interview confirmed the wound care treatment ordered by the Wound Care Physician on October 9, 2013, were not added to the resident's plan of care. Resident #79 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the nursing admission assessment dated [DATE], revealed the resident had a blanchable red area on the coccyx measuring 1.3 cm (centimeters) x 1.5 cm. Medical record review of the Pressure Ulcer Documentation Form dated March 19, 2013, revealed a wound was discovered on the coccyx which as a Stage 3 pressure ulcer measuring 3 cm (centimeters) x 1.5 cm x 0.2 cm, with 25% (percent) granulation and 50% slough. Medical record review of treatment records from admission through March 19, 2013, revealed documentation the resident's skin was intact when assessed weekly. Continued review of the form dated May 7, 2013, revealed the wound increased to a stage 4, measuring 6.5 cm x 4 cm x 1.5 cm with tunneling (open track from wound into tissue). Review of a physician's progress note dated May 8, 2013, revealed, .pulse lavage saline to wound. Santyl (wound debrider) to coccyx wound when dressing. Start KCI wound vac (potassium chloride [DEVICE]) 125 mg (milligrams) intermittent every other day trial. Medical record review of a hospital History and Physical dated May 23, 2013, revealed the resident underwent [REDACTED]. Medical record review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was dependent for transfers, bathing, dressing, grooming; had a Foley catheter; was incontinent of bowel; required two person assistance for transfers and Activities of Daily Living (ADLs); and had one stage 4 pressure ulcer and one unstageable pressure ulcer. Medical record review of a hospital admitted d September 9, 2013, revealed the resident underwent [REDACTED]. Review of the care plan initiated on January 16, 2013, and revised on September 20, 2013, revealed no documentation of the use of a suprapubic catheter or care of the catheter. Continued review of the care plan revealed no documentation of specific care for the sacral decubitus but stated .continue with care. Interview with the DON on October 3, 2013, at 1:40 p.m., in the nurses' station, confirmed the care plan did not reflect the resident's suprapubic catheter and its specific care nor did it reflect the wound care of the resident's decubitus. Resident # 62 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had short and long term memory problems; required extensive assistance of one person physical assistance for transfers, walk in corridor, dressing, personal hygiene and bathing; required extensive assistance of two plus person physical assistance for bed mobility and toilet use; was continent of bowel and bladder; and had no falls. Review of facility documentation revealed the resident had a fall from the bed with no injury on January 13, 2013, at 5:00 a.m. Review of the facility fall report revealed the

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F 0280	(continued... from page 15) resident had a fall from the bed with a laceration, was sent to the emergency roiagnom on [DATE], at 3:30 p.m. Medical record review of the Resident Fall Evaluation revealed the resident experienced two falls on January 13, 2013. Review of the facility fall report revealed the resident had a fall from the bed with no injury on January 20, 2013, at 10:00 p.m., and was sent to the emergency room due to complaints of a headache. Medical record review of the Resident Fall Evaluation revealed no documentation of a fall evaluation after the fall on January 20, 2013. Medical record review of the Nursing Note dated January 21, 2013, at 2:00 a.m., revealed there resident was readmitted to the facility from the hospital. Review of the Care Plan initiated on February 28, 2010, and updated on December 4, 2012, revealed a problem for Risk for falls related to: unstable health condition, unsteady gait, history of falls.Goal: No significant injury with the target date of February 10, 2013. Further review revealed no additional interventions following the two falls on January 13, 2013, or for the fall on January 20, 2013. Review of the facility's policy titled Falls Management Policy dated September 15, 2001 and revised on June 1, 2013, revealed .communicate patient's fall risk status to caregivers.develop individualized plan of care.review and revise care plan regularly.If the patient falls: Perform Neurological Assessment for unwitnessed falls and witnessed falls with head injury.Complete the Change of Condition Note.Patient Fall Investigation Form.Update care plan to reflect new interventions.Document.Effectiveness of interventions.Conduct Interdisciplinary Team meeting within 72 hours of fall.The Administrator and Director of Nursing will conduct a post fall review. Further review revealed Refer to Falls Care Delivery Process. Review of the Falls Care Delivery Process , revised on June 1, 2013, revealed Response to a Patient Fall.Evaluate and monitor patient for 72 hours after the fall. Perform Neurological Assessments for all unwitnessed falls and witnessed falls with head injury. Complete change of condition note.Review patient's medical record and assessments to identify any causes that may have contributed to the fall.Investigate fall circumstances.Review [MEDICATION NAME]/Extrinsic Fall Risk Factors to implement new interventions or remove environmental risk factors to prevent future falls.Implement immediate interventions after the fall.Update care plan with new interventions as appropriate.Communicate interventions to staff.Conduct Interdisciplinary Team meeting within 72 hours of patient fall to perform the following: Review and complete.investigation form.Determine need for additional action/interventions. Add additional interventions to.care plan as indicated by investigation.Communicate information to staff and care plan team.The Director of Nursing (or designee) will: Complete the follow-up recommendations within five working days. Review for completion. Observations on October 2, 2013, at 1:15 p.m., and October 3, 2013, at 7:45 a.m., revealed the resident in bed with a pad alarm attached, the call light within reach, and a locked wheel chair beside the bed. Interview with the Medical Records Director on October 3, 2013, at 11:00 a.m., in the conference room, confirmed the Care Plan initiated on February 28, 2010, and updated on December 4, 2012, was the only Care Plan used during January 2013 and was effective through the goal date on February 10, 2013. Interview on October 3, 2013, at 1:55 p.m. in the business office, with the Administrator and Director of Nursing, confirmed the Care Plan following the falls on January 13, 2013, 5:00 a.m. and 3:30 p.m., and on January 20, 2013, had not been updated with new interventions. Further interview confirmed the facility failed to follow their policy to revise the Care Plans after falls. Resident #120 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Review of facility falls report revealed the resident had five falls on the following dates: February 25, 2013, March 3, 12 and 22, 2013, and April 10, 2013. Medical record review of the care plan with the initial date of February 6, 2013, revealed a focus of Risk for falls related to: unstable health condition. Further review revealed the approaches initiated on February 6, 2013, of Have commonly used articles within easy reach. Resident to wear non-slip footwear. Further review of the care plan revealed an undated approach of Encourage use of call light for assistance with transferring needs. Further review of the care plan revealed the facility failed to include new interventions after the falls on February 25, 2013, March 3, 2013, and April 10, 2013. Interview on November 5, 2013, at 3:15 p.m., in the Administrator's office, with the Administrator, Director of Clinical Services, and the Director of Nursing confirmed the facility failed to revise the care plan with new interventions after the falls on February 25, 2013, March 3, 12 and 22, 2013, and April 10, 2013. Resident #26 was initially admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the facility documentation revealed the resident had five falls on the following dates: July 4, 2013, at 8:45 a.m., and 9:00 a.m.; July 8, 2013; October 3, 2013, and October 19, 2013. Medical record review of the care plan with the initial date of June 7, 2013, revealed a focus of Risk for falls related to: unsteady gait Further review revealed the approaches initiated on June 7, 2013, of Have commonly used articles within easy reach. Resident to wear non-slip footwear. Encourage resident to use handrails or assistive devices properly. Further review of the care plan revealed the facility failed to include new interventions after both falls on July 4, 2013; July 8, 2013, and on October 4, 2013. Interview with the Director of Nursing, Administrator, Director of Clinical Services, and the Regional Vice President, on November 6, 2013, at 10:35 a.m., in the conference room confirmed the facility failed to revise the care plan to include any new interventions after both falls on July 4, 2013; July 8, 2013, and on October 4, 2013. Resident #93 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the quarterly MDS (Minimal Data Set) dated April 16, 2013, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 4 indicating severe cognitive impairment. Further review of the MDS, revealed the resident was totally dependent for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. Medical record review of the facility's fall report, revealed resident #93 had falls/incidents documented on January 23, 2013, February 11, 2013, February 13, 2013, February 15, 2013, and February 25, 2013. Medical record review of the Care Plan updated January 31, 2013, April 16, 2013 and April 22, 2013, revealed resident #93 was care planned as being at risk for falls r/t (related to) unstable health condition. Further review of the Care Plan, revealed no new interventions had been added to address the resident's falls on February 11, 2013, February 13, 2013, February 15, 2013, and February 25, 2013. Interview with the DON (Director of Nursing) on November 5, 2013, at 12:20 p.m., in the conference room, confirmed the facility failed to revise the Care Plan to reflect new interventions to address the resident's falls occurring on February 11, 2013, February 13, 2013, February 15, 2013, and February 25, 2013. Resident #100 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of an annual MDS (Minimal Data Set) dated February 25, 2013, revealed the resident was dependent for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. Further review of the MDS revealed, the resident had a BIMS (Brief Interview for Mental Status) score of 15 (no cognitive impairment). Medical record review of a quarterly MDS dated [DATE], revealed the resident required extensive assistance for bed mobility and transfers, required limited assistance from for locomotion and was totally dependent for dressing, toilet use, personal hygiene and bathing. Further review of the MDS revealed, the resident had a BIMS score of 7 indicating severe cognitive impairment. Medical record review of the facility's fall reports, revealed Resident #100 had falls/incidents documented on February 18, 2013, February 21, 2013, February 23, 2013, April 5, 2013, April 20, 2013, and May 2, 2013. Medical record review of the Care Plan updated February 18, 2013, February 19, 2013, April 26, 2013, and July 31, 2013, revealed resident #100 was care planned for at risk for falls related to bilateral aka (above knee amputation), unstable health condition, pain, and decreased safety awareness. Further review of the care plan, revealed no new interventions to address the resident's falls on February 21, 2013, and May 2, 2013. Interview with the DON (Director of Nursing) on November 6, 2013, at 8:30 a.m., in the business office, confirmed the facility failed to revise the Care Plan to reflect new interventions to address the resident's falls occurring on February 21, 2013 and May 2, 2013. Resident #52 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed the resident had short and long term memory problems; had impaired decision-making; required assistance of one person for bathing, dressing, and grooming; required assistance with transfers; was incontinent of bowel and bladder; and had a fall since the last assessment. Medical record review of the physician's orders [REDACTED]. Medical record review of the facility fall report dated July 3, 2013, which was incorrect, revealed the resident had a fall in the past 30 days, and had no issues contributing to falls. Medical record review of Interdisciplinary Team Progress Notes revealed an entry dated August 8, 2013, .reviewed d/t (due to) recent fall on August 4, 2013. Pt. was trying to transfer self from w/c (wheelchair) to another chair and fell in floor. Pt re-educated to ask for assistance before transferring. This is an inappropriate inv\tervention considering the resident had long and short term memory deficits as well as impaired decision-making. Review of a facility fall report dated June 4, 2013 (incorrect date), revealed the resident was attempting to ambulate independently in the solarium from the wheelchair to another chair. Continued review of the docu
F 0281	**Make sure services provided by the nursing facility meet professional standards of quality.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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 0281

(continued... from page 16)
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, review of facility policy, and interview, the facility failed to develop an initial care plan for one resident (#113) of sixty-five residents reviewed. The findings included: Resident #113 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Nursing assessment dated [DATE], revealed the
resident was alert; had no mood or behavior problems; had clear speech; was oriented to person, place and time; was modified independent with difficulty in new situations; received psychoactive medications for anxiety; and had no impairment in the upper or lower extremities. Medical record review of the Care Plan revealed the Care Plan was completed on October 1, 2013 (five days after the admission). Review of facility policy, Care Plan, dated May 1, 2011, revealed .an initial care plan is developed within 24 hours of admission. Interview with Minimum Data Set (MDS) Nurse #1 on October 1, 2013, at 2:30 p.m., in the MDS office confirmed the facility had failed to develop an initial care plan within twenty-four hours of admission.

F 0281

Make sure services provided by the nursing facility meet professional standards of quality.
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Based on medical record review, review of facility policy, and interview, the facility failed to develop an initial care plan for one resident (#113) of sixty-five residents reviewed. The findings included: Resident #113 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Nursing assessment dated [DATE], revealed the
resident was alert; had no mood or behavior problems; had clear speech; was oriented to person, place and time; was modified independent with difficulty in new situations; received psychoactive medications for anxiety; and had no impairment in the upper or lower extremities. Medical record review of the Care Plan revealed the Care Plan was completed on October 1, 2013 (five days after the admission). Review of facility policy, Care Plan, dated May 1, 2011, revealed .an initial care plan is developed within 24 hours of admission. Interview with Minimum Data Set (MDS) Nurse #1 on October 1, 2013, at 2:30 p.m., in the MDS office confirmed the facility had failed to develop an initial care plan within twenty-four hours of admission.

F 0309

Provide necessary care and services to maintain the highest well being of each resident .
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, review of manufacturer's instructions, observation, and interview, the facility failed to follow physician orders [REDACTED].#114) of sixty-five residents reviewed. The findings included: Resident #33 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set (MDS) dated
[DATE], revealed the resident was cognitively intact; required extensive assistance with all Activities of Daily Living (ADL's); and had frequent pain that limited daily activities and made it hard to sleep at night. Medical record review of the Care Plan dated May 3, 2013, revealed the resident had a self care deficit related to change in mobility, anxiety, and pain; a potential for pain related to wounds; and use of drugs that altered the mind. Medical record review of the admission Physician order [REDACTED].-325 mg 1 tab every 6 hours as needed. Medical record review of a Nurse's Admission Note dated May 3, 2013, at 8:10 p.m., revealed, .C/O (complain) of pain/anxiety. Medical record review of the Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED] Interview with the resident on September 25,
2013, at 8:00 a.m., in the resident's room, revealed the resident had a short stay in the hospital and when the resident returned in May 2013, the resident could not get pain medications until the next morning. Continued interview revealed I was miserable; I finally got my medicine about 6:00 a.m. Interview with the Director of Nursing (DON) on September 26, 2013, at 10:35 a.m., in the conference room, revealed the resident complained of pain and anxiety on admission and the resident had a [MEDICATION NAME] Patch 100 mcg in place on admission from the hospital dated May 1, 2013. Continued interview revealed the resident was administered pain and anxiety medication on May 4, 2013, at 2:30 a.m. (six hours later) and the [MEDICATION NAME] Patch was changed on May 6, 2013, (scheduled every 72 hours, but applied 5 days after the last application). Further interview confirmed the facility had failed to follow physician orders [REDACTED]. The facility's failure to follow physician's orders [REDACTED].#33 who experienced unrelieved pain and anxiety.

Resident #114 was admitted to the facility from the hospital on September 14, 2013, with [DIAGNOSES REDACTED]. Review of the manufacturer's instructions for the use of the rectal tube revealed, .Contraindications.1. This product is not intended for use for more than 29 consecutive days.Precautions 1. Close attention should be exercised with the use of the device in patients who have [MEDICAL CONDITION] bowel conditions.4. The use of the device is not indicated for solid or soft-formed stool.the following adverse events could occur.Rectal/anal bleeding due to pressure necrosis or ulceration of rectal or anal mucosa; Peri-anal skin breakdown; Temporary loss of anal sphincter muscle tone; Infection; Bowel Obstruction; Perforation of the bowel. Medical record review of the admission nursing assessment dated [DATE], revealed, .Bowel Elimination.Rectal tube to BSB (bedside bag). Medical record review of the physician orders [REDACTED]. Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed cognitive skills severely impaired, always incontinent of urine, bowel continence not rated (had a rectal tube in place from admission). Medical record review of a Nurse's Note dated October 29, 2013, revealed, Resident out to wound care per ambulance. Will also have a new rectal seal placed. Observation on October 31, 2013, at 10:40 a.m., in the resident's room revealed the resident lying on back in an air bed with son at the bedside. Interview with the son, during the observation, revealed the resident had a rectal tube in place and the son stated (Resident) has not had any stool from the tube for two days now. Interview at the nursing station, with the Unit Manager/Registered Nurse (RN) #1, on October 31, 2013, at 11:00 a.m., revealed the facility did not have the manufacturer's instructions for the rectal tube. Interview revealed the original date the rectal tube had been placed at the hospital had not been determined by the nursing home staff. Interview verified a plan of care for the rectal tube had not been developed. Interview on October 31, 2013, at 1:30 p.m., in the nursing station with RN #1, revealed the rectal tube had been in place since September 3, 2013. Interview confirmed the resident had a [DIAGNOSES REDACTED]. Interview continued and confirmed the manufacturer's instructions indicated the rectal tube should not be used continuously beyond 29 days and the resident's had been used continuously for 58 days. Interview confirmed the nursing staff had requested the rectal tube be replaced while at the hospital's Wound Care Center on October 29, 2013, due to dislodging on the same day. Interview in nursing station with the Wound Care Physician on November 4, 2013, at 10:50 a.m., revealed, I apologize for having the rectal tube replaced last week, I didn't know how long it had been in.

F 0309

Provide necessary care and services to maintain the highest well being of each resident .
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, review of manufacturer's instructions, observation, and interview, the facility failed to follow physician orders [REDACTED].#114) of sixty-five residents reviewed. The findings included: Resident #33 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the quarterly Minimum Data Set (MDS) dated
[DATE], revealed the resident was cognitively intact; required extensive assistance with all Activities of Daily Living (ADL's); and had frequent pain that limited daily activities and made it hard to sleep at night. Medical record review of the Care Plan dated May 3, 2013, revealed the resident had a self care deficit related to change in mobility, anxiety, and pain; a potential for pain related to wounds; and use of drugs that altered the mind. Medical record review of the admission Physician order [REDACTED].-325 mg 1 tab every 6 hours as needed. Medical record review of a Nurse's Admission Note dated May 3, 2013, at 8:10 p.m., revealed, .C/O (complain) of pain/anxiety. Medical record review of the Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED] Interview with the resident on September 25,
2013, at 8:00 a.m., in the resident's room, revealed the resident had a short stay in the hospital and when the resident returned in May 2013, the resident could not get pain medications until the next morning. Continued interview revealed I was miserable; I finally got my medicine about 6:00 a.m. Interview with the Director of Nursing (DON) on September 26, 2013, at 10:35 a.m., in the conference room, revealed the resident complained of pain and anxiety on admission and the resident had a [MEDICATION NAME] Patch 100 mcg in place on admission from the hospital dated May 1, 2013. Continued interview revealed the resident was administered pain and anxiety medication on May 4, 2013, at 2:30 a.m. (six hours later) and the [MEDICATION NAME] Patch was changed on May 6, 2013, (scheduled every 72 hours, but applied 5 days after the last application). Further interview confirmed the facility had failed to follow physician orders [REDACTED]. The facility's

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NAME OF PROVIDER OF SUPPLIER **WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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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F 0309	(continued... from page 17) failure to follow physician's orders [REDACTED].#33 who experienced unrelieved pain and anxiety. Resident #114 was admitted to the facility from the hospital on September 14, 2013, with [DIAGNOSES REDACTED]. Review of the manufacturer's instructions for the use of the rectal tube revealed, .Contraindications.1. This product is not intended for use for more than 29 consecutive days.Precautions 1. Close attention should be exercised with the use of the device in patients who have [MEDICAL CONDITION] bowel conditions.4. The use of the device is not indicated for solid or soft-formed stool.the following adverse events could occur.Rectal/anal bleeding due to pressure necrosis or ulceration of rectal or anal mucosa; Peri-anal skin breakdown; Temporary loss of anal sphincter muscle tone; Infection; Bowel Obstruction; Perforation of the bowel. Medical record review of the admission nursing assessment dated [DATE], revealed, .Bowel Elimination.Rectal tube to BSB (bedside bag). Medical record review of the physician orders [REDACTED]. Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed cognitive skills severely impaired, always incontinent of urine, bowel continence not rated (had a rectal tube in place from admission). Medical record review of a Nurse's Note dated October 29, 2013, revealed, Resident out to wound care per ambulance. Will also have a new rectal seal placed. Observation on October 31, 2013, at 10:40 a.m., in the resident's room revealed the resident lying on back in an air bed with son at the bedside. Interview with the son, during the observation, revealed the resident had a rectal tube in place and the son stated (Resident) has not had any stool from the tube for two days now. Interview at the nursing station, with the Unit Manager/Registered Nurse (RN) #1, on October 31, 2013, at 11:00 a.m., revealed the facility did not have the manufacturer's instructions for the rectal tube. Interview revealed the original date the rectal tube had been placed at the hospital had not been determined by the nursing home staff. Interview verified a plan of care for the rectal tube had not been developed. Interview on October 31, 2013, at 1:30 p.m., in the nursing station with RN #1, revealed the rectal tube had been in place since September 3, 2013. Interview confirmed the resident had a [DIAGNOSES REDACTED]. Interview continued and confirmed the manufacturer's instructions indicated the rectal tube should not be used continuously beyond 29 days and the resident's had been used continuously for 58 days. Interview confirmed the nursing staff had requested the rectal tube be replaced while at the hospital's Wound Care Center on October 29, 2013, due to dislodging on the same day. Interview in nursing station with the Wound Care Physician on November 4, 2013, at 10:50 a.m., revealed, I apologize for having the rectal tube replaced last week, I didn't know how long it had been in.
F 0314	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, observation, and interview, the facility failed to prevent the development of avoidable pressure ulcers for four residents (#95, #114, #35, #73) of fourteen residents with pressure ulcers reviewed. The facility's failure to perform accurate assessments and obtain physician's orders placed residents #95, #114, #35 in Immediate Jeopardy (a situation in which the provider's non-compliance caused or is likely to cause serious injury, harm, impairment, or death). The systemic failure to ensure orders physician's orders for a medical device was obtained; skin assessments were performed correctly; pressure ulcers were assessed accurately; and treatments ordered by the physician were documented, was likely to place any resident at risk for pressure ulcers in Immediate Jeopardy. The Immediate Jeopardy was effective from November 26, 2012, and is ongoing. The Regional Vice President, Director of Clinical Services, Administrator, and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m., in the conference room. The findings included: Resident #95 was admitted to a Trauma Center on July 27, 2012, following an accident while burning brush in which there was an explosion. Two days later the family and friends were unable to contact the resident and a neighbor found the resident in the house, minimally responsive and lethargic. As a result of the accident the resident was a C6 quadriplegic (fracture of neck just above shoulders leaving resident unable to move from the neck down) [MEDICAL CONDITION] 15% (percent) of the body, including face, right arm, left arm, and bilateral lower extremities. Resident #95 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the discharge recommendations from Physical Therapy at an outside hospital, dated August 20, 2012, revealed .the following anti-contracture devices were applied to patient: Multipodus boots BLEs (bilateral lower extremities) continuously when supine. Interview with the Director of Nursing (DON) on October 3, 2013, at 12:50 p.m., at the nurses station, revealed the resident was admitted to the facility from the hospital on October 5, 2012, with a multipodus boot (for management of footdrop) in place on the left foot. Medical record review of the Interim Care Plan dated October 5, 2012, revealed, .potential for pain related to wounds.alteration in skin integrity r/t (related to) Burn.report new open areas. Medical record review of the admission nursing assessment dated [DATE], revealed the resident had an open area on the left knee, open/abrasion on the right lower extremity, reddened area to the scrotum area, sore/scabbed over area to the coccyx, reddened right lower extremity, and reddened area on the right side. Medical record review of the Admission Physician orders dated October 5, 2012, revealed, .float heels.pressure reducing mattress to bed.weekly skin check by licensed nurse. Medical record review of a Nurse's Note dated October 5, 2012, at 3:45 p.m., revealed, .skin pink warm, multiple red areas D/T (due to)[MEDICAL CONDITION] total Norton plus score (11) (indicates very high risk). Medical record review of the Treatment Administration Record (TAR) dated October 5-31, 2012, revealed, .open area to coccyx apply exuderm change q (every) 3 days (start date October 9, 2012).Weekly skin check. Continued review of the October TAR revealed no weekly skin assessments documented in October. Medical record review of an admission Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all Activities of Daily Living (ADL's); at risk for pressure ulcers; and had no pressure ulcers on admission. Medical record review revealed the resident was admitted to the hospital on October 24-29, 2012, for Altered Mental Status, Urinary Tract Infection, and for treatment of [REDACTED]. Medical record review of the Nursing Assessment Re-admitted d October 29, 2012, revealed .Skin/Wound condition present: no.red area (coccyx).scabbed area (right lower extremity) scab area (top of right foot).red area (right forearm).Norton Score 12 (very high risk). Medical record review of the Care Plan dated October 30, 2012, revealed, .potential for pain related to wounds.alteration in skin integrity r/t Burn.report new open areas.10/30/12 coccyx shearing. Medical record review of the Care Plan dated October 31, 2012, revealed .Skin (with) Stage II (partial loss of skin as shallow open ulcer)on coccyx. Medical record review of Treatment Administration Records (TAR) dated November 2012, revealed the resident was ordered Exuderm on November 12, 2012, to be applied to coccyx and change every three days. Continued review of the TAR revealed the treatment was not documented as being administered on November 20, 23, and 29, 2012. Further review of the TAR revealed an order to apply skin prep to bilateral heels each shift. Further review of the TAR revealed no documentation this was administered on the night shift on November 26, 29, and 30, 2012. Medical record review of a Nurse's Note dated November 26, 2012, at 10:00 a.m., revealed, .Blister noted to L (left) heel possibly caused by boot resident wears to prevent foot drop. Medical record review of a Nurse Practitioner (NP) note on November 26, 2012, revealed .Skin: normal. Medical record review of the Physician's orders from admission on October 5, 2012, to discharge on May 1, 2013, revealed no order for a boot. Medical record review of the resident's chart revealed no information regarding the application of the boot, the schedule of the boot, and/or the staff responsible for monitoring the boot. Medical record review of a Physician's order dated November 26, 2012, revealed, .Skin prep (strengthen skin to prevent breakdown) bilateral heels q (every) shift. Medical record review of a Physician's order dated November 26, 2012, revealed, .cleanse blister to left heel. Medical record review of an Interdisciplinary Progress Note (IDT) dated December 11, 2012, revealed, .open area to coccyx. and no documentation of the left heel blister. Medical record review of an IDT note dated December 18, 2012, revealed, .wound care to L heel.area to coccyx healed. Medical record review of Nutrition notes dated December 21, 2012, revealed .gradual weight trending down. Remains on fortified food with meals; refused house shakes repeatedly; remains on decubivite. Medical record review revealed no wound measurements for the left heel documented until December 27, 2012 (thirty-one days after discovery). Medical record review of a Pressure Ulcer Documentation Form dated December 27, 2012, revealed, .Left Heel Stage U (unstageable - base of ulcer covered with slough or eschar).Wound Measurements length 2 cm (centimeter) width 1.5 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Review of the TAR dated December 2012, revealed an order to cleanse blister to left heel with wound cleanser; apply hydrogel, purachol, and wrap with roll gauze twice daily. Continued review of the TAR for December 2012, revealed no documentation the treatment was administered on December 6, 12, 20, 21, 23, and 30, 2012, on the day shift, and December 3, 11, 23, and 27, 2012, on the night shift. Further review of the December TAR revealed the order for skin prep bilateral

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F 0314	(continued... from page 18) heels each shift was not documented as being administered on December 14, 20, and 30, 2012, on days and December 3, 11, 17, 23, 24, and 27, 2012, on nights. Medical record review of a Pressure Ulcer Documentation Form dated January 3, 2013, revealed, .Left Heel Stage U.Wound Measurements length 1.5 cm. width 1.5 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Medical record review of a physician progress notes [REDACTED]. Medical record review of a Pressure Ulcer Documentation Form dated January 8, 2013, revealed, .Left Heel Stage U.Wound Measurements length 1.5 cm. width 1 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Continued review of nutrition note dated January 10, 2013, revealed .left heel ulcer; protein powder BID (twice daily); snack BID; [MEDICATION NAME] started for appetite; [MEDICATION NAME] 2.7 (normal range 3.4 - 4.5); update food preferences. Review of the TAR for January 2013, revealed an order to cleanse blister to left heel with wound cleanser; apply hydrogel, purachol; wrap with roll gauze. Continued review of the January TAR revealed no documentation the treatment was administered on January 13, 18, 25, 29, and 30, 2013, on days and December 29 and 30, 2012, on nights. Continued review of the TAR for January revealed an order for [REDACTED]. Medical record review of a quarterly MDS dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all ADL's; at risk for pressure ulcers; had one Stage 1 pressure ulcer and no unstageable pressure ulcers. Medical record review of a Care Plan dated January 10, 2013, revealed, .Alteration in skin integrity r/t (related to): foot ulcer (left heel) shearing to coccyx.date initiated: 10/29/12.Revision on: 1/10/2013. Medical record review of a Pressure Ulcer Documentation Form dated January 16, 2013, revealed, .Left Heel Stage U.Wound Measurements length 2 cm. width 1 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Medical record review of a Pressure Ulcer Documentation Form dated January 23, 2013, revealed, .Left Heel Stage U.Wound Measurements length 1.5 cm. width .5 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Medical record review of a Pressure Ulcer Documentation Form dated January 30, 2013, revealed, .Left Heel Stage U.Wound Measurements length 1.5 cm. width .5 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Medical record review of an IDT note dated February 1, 2013, revealed, .wound care with positive results. Medical record review of a Pressure Ulcer Documentation Form dated February 5, 2013, revealed, .Left Heel Stage DTI (deep tissue injury)(purple area of intact skin or blood-filled blister).Wound Measurements length 1.5 cm. width 1.5 cm, no depth, no tunneling, no odor, exudates sm (small) type ser (serous), 100 % eschar (necrotic tissue), [MEDICAL CONDITION] present, no order change.no notification of change (to physician or family). Continued review revealed the wound now had serous drainage and the width of the ulcer had increased from 0.5 cm to 1.5 cm. Medical record review of a Pressure Ulcer Documentation Form dated February 12, 2013, revealed, .Left Heel Stage DTI.no Wound Measurements, no tunneling, no odor, exudate sm type ser, 100% eschar, [MEDICAL CONDITION] present, no order change.no notification of change (to physician or family). Continued review revealed the wound continued to have drainage. Medical record review of nutrition notes dated February 15, 2013, revealed .milk TID (three times daily); snacks BID (twice daily); protein powder BID; [MEDICATION NAME] (appetite stimulant); hydration encouraged throughout day. Medical record review of a NP note on February 18, 2013, revealed no skin concerns. Medical record review of a Pressure Ulcer Documentation Form dated February 19, 2013, and March 1, 2013, revealed, .Left Heel Stage DTI.no Wound Measurements, no tunneling, no odor, exudate sm type ser, 100 % eschar, [MEDICAL CONDITION] present, no order change.no notification of change (to physician or family). Continued review revealed the documentation was incomplete with no wound measurements. Medical record review of a Pressure Ulcer Documentation Form dated March 12, 2013, revealed, .Left Heel Stage DTI.Wound Measurements Length 1.7 cm, width 1.6 cm no depth documentation, no odor, exudates sm type ser, 25% slough (necrotic tissue.in process of separating) 75% eschar, [MEDICAL CONDITION] present,.no notification of change (to physician or family). Continued review of the medical record revealed the ulcer had increased in size; still had drainage; and necrotic tissue was present in the wound. Medical record review of a Physician's order dated March 13, 2013, revealed, .cleanse blister to left heel with wound cleanser.apply Santyl (removes necrotic tissue). Medical record review of a Pressure Ulcer Documentation Form dated March 19, 2013, revealed, .Left Heel Stage DTI.Wound Measurements Length 2 cm, Width 1.8 cm, no depth documented, no tunneling, no odor, exudates sm type ser, 100% slough, no order change.no notification of change (to physician or family). Continued review revealed the wound had increased in size; still had drainage; and still had necrotic tissue. Review of the TAR for March 2013, revealed the order for skin prep bilateral heels each shift and the treatment was not documented as administered on March 2, 3, 4, 8, 11, 12, 17, 18, 21, 23, 24, 25, 27, 28, and 30, 2013, on the night shift. Continued review of the TAR for March 2013, revealed an order for [REDACTED]. Medical record review revealed no documentation of the left heel pressure ulcer after March 19, 2013, through April 3, 2013 (fifteen days). Medical record review of a Physician's order dated March 20, 2013, revealed, .skin prep to bottom of left lateral foot and area under bottom of left small toe q (every) shift. Medical record review of a IDT note dated March 21, 2013, revealed, .new bed (with) air mattress which allows more room so (resident's) feet don't touch foot board d/t (due to) Pt (patient) sliding down in bed. Medical record review of a physician progress notes [REDACTED]. Medical record review of a Physician's order dated March 22, 2013, revealed, [MEDICATION NAME] 100 mg (milligram) po (by mouth) bid (twice daily) x (times) 10 days (wound infection). Medical record review of a NP note on April 1, 2013, revealed no documentation of skin concerns. Medical record review of an IDT note dated April 3, 2013, revealed, .Left heel.2.8 x 2.2 cm tx (treatment) (with) Santyl. Medical record review of nutrition notes dated April 4, 2013, revealed .eats 75 - 100% of all meals; received fortified foods for extra calories and protein to promote healing. Medical record review of a Physician's order dated April 8, 2013, revealed, [MEDICATION NAME] (antibiotic) 875-125 mg by mouth every eight hours for seven days wound. Medical record review of a Physician Order dated April 8, 2013, revealed, .Wound care consult complex. Medical record review of a Pressure Ulcer Documentation Form dated April 10, 2013, revealed .left heel 3 x 2.6 x 1 with 100% slough; left lower posterior leg upper wound 2.8 x 0.1, stage II; left lower posterior leg lower wound - 1.7 x 1.1 - stage II. Continued review revealed the heel ulcer had increased in size again. Further review revealed this is the first documentation of the two ulcers on the resident's left leg. Medical record review of a Diagnostic Imaging Report dated April 12, 2013, revealed, .lower extremity arterial evaluation including brachial.values are normal. Medical record review of a New Patient Medical History from the Wound Care Physician, dated April 12, 2013, revealed, .Heel Ulcers/Leg Ulcers.L heel 2.3 x 2.7 x 1.0 cm (centimeters). Medical record review of an IDT note dated April 18, 2013, revealed, .Left heel.5.2 x 2.5 x 1.5 cm 100 % slough tx to area (with) Santyl. Left lower leg lower ulcer 2.4 x 1.2 x 0.1, stage II; left lower leg upper ulcer 2.0 x 1.0 x 0.1, stage II. Medical record review of a NP note on April 29, 2013, revealed no skin concerns. Review of the TAR for April 2013, revealed an order for [REDACTED]. Continued review of the TAR revealed these treatments were not documented on April 21, 24, 29, and 30, 2013. Medical record review of a Physician Order dated May 1, 2013, revealed, .send to (hospital) for direct admit.wound debridement. Medical record review of the hospital History and Physical dated May 1, 2013, revealed .patient was seen in evaluation for multiple lower extremity ulcers, especially on the left heel. Patient was noted to have deep tissue injury and eschar that had slowly become more progressively exudative and was not adequately debrided at the bedside. Medical record review of Magnetic Resonance Imaging of the left foot dated May 3, 2013, revealed .evidence for osteo[DIAGNOSES REDACTED] (inflammation of the bone) in underlying calcaneous (heel bone), talar (ankle bone) head, neck; septic arthritis of tibiotalar (junction of large lower leg bone and ankle bone) joint; osteo[DIAGNOSES REDACTED] posterior malleolus (Protruberance on outside of ankle) tibia. Medical record review of cultures of the wounds on the heel and lower extremities revealed [MEDICAL CONDITION] (multi drug resistant organism) in calf wound, ankle, and left talus bone. Medical record review of a consultation by an Orthopedic Surgeon, dated May 3, 2013, revealed .Ulceration on back of right leg 1 x 6 cm, full thickness necrosis with exposed fascia in the depth of the wound. Left foot with ulceration and drainage from wound on anterior aspect of ankle joint; ulceration over heel 5 x 5 cm with black necrotic tissue on lateral side and necrosis on medial side, lateral side with track going down to calcaneous with foul odor. I explained I would not be able to remove all the infected bone without performing an amputation. Medical record review of the preoperative assessment dated [DATE], revealed .osteo[DIAGNOSES REDACTED] left calcaneous, left talus; stage IV (full skin loss with bone, tendon, or muscle is exposed) left heel and dorsum of foot; septic arthritis left ankle joint; stage III (full skin loss with subcutaneoue fat visible) pressure ulcer right posterior leg. Medical record review of the operative report dated May 5, 2013, revealed .left [MEDICAL CONDITION] was performed along with excision and closure of stage III ulcer to right posterior leg, 6 x 1.5 cm. Review of facility policy, Skin Integrity Management, dated October 1, 2010, revealed, .Staff continually observes and monitors patients for changes and implements revisions to the plan of care.to prevent the occurrence of pressure ulcers.perform wound observations and measurements and complete skin integrity report.develop comprehensive, interdisciplinary plan of care.document appearance and condition of the wound weekly.assure all skin treatments are documented on MDS (Minimum Data Set). Interview with the Medical Records Director on October 3, 2013, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER **WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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 0314

(continued... from page 19)
7:30 a.m., in the Medical Records Department, confirmed there was no documentation of wound measurements prior to December 27, 2012. Interview with MDS nurse #1 on October 3, 2013, at 8:00 a.m., in the MDS Office, confirmed the MDS dated [DATE], and November 2012, did not include a comprehensive assessment of the resident's pressure ulcers. Continued interview confirmed the Care Plan had not been updated to reflect the resident's pressure ulcer treatments or assessments until March 12, 2013. Interview with Registered Nurse (RN) #1 on October 3, 2013, at 9:00 a.m., on the A-Wing, revealed RN #1 had no measurements prior to late February or early March 2013. Interview with the resident's physician on October 3, 2013, at 11:35 a.m., on the A-Wing, confirmed the physician expected the facility to obtain an order with specific instructions for application and maintenance of a multipodus boot (footdrop management). Continued interview confirmed the physician expected the facility to complete weekly skin assessments with wound measurements for all pressure ulcers and notify the physician with changes. Interview with the Director of Nursing (DON) on October 3, 2013, at 12:50 p.m., at the Nurse's Station, confirmed there was no physician order for [REDACTED]. Further interview confirmed the left heel ulcer was caused by the multipodus boot and no documentation the left heel was assessed until the blister was discovered on November 26, 2012. Telephone interview with the Wound Care Physician on November 4, 2013, at 3:44 p.m., revealed the physician was consulted on the resident .about a month before the resident was admitted to the hospital. Continued interview with the Wound Care Physician revealed the resident had an ulcer on the left heel and on both shins, described as the lateral side of the leg where the calf meets the side of the leg. Further interview with the Wound Care Physician revealed the physician debrided (removed dead tissue to allow wound healing) the ulcers while the resident was still in the facility but the physician felt the area was regressing and the resident needed an Orthopedic consult because the wounds were deeper than the Wound Care Physician could handle. Continued interview with the Wound Care physician revealed .the foot was so gone from the pressure ulcers it had to be amputated. Further interview with the Wound Care Physician revealed he/she had not observed the multipodus boot in place and the resident's feet were usually propped with pillows when the physician visited the resident. Interview with the Unit Manager/Wound Care Nurse on November 5, 2013, at 7:50 a.m., in the conference room, revealed the resident had ulcers on the left heel, left foot, small toe, right heel, lateral foot, scab on right great toe, 2 on back of left leg which were stage II. Further interview with the Wound Care Nurse revealed the right heel wound was the only wound noted on the right leg. Interview with the Assistant Director of Nursing (ADON) on November 5, 2013, at 7:58 a.m., in the conference room, revealed the resident had own multipodus boots from the hospital. Further interview with the ADON revealed the resident wore the multipodus boots at all times except for showers. Continued interview with the ADON revealed .I can't remember exactly what the area looked like but there was stuff on both legs. Interview with the resident's attending physician on November 7, 2013, at 12:38 p.m., in the conference room, revealed the physician remembered the resident as being quadriplegic and also remembered the multipodus boot. Continued interview with the physician revealed the physician did not recall writing an order for [REDACTED]. specifics. Further interview with the physician revealed the physician expected nursing to check the skin under the boot every shift; ensure the boot was applied properly; make sure the boot was clean; and ensure the ulcer was not worsening. Continued interview with the physician revealed if the boot was not applied correctly it could cause problems including ulceration. Further interview with the physician revealed the physician . brought the Wound Care Physician on board but couldn't remember exactly when, specifically to care for the wounds. Continued interview with the physician revealed the facility usually called the Nurse Practitioner first with problems and if they could not reach the Nurse Practitioner then they would call the physician. In summary this fifty-eight year old resident was burning brush; an explosion occurred; two days later was found by a neighbor; and transferred to a trauma center where he was discovered to [MEDICAL CONDITION] 15% of the body and a neck fracture which rendered the resident a quadriplegic. The resident was admitted to the facility with a multipodus boot on the left foot to help prevent footdrop. The facility failed to obtain a physician's order for use of the multipodus boot and interview revealed the boot was on the resident's foot except for showers. A blister was noted to the left heel on November 26, 2012, but wound measurements were not begun until December 27, 2012. The wound became a pressure ulcer and the resident developed two decubitus ulcers on the left leg which were Stage II pressure ulcers. The resident developed a pressure ulcer on the back of the right leg which was not assessed by the facility. On May 1, 2013, the resident was transferred to the hospital after the Wound Care physician assessed the heel ulcer to be Stage IV; the right leg ulcer to be Stage III; and the left leg ulcers to be Stage II. Tests revealed the resident was [MEDICAL CONDITION] in the wounds and also had osteo[DIAGNOSES REDACTED] in the bones of the ankle. The Orthopedic Surgeon felt there was no way to save the foot so the resident underwent [REDACTED]. The facility failed to: 1. obtain a physician's order for use of the multipodus boot. 2. perform accurate assessments of the resident's skin, including the feet. 3. notify the physician of the development of a heel blister in a timely manner. 4. follow professional standards for care of the multipodus boot and the resident's foot. 5. follow physician orders as evidenced by many blanks in documentation of skin assessment weekly; application of exuderm to coccyx; application of skin prep to heels; and other treatments ordered by the physician. 6. document wound measurements on the heel ulcer for thirty-one days. 7. assess the resident appropriately until two stage II ulcers were discovered on the right leg. 8. recognize a stage III ulcer on the back of the resident's right leg (was not discovered until the resident was admitted to the hospital. These omissions led to a worsening of the ulcer ultimately requiring a below knee amputation.

Predicting Pressure Sore Risk completed August 19, 2013, revealed the resident had a score of 15, indicating mild risk. Resident #114 was admitted to the facility from the hospital on September 14, 2013, with [DIAGNOSES REDACTED]. Medical record review of the admission nursing assessment dated [DATE], revealed the resident had excoriation of the right buttock area, black areas of the left and right heels, and scored the pressure ulcer risk at 5 (indicating high risk on the Norton scale). Medical record review of the admission nursing note dated September 14, 2013, revealed, .Heel protectors placed on bilateral feet d/t (due to) black areas on each heel.Skin very thin and easy to tear. Medical record review of the physician orders dated September 14, 2013, revealed, Braden Skin assessment on admission/readmission and weekly x4 (for four weeks).Pressure reducing mattress to bed.weekly skin check by licensed nurse. Medical record review revealed the Braden Scale - For Predicting Pressure Sore Risk dated September 14, 2013, scored the resident an 8 which represented severe risk. Record review continued and revealed the Braden Skin assessment was not completed on the subsequent weekly intervals for the next three weeks. Medical record review of the initial Physical Therapy Evaluation dated September 16, 2013, revealed, .Per patient's son.4 months (prior).was ambulating, living in ALF (Assisted Living Facility).had feeding tube placed 8-27-13 secondary to aspiration.presents with B (bilateral) UE & LE (upper and lower extremity) contractures.appears to have been bedbound for an extended period of time. Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed cognitive skills severely impaired, required two person assistance for bed mobility, always incontinent of urine, with one Stage 1 pressure ulcer and two Unstageable pressure ulcers. Medical record review of the September 2013 Treatment Administration Record (TAR) revealed an entry for Duoderm to Right Buttock every 3 days and PRN (as needed). Review of the TAR revealed the treatment with Duoderm began on admission and continued through the end of the month of September. Review of the October TAR revealed the Duoderm treatment to the right buttock was not continued on the TAR in October 2013. Medical record review of the physician's History & Physical dated October 3, 2013, revealed no entry under physical examination, assessment, or plan related to the resident's skin integrity and/or pressure ulcers. Medical record review of the Wound Care Physician's orders dated October 1, 2013, after the resident was seen in the facility revealed, .Turn q (every) 2 hours. Do not use gerichair - may (increase) sacral wound. Medical record review of the Wound Care Physician's orders dated October 9, 2013, revealed, Sacral wound.Cleanse wound with wound cleanser.Fill wound with: [MEDICATION NAME] dressing with: bordered gauze.change: Daily.Return to Center in 2 weeks. Medical record review revealed the October 2013 Treatment Administration Record (TAR) or care plan did not include the Wound Care Physician's Orders from October 1 or 9, 2013. Medical record review revealed the tracking of the sacral/coccyx pressure ulcer began on October 15, 2013, fourteen days after the pressure ulcer was first assessed by the Wound Care Physician. Review of the tracking, on the Skin Integrity Report revealed, Stage II, granulating, 2 cm (centimeters) Length, 1.2 cm Width, and 0.1 cm Depth. Medical record review of the Wound Care Physician's orders dated October 15, 2013, revealed, Sacrum wound.Cleanse wound with wound cleanser.Apply Santyl (a [MEDICATION NAME] agent) to the wound bed.Cover wound with: [MEDICATION NAME] dressing with:
Sacral foam adhesive.change: Daily.Return to Center in 2 weeks.area (refering to the pressure ulcer) 2.25 square centimeters. Medical record review of the October 2013 TAR revealed the daily wound care to the sacrum/coccyx pressure ulcer was to be completed by the nigh

F 0314

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0314	(continued... from page 20) **sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, observation, and interview, the facility failed to prevent the development of avoidable pressure ulcers for four residents (#95, #114, #35, #73) of fourteen residents with pressure ulcers reviewed. The facility's failure to perform accurate assessments and obtain physician's orders placed residents #95, #114, #35 in Immediate Jeopardy (a situation in which the provider's non-compliance caused or is likely to cause serious injury, harm, impairment, or death). The systemic failure to ensure orders physician's orders for a medical device was obtained; skin assessments were performed correctly; pressure ulcers were assessed accurately; and treatments ordered by the physician were documented, was likely to place any resident at risk for pressure ulcers in Immediate Jeopardy. The Immediate Jeopardy was effective from November 26, 2012, and is ongoing. The Regional Vice President, Director of Clinical Services, Administrator, and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m., in the conference room. The findings included: Resident #95 was admitted to a Trauma Center on July 27, 2012, following an accident while burning brush in which there was an explosion. Two days later the family and friends were unable to contact the resident and a neighbor found the resident in the house, minimally responsive and lethargic. As a result of the accident the resident was a C6 quadriplegic (fracture of neck just above shoulders leaving resident unable to move from the neck down) [MEDICAL CONDITION] 15% (percent) of the body, including face, right arm, left arm, and bilateral lower extremities. Resident #95 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the discharge recommendations from Physical Therapy at an outside hospital, dated August 20, 2012, revealed .the following anti-contracture devices were applied to patient: Multipodus boots BLEs (bilateral lower extremities) continuously when supine. Interview with the Director of Nursing (DON) on October 3, 2013, at 12:50 p.m., at the nurses station, revealed the resident was admitted to the facility from the hospital on October 5, 2012, with a multipodus boot (for management of footdrop) in place on the left foot. Medical record review of the Interim Care Plan dated October 5, 2012, revealed, .potential for pain related to wounds.alteration in skin integrity r/t (related to) Burn.report new open areas. Medical record review of the admission nursing assessment dated [DATE], revealed the resident had an open area on the left knee, open/abrasion on the right lower extremity, reddened area to the scrotum area, sore/scabbed over area to the coccyx, reddened right lower extremity, and reddened area on the right side. Medical record review of the Admission Physician orders dated October 5, 2012, revealed, .float heels.pressure reducing mattress to bed.weekly skin check by licensed nurse. Medical record review of a Nurse's Note dated October 5, 2012, at 3:45 p.m., revealed, .skin pink warm, multiple red areas D/T (due to)[MEDICAL CONDITION] total Norton plus score (11) (indicates very high risk). Medical record review of the Treatment Administration Record (TAR) dated October 5-31, 2012, revealed, .open area to coccyx apply exuderm change q (every) 3 days (start date October 9, 2012).Weekly skin check. Continued review of the October TAR revealed no weekly skin assessments documented in October. Medical record review of an admission Minimum Data Set (MDS) dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all Activities of Daily Living (ADL's); at risk for pressure ulcers; and had no pressure ulcers on admission. Medical record review revealed the resident was admitted to the hospital on October 24-29, 2012, for Altered Mental Status, Urinary Tract Infection, and for treatment of [REDACTED]. Medical record review of the Nursing Assessment Re-admitted d October 29, 2012, revealed .Skin/Wound condition present: no.red area (coccyx).scabbed area (right lower extremity) scab area (top of right foot).red area (right forearm).Norton Score 12 (very high risk). Medical record review of the Care Plan dated October 30, 2012, revealed, .potential for pain related to wounds.alteration in skin integrity r/t Burn.report new open areas.10/30/12 coccyx shearing. Medical record review of the Care Plan dated October 31, 2012, revealed .Skin (with) Stage II (partial loss of skin as shallow open ulcer)on coccyx. Medical record review of Treatment Administration Records (TAR) dated November 2012, revealed the resident was ordered Exuderm on November 12, 2012, to be applied to coccyx and change every three days. Continued review of the TAR revealed the treatment was not documented as being administered on November 20, 23, and 29, 2012. Further review of the TAR revealed an order to apply skin prep to bilateral heels each shift. Further review of the TAR revealed no documentation this was administered on the night shift on November 26, 29, and 30, 2012. Medical record review of a Nurse's Note dated November 26, 2012, at 10:00 a.m., revealed, .Blister noted to L (left) heel possibly caused by boot resident wears to prevent foot drop. Medical record review of a Nurse Practitioner (NP) note on November 26, 2012, revealed .Skin: normal. Medical record review of the Physician's orders from admission on October 5, 2012, to discharge on May 1, 2013, revealed no order for a boot. Medical record review of the resident's chart revealed no information regarding the application of the boot, the schedule of the boot, and/or the staff responsible for monitoring the boot. Medical record review of a Physician's order dated November 26, 2012, revealed, .Skin prep (strengthen skin to prevent breakdown) bilateral heels q (every) shift. Medical record review of a Physician's order dated November 26, 2012, revealed, .cleanse blister to left heel. Medical record review of an Interdisciplinary Progress Note (IDT) dated December 11, 2012, revealed, .open area to coccyx. and no documentation of the left heel blister. Medical record review of an IDT note dated December 18, 2012, revealed, .wound care to L heel.area to coccyx healed. Medical record review of Nutrition notes dated December 21, 2012, revealed .gradual weight trending down. Remains on fortified food with meals; refused house shakes repeatedly; remains on decubivite. Medical record review revealed no wound measurements for the left heel documented until December 27, 2012 (thirty-one days after discovery). Medical record review of a Pressure Ulcer Documentation Form dated December 27, 2012, revealed, .Left Heel Stage U (unstageable - base of ulcer covered with slough or eschar).Wound Measurements length 2 cm (centimeter) width 1.5 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Review of the TAR dated December 2012, revealed an order to cleanse blister to left heel with wound cleanser; apply hydrogel, purachol, and wrap with roll gauze twice daily. Continued review of the TAR for December 2012, revealed no documentation the treatment was administered on December 6, 12, 20, 21, 23, and 30, 2012, on the day shift, and December 3, 11, 23, and 27, 2012, on the night shift. Further review of the December TAR revealed the order for skin prep bilateral heels each shift was not documented as being administered on December 14, 20, and 30, 2012, on days and December 3, 11, 17, 23, 24, and 27, 2012, on nights. Medical record review of a Pressure Ulcer Documentation Form dated January 3, 2013, revealed, .Left Heel Stage U.Wound Measurements length 1.5 cm. width 1.5 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Medical record review of a physician progress notes [REDACTED]. Medical record review of a Pressure Ulcer Documentation Form dated January 8, 2013, revealed, .Left Heel Stage U.Wound Measurements length 1.5 cm. width 1 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Continued review of nutrition note dated January 10, 2013, revealed .left heel ulcer; protein powder BID (twice daily); snack BID; [MEDICATION NAME] started for appetite; [MEDICATION NAME] 2.7 (normal range 3.4 - 4.5); update food preferences. Review of the TAR for January 2013, revealed an order to cleanse blister to left heel with wound cleanser; apply hydrogel, purachol; wrap with roll gauze. Continued review of the January TAR revealed no documentation the treatment was administered on January 13, 18, 25, 29, and 30, 2013, on days and December 29 and 30, 2012, on nights. Continued review of the TAR for January revealed an order for [REDACTED]. Medical record review of a quarterly MDS dated [DATE], revealed the resident was moderately impaired for daily decision making; totally dependent for all ADL's; at risk for pressure ulcers; had one Stage 1 pressure ulcer and no unstageable pressure ulcers. Medical record review of a Care Plan dated January 10, 2013, revealed, .Alteration in skin integrity r/t (related to): foot ulcer (left heel) shearing to coccyx.date initiated: 10/29/12.Revision on: 1/10/2013. Medical record review of a Pressure Ulcer Documentation Form dated January 16, 2013, revealed, .Left Heel Stage U.Wound Measurements length 2 cm. width 1 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Medical record review of a Pressure Ulcer Documentation Form dated January 23, 2013, revealed, .Left Heel Stage U.Wound Measurements length 1.5 cm. width .5 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Medical record review of a Pressure Ulcer Documentation Form dated January 30, 2013, revealed, .Left Heel Stage U.Wound Measurements length 1.5 cm. width .5 cm, (no depth documentation), no undermining, no tunneling, no odor, no exudate, no order change. Medical record review of an IDT note dated February 1, 2013, revealed, .wound care with positive results. Medical record review of a Pressure Ulcer Documentation Form dated February 5, 2013, revealed, .Left Heel Stage DTI (deep tissue injury)(purple area of intact skin or blood-filled blister).Wound Measurements length 1.5 cm. width 1.5 cm, no depth, no tunneling, no odor, exudates sm (small) type ser (serous), 100 % eschar (necrotic tissue), [MEDICAL CONDITION] present, no order change.no notification of change (to physician or family). Continued review revealed the wound now had serous drainage and the width of the ulcer had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER **WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **32 MEMORIAL DRIVE** **WINCHESTER, TN 37398**

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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F 0314	(continued... from page 21) increased from 0.5 cm to 1.5 cm. Medical record review of a Pressure Ulcer Documentation Form dated February 12, 2013, revealed, .Left Heel Stage DTI.no Wound Measurements, no tunneling, no odor, exudate sm type ser, 100% eschar, [MEDICAL CONDITION] present, no order change.no notification of change (to physician or family). Continued review revealed the wound continued to have drainage. Medical record review of nutrition notes dated February 15, 2013, revealed .milk TID (three times daily); snacks BID (twice daily); protein powder BID; [MEDICATION NAME] (appetite stimulant); hydration encouraged throughout day. Medical record review of a NP note on February 18, 2013, revealed no skin concerns. Medical record review of a Pressure Ulcer Documentation Form dated February 19, 2013, and March 1, 2013, revealed, .Left Heel Stage DTI.no Wound Measurements, no tunneling, no odor, exudate sm type ser, 100 % eschar, [MEDICAL CONDITION] present, no order change.no notification of change (to physician or family). Continued review revealed the documentation was incomplete with no wound measurements. Medical record review of a Pressure Ulcer Documentation Form dated March 12, 2013, revealed, .Left Heel Stage DTI.Wound Measurements Length 1.7 cm, width 1.6 cm no depth documentation, no odor, exudates sm type ser, 25% slough (necrotic tissue.in process of separating) 75% eschar, [MEDICAL CONDITION] present,.no notification of change (to physician or family). Continued review of the medical record revealed the ulcer had increased in size; still had drainage; and necrotic tissue was present in the wound. Medical record review of a Physician's order dated March 13, 2013, revealed, .cleanse blister to left heel with wound cleanser.apply Santyl (removes necrotic tissue). Medical record review of a Pressure Ulcer Documentation Form dated March 19, 2013, revealed, .Left Heel Stage DTI.Wound Measurements Length 2 cm, Width 1.8 cm, no depth documented, no tunneling, no odor, exudates sm type ser, 100% slough, no order change.no notification of change (to physician or family). Continued review revealed the wound had increased in size; still had drainage; and still had necrotic tissue. Review of the TAR for March 2013, revealed the order for skin prep bilateral heels each shift and the treatment was not documented as administered on March 2, 3, 4, 8, 11, 12, 17, 18, 21, 23, 24, 25, 27, 28, and 30, 2013, on the night shift. Continued review of the TAR for March 2013, revealed an order for [REDACTED]. Medical record review revealed no documentation of the left heel pressure ulcer after March 19, 2013, through April 3, 2013 (fifteen days). Medical record review of a Physician's order dated March 20, 2013, revealed, .skin prep to bottom of left lateral foot and area under bottom of left small toe q (every) shift. Medical record review of a IDT note dated March 21, 2013, revealed, .new bed (with) air mattress which allows more room so (resident's) feet don't touch foot board d/t (due to) Pt (patient) sliding down in bed. Medical record review of a physician progress notes [REDACTED]. Medical record review of a Physician's order dated March 22, 2013, revealed, [MEDICATION NAME] 100 mg (milligram) po (by mouth) bid (twice daily) x (times) 10 days (wound infection). Medical record review of a NP note on April 1, 2013, revealed no documentation of skin concerns. Medical record review of an IDT note dated April 3, 2013, revealed, .Left heel.2.8 x 2.2 cm tx (treatment) (with) Santyl. Medical record review of nutrition notes dated April 4, 2013, revealed .eats 75 - 100% of all meals; received fortified foods for extra calories and protein to promote healing. Medical record review of a Physician's order dated April 8, 2013, revealed, [MEDICATION NAME] (antibiotic) 875-125 mg by mouth every eight hours for seven days wound. Medical record review of a Physician Order dated April 8, 2013, revealed, .Wound care consult complex. Medical record review of a Pressure Ulcer Documentation Form dated April 10, 2013, revealed .left heel 3 x 2.6 x 1 with 100% slough; left lower posterior leg upper wound 2.8 x 0.1, stage II; left lower posterior leg lower wound - 1.7 x 1.1 - stage II. Continued review revealed the heel ulcer had increased in size again. Further review revealed this is the first documentation of the two ulcers on the resident's left leg. Medical record review of a Diagnostic Imaging Report dated April 12, 2013, revealed, .lower extremity arterial evaluation including brachial.values are normal. Medical record review of a New Patient Medical History from the Wound Care Physician, dated April 12, 2013, revealed, .Heel Ulcers/Leg Ulcers.L heel 2.3 x 2.7 x 1.0 cm (centimeters). Medical record review of an IDT note dated April 18, 2013, revealed, .Left heel.5.2 x 2.5 x 1.5 cm 100 % slough tx to area (with) Santyl. Left lower leg lower ulcer 2.4 x 1.2 x 0.1, stage II; left lower leg upper ulcer 2.0 x 1.0 x 0.1, stage II. Medical record review of a NP note on April 29, 2013, revealed no skin concerns. Review of the TAR for April 2013, revealed an order for [REDACTED]. Continued review of the TAR revealed these treatments were not documented on April 21, 24, 29, and 30, 2013. Medical record review of a Physician Order dated May 1, 2013, revealed, .send to (hospital) for direct admit.wound debridement. Medical record review of the hospital History and Physical dated May 1, 2013, revealed .patient was seen in evaluation for multiple lower extremity ulcers, especially on the left heel. Patient was noted to have deep tissue injury and eschar that had slowly become more progressively exudative and was not adequately debrided at the bedside. Medical record review of Magnetic Resonance Imaging of the left foot dated May 3, 2013, revealed .evidence for osteo[DIAGNOSES REDACTED] (inflammation of the bone) in underlying calcaneous (heel bone), talar (ankle bone) head, neck; septic arthritis of tibiotalar (junction of large lower leg bone and ankle bone) joint; osteo[DIAGNOSES REDACTED] posterior malleolus (Protruberance on outside of ankle) tibia. Medical record review of cultures of the wounds on the heel and lower extremities revealed [MEDICAL CONDITION] (multi drug resistant organism) in calf wound, ankle, and left talus bone. Medical record review of a consultation by an Orthopedic Surgeon, dated May 3, 2013, revealed .Ulceration on back of right leg 1 x 6 cm, full thickness necrosis with exposed fascia in the depth of the wound. Left foot with ulceration and drainage from wound on anterior aspect of ankle joint; ulceration over heel 5 x 5 cm with black necrotic tissue on lateral side and necrosis on medial side, lateral side with track going down to calcaneous with foul odor. I explained I would not be able to remove all the infected bone without performing an amputation. Medical record review of the preoperative assessment dated [DATE], revealed .osteo[DIAGNOSES REDACTED] left calcaneous, left talus; stage IV (full skin loss with bone, tendon, or muscle is exposed) left heel and dorsum of foot; septic arthritis left ankle joint; stage III (full skin loss with subcutaneoue fat visible) pressure ulcer right posterior leg. Medical record review of the operative report dated May 5, 2013, revealed .left [MEDICAL CONDITION] was performed along with excision and closure of stage III ulcer to right posterior leg, 6 x 1.5 cm. Review of facility policy, Skin Integrity Management, dated October 1, 2010, revealed, .Staff continually observes and monitors patients for changes and implements revisions to the plan of care.to prevent the occurrence of pressure ulcers.perform wound observations and measurements and complete skin integrity report.develop comprehensive, interdisciplinary plan of care.document appearance and condition of the wound weekly.assure all skin treatments are documented on MDS (Minimum Data Set). Interview with the Medical Records Director on October 3, 2013, at 7:30 a.m., in the Medical Records Department, confirmed there was no documentation of wound measurements prior to December 27, 2012. Interview with MDS nurse #1 on October 3, 2013, at 8:00 a.m., in the MDS Office, confirmed the MDS dated [DATE], and November 2012, did not include a comprehensive assessment of the resident's pressure ulcers. Continued interview confirmed the Care Plan had not been updated to reflect the resident's pressure ulcer treatments or assessments until March 12, 2013. Interview with Registered Nurse (RN) #1 on October 3, 2013, at 9:00 a.m., on the A-Wing, revealed RN #1 had no measurements prior to late February or early March 2013. Interview with the resident's physician on October 3, 2013, at 11:35 a.m., on the A-Wing, confirmed the physician expected the facility to obtain an order with specific instructions for application and maintenance of a multipodus boot (footdrop management). Continued interview confirmed the physician expected the facility to complete weekly skin assessments with wound measurements for all pressure ulcers and notify the physician with changes. Interview with the Director of Nursing (DON) on October 3, 2013, at 12:50 p.m., at the Nurse's Station, confirmed there was no physician order for [REDACTED]. Further interview confirmed the left heel ulcer was caused by the multipodus boot and no documentation the left heel was assessed until the blister was discovered on November 26, 2012. Telephone interview with the Wound Care Physician on November 4, 2013, at 3:44 p.m., revealed the physician was consulted on the resident .about a month before the resident was admitted to the hospital. Continued interview with the Wound Care Physician revealed the resident had an ulcer on the left heel and on both shins, described as the lateral side of the leg where the calf meets the side of the leg. Further interview with the Wound Care Physician revealed the physician debrided (removed dead tissue to allow wound healing) the ulcers while the resident was still in the facility but the physician felt the area was regressing and the resident needed an Orthopedic consult because the wounds were deeper than the Wound Care Physician could handle. Continued interview with the Wound Care physician revealed .the foot was so gone from the pressure ulcers it had to be amputated. Further interview with the Wound Care Physician revealed he/she had not observed the multipodus boot in place and the resident's feet were usually propped with pillows when the physician visited the resident. Interview with the Unit Manager/Wound Care Nurse on November 5, 2013, at 7:50 a.m., in the conference room, revealed the resident had ulcers on the left heel, left foot, small toe, right heel, lateral foot, scab on right great toe, 2 on back of left leg which were stage II. Further interview with the Wound Care Nurse revealed the right heel wound was the only wound noted on the right leg. Interview with the Assistant Director of Nursing (ADON) on November 5, 2013, at 7:58 a.m., in the conference room, revealed the resident had own multipodus boots from the hospital. Further interview with the ADON revealed the resident wore the multipodus boots at all times except for showers. Continued interview with the ADON

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F 0314	(continued... from page 22) revealed .I can't remember exactly what the area looked like but there was stuff on both legs. Interview with the resident's attending physician on November 7, 2013, at 12:38 p.m., in the conference room, revealed the physician remembered the resident as being quadriplegic and also remembered the multipodus boot. Continued interview with the physician revealed the physician did not recall writing an order for [REDACTED]. specifics. Further interview with the physician revealed the physician expected nursing to check the skin under the boot every shift; ensure the boot was applied properly; make sure the boot was clean; and ensure the ulcer was not worsening. Continued interview with the physician revealed if the boot was not applied correctly it could cause problems including ulceration. Further interview with the physician revealed the physician . brought the Wound Care Physician on board but couldn't remember exactly when, specifically to care for the wounds. Continued interview with the physician revealed the facility usually called the Nurse Practitioner first with problems and if they could not reach the Nurse Practitioner then they would call the physician. In summary this fifty-eight year old resident was burning brush; an explosion occurred; two days later was found by a neighbor; and transferred to a trauma center where he was discovered to [MEDICAL CONDITION] 15% of the body and a neck fracture which rendered the resident a quadriplegic. The resident was admitted to the facility with a multipodus boot on the left foot to help prevent footdrop. The facility failed to obtain a physician's order for use of the multipodus boot and interview revealed the boot was on the resident's foot except for showers. A blister was noted to the left heel on November 26, 2012, but wound measurements were not begun until December 27, 2012. The wound became a pressure ulcer and the resident developed two decubitus ulcers on the left leg which were Stage II pressure ulcers. The resident developed a pressure ulcer on the back of the right leg which was not assessed by the facility. On May 1, 2013, the resident was transferred to the hospital after the Wound Care physician assessed the heel ulcer to be Stage IV; the right leg ulcer to be Stage III; and the left leg ulcers to be Stage II. Tests revealed the resident was [MEDICAL CONDITION] in the wounds and also had osteo[DIAGNOSES REDACTED] in the bones of the ankle. The Orthopedic Surgeon felt there was no way to save the foot so the resident underwent [REDACTED]. The facility failed to: 1. obtain a physician's order for use of the multipodus boot. 2. perform accurate assessments of the resident's skin, including the feet. 3. notify the physician of the development of a heel blister in a timely manner. 4. follow professional standards for care of the multipodus boot and the resident's foot. 5. follow physician orders as evidenced by many blanks in documentation of skin assessment weekly; application of exuderm to coccyx; application of skin prep to heels; and other treatments ordered by the physician. 6. document wound measurements on the heel ulcer for thirty-one days. 7. assess the resident appropriately until two stage II ulcers were discovered on the right leg. 8. recognize a stage III ulcer on the back of the resident's right leg (was not discovered until the resident was admitted to the hospital. These omissions led to a worsening of the ulcer ultimately requiring a below knee amputation. Predicting Pressure Sore Risk completed August 19, 2013, revealed the resident had a score of 15, indicating mild risk. Resident #114 was admitted to the facility from the hospital on September 14, 2013, with [DIAGNOSES REDACTED]. Medical record review of the admission nursing assessment dated [DATE], revealed the resident had excoriation of the right buttock area, black areas of the left and right heels, and scored the pressure ulcer risk at 5 (indicating high risk on the Norton scale). Medical record review of the admission nursing note dated September 14, 2013, revealed, .Heel protectors placed on bilateral feet d/t (due to) black areas on each heel.Skin very thin and easy to tear. Medical record review of the physician orders dated September 14, 2013, revealed, Braden Skin assessment on admission/readmission and weekly x4 (for four weeks).Pressure reducing mattress to bed.weekly skin check by licensed nurse. Medical record review revealed the Braden Scale - For Predicting Pressure Sore Risk dated September 14, 2013, scored the resident an 8 which represented severe risk. Record review continued and revealed the Braden Skin assessment was not completed on the subsequent weekly intervals for the next three weeks. Medical record review of the initial Physical Therapy Evaluation dated September 16, 2013, revealed, .Per patient's son.4 months (prior).was ambulating, living in ALF (Assisted Living Facility).had feeding tube placed 8-27-13 secondary to aspiration.presents with B (bilateral) UE & LE (upper and lower extremity) contractures.appears to have been bedbound for an extended period of time. Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed cognitive skills severely impaired, required two person assistance for bed mobility, always incontinent of urine, with one Stage 1 pressure ulcer and two Unstageable pressure ulcers. Medical record review of the September 2013 Treatment Administration Record (TAR) revealed an entry for Duoderm to Right Buttock every 3 days and PRN (as needed). Review of the TAR revealed the treatment with Duoderm began on admission and continued through the end of the month of September. Review of the October TAR revealed the Duoderm treatment to the right buttock was not continued on the TAR in October 2013. Medical record review of the physician's History & Physical dated October 3, 2013, revealed no entry under physical examination, assessment, or plan related to the resident's skin integrity and/or pressure ulcers. Medical record review of the Wound Care Physician's orders dated October 1, 2013, after the resident was seen in the facility revealed, .Turn q (every) 2 hours. Do not use gerichair - may (increase) sacral wound. Medical record review of the Wound Care Physician's orders dated October 9, 2013, revealed, Sacral wound.Cleanse wound with wound cleanser.Fill wound with: [MEDICATION NAME] dressing with: bordered gauze.change: Daily.Return to Center in 2 weeks. Medical record review revealed the October 2013 Treatment Administration Record (TAR) or care plan did not include the Wound Care Physician's Orders from October 1 or 9, 2013. Medical record review revealed the tracking of the sacral/coccyx pressure ulcer began on October 15, 2013, fourteen days after the pressure ulcer was first assessed by the Wound Care Physician. Review of the tracking, on the Skin Integrity Report revealed, Stage II, granulating, 2 cm (centimeters) Length, 1.2 cm Width, and 0.1 cm Depth. Medical record review of the Wound Care Physician's orders dated October 15, 2013, revealed, Sacrum wound.Cleanse wound with wound cleanser.Apply Santyl (a [MEDICATION NAME] agent) to the wound bed.Cover wound with: [MEDICATION NAME] dressing with: Sacral foam adhesive.change: Daily.Return to Center in 2 weeks.area (refering to the pressure ulcer) 2.25 square centimeters. Medical record review of the October 2013 TAR revealed the daily wound care to the sacrum/coccyx pressure ulcer was to be completed by the nigh
F 0315	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, and interview, the facility failed to assess urinary function for one resident (#113) of sixty-five residents reviewed. The findings included: Resident #113 was admitted to the facility on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. Medical record review of the Nursing assessment dated [DATE], revealed the resident was alert; had no mood or behavior problems; was oriented to person, place and time; received psychoactive medications for anxiety; and had an indwelling catheter. Medical record review revealed no diagnoses for the indwelling catheter and no bowel and bladder assessment was completed since admission. Review of facility policy, Catheter Use, dated October 1, 2005, revealed .Indwelling catheter may be used if patient meets one of the following [MEDICAL CONDITION] to manage retention.persistent overflow. Review of facility policy, Continence Management, dated October 1, 2010, revealed .Patients with an indwelling catheter will be assessed to determine appropriateness of an indwelling catheter. Interview with the Director of Nursing (DON) on October 1, 2013, at 4:15 p.m., in the Nurse's Station revealed bowel and bladder assessments were to be completed within twenty-four to seventy-two hours after admission. Interview with the DON on October 1, 2013, at 4:45 p.m., at the Nurse's Station confirmed there was no diagnosis for the Foley catheter and no bowel and bladder assessment was completed for the resident since admission (four days later).
F 0315	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of facility policy, and interview, the facility failed to assess urinary function

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0315	(continued... from page 23) for one resident (#113) of sixty-five residents reviewed. The findings included: Resident #113 was admitted to the facility on [DATE], with diagnosed including: [DIAGNOSES REDACTED]. Medical record review of the Nursing assessment dated [DATE], revealed the resident was alert; had no mood or behavior problems; was oriented to person, place and time; received psychoactive medications for anxiety; and had an indwelling catheter. Medical record review revealed no diagnoses for the indwelling catheter and no bowel and bladder assessment was completed since admission. Review of facility policy, Catheter Use, dated October 1, 2005, revealed .Indwelling catheter may be used if patient meets one of the following [MEDICAL CONDITION] to manage retention.persistent overflow. Review of facility policy, Continence Management, dated October 1, 2010, revealed .Patients with an indwelling catheter will be assessed to determine appropriateness of an indwelling catheter. Interview with the Director of Nursing (DON) on October 1, 2013, at 4:15 p.m., in the Nurse's Station revealed bowel and bladder assessments were to be completed within twenty-four to seventy-two hours after admission. Interview with the DON on October 1, 2013, at 4:45 p.m., at the Nurse's Station confirmed there was no diagnosis for the Foley catheter and no bowel and bladder assessment was completed for the resident since admission (four days later).
F 0323	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, medical record review, review of the Fall Risk Evaluation forms, review of the facility fall reports, review of facility documentation, interview, and observation, the facility failed to investigate and develop new interventions to address falls for fourteen residents (#35, #73, #17, #24, #42, #119, #100, #62, #120, #26, #23, #113, #52, and #89) of twenty-two residents with falls reviewed. The facility's failure to investigate and develop new interventions to address falls placed residents #35 and #73 in Immediate Jeopardy (a situation in which the provider's non-compliance has caused or likely to cause serious injury, harm, impairment or death). The Immediate Jeopardy was effective on November 26, 2012, and is ongoing. The Regional Vice President, Director of Clinical Services, Administrator and Director of Nursing were informed of the Immedicate Jeopardy on November 6, 2013, at 2:30 p.m. in the conference room. The findings included: Review of the facility policy entitled Falls Management, effective on September 15, 2001, and revised on June 1, 2013, revealed, .If patient falls.Update care plan to reflect new interventions. Review of the facility policy entitled Falls Care Delivery Process, with revision date of June 1, 2013, revealed, .response to a Patient Fall: .Complete.Resident Incident report.to implement new interventions.Investigate fall circumstances.Implement immediate interventions after the fall.Complete Condition of Change Document.staff.Conduct interdisciplinary team meeting within 72 hours of patient fall to perform the following: .Update care plan with new interventions as appropriate.Communicate interventions to staff. Review of the facility policy entitled Falls Management, with revision date of June 1, 2013, revealed, .If patient falls:.Perform Neurological Assessment for all unwitnessed falls and witnessed falls with head injury. Review of the facility policy entitled Assessment: Neurological with revision date of October 1, 2012, revealed, Neurological assessment will be performed as indicated or ordered. When a patient sustains an injury to the head and/or unwitnessed fall, neurological assessment will be performed: every 30 minutes x (for) two hours, then every one hour x four hours, then every four hours x 24 hours. Resident #35 was admitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review revealed the resident was readmitted [DATE], after an Open Reduction and Internal Fixation of a Right Hip Fracture. Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Mental Status score of 14, indicating no cognitive impairment. Medical record review of the Fall Risk Evaluation completed on admission and at quarterly reviews on March 8, and June 8, 2013, revealed the resident was high risk for falls. Medical record review of the physical therapy (PT) notes from admission through June 13, 2013, revealed the resident received PT for transfers and gait training. Review of the PT notes dated June 3, 2013, revealed, .good progress with gait. However pt (patient) continues to demonstrate poor safety awareness and judgement.Patient continues to require minimal assist for sit to stand for transfers secondary to bilateral hip weakness. Pt's visual handicap will prevent gait independence. Further review revealed the resident was able to ambulate up to 300 feet with a rolling walker and began a restorative nursing program on June 15, 2013, to continue ambulation with the rolling walker. Medical record review of facility fall reports and Care Plans (from December 2012 through September 2013) revealed the resident had a history of [REDACTED]. January 12, 2013, at 4:20 a.m., fell on the way to bathroom, unwitnessed, no neuro (neurological) checks (to assess for head injury) were done, no root cause or contributing factors identified, Safety alarm. was added to the resident's care plan; January 15, 2013, no facility report provided for review, no neuro checks were done, no root cause or contributing factors identified, no new intervention developed; March 6, 2013 at 7:50 a.m., the fall report was initiated March 6, 2013 and completed six months later, on October 1, 2013, by the Director of Nurses. Review revealed the resident was found face down on the floor, complained of a headache, had a small skin tear of the right elbow, was seen in the emergency room , no neuro checks were done, no root cause or contributing factors identified, no new intervention developed; March 21, 2013, at 7:20 a.m., fall report related to the fall was not completed. Review revealed, .asked resident what happened.stated 'I just changed seats was trying to go to the bathroom and slid out of the bed onto my bottom, no root cause or contributing factors identified, no new intervention developed; April 1, 2013, at 11:55 p.m., facility fall report was not completed. Review revealed the resident was seen in the emergency room for a hematoma at the back of head the size of a baseball. No root cause or contributing factors identified. Review revealed a scoop mattress was care planned; May 21, 2013, at 4:15 p.m., facility fall report revealed this was a witnessed fall. An investigation of the falI was not completed. Review revealed the resident was assisted to the bathroom by a Certified Nurse Aide (CNA) who left the resident's side to assist the roommate and witnessed the resident stand, adjust clothing, tumble into the bathtub, and hit head. Review revealed the resident was not seen in the emergency room . No root cause or contributing factors were identified and no new intervention was developed; May 25, 2013, at 7:25 a.m., facility fall report revealed a CNA heard the safety alarm, saw the bathroom emergency call light blinking, and found the resident in the bathroom on the floor with bruises, a skin tear to the left arm. Review of subsequent facility documentation addressed a large bruise to the right hip, discovered on May 27, 2013, and the bruise was attributed to the fall of May 21, 2013. Review revealed the resident was seen in the emergency room . No neuro checks were done, no root cause or contributing factors identified, no new intervention developed; July 19, 2013, at 8:20 a.m., facility fall report was not initiated until October 1, 2013, by the DON. Review revealed the resident was found on the floor and old skin tear re-opened. No neuro checks completed, no root cause or contributing factors identified. Review of the Care Plan revealed, 7/19/13 fall.Intervention.Reacher/grabber. Review of a Nurse's Note revealed a bruise was reported on July 20, 2013, with bruising of the left hip and left lower leg noted and attributed to the fall of July 19, 2013; August 12, 2013, at 3:40 a.m., facility fall report revealed To resident room to answer call light, resident sitting in floor beside the bed.noted abrasion to right cheek and resident c/o (complained of) pain to right hip. Interview by telephone on October 3, 2013, at 7:12 a.m., with registered nurse (RN) #3 (the RN on duty the night of August 12, 2013) revealed when the resident fell and broke the right hip, on the night of August 12, 2013, there were two nurses on duty, who were both drawing blood and the two CNAs on duty were down another hall. Interview continued and revealed I heard (resident #35) way down at the end of B hall.found her on the floor. Medical record review of a History and Physical on admission to the hospital on August 12, 2013, revealed, .XXX[AGE] year-old.trying to get out of bed where a call light had been put on.did not get much help so.tried to get up by self and water spilled.slid and broke hip.Assessment and Plan: fall with right intertrochanteric fracture.still alert.wants surgery. Review of the occupational therapy (OT) note dated August 21, 2013, revealed, .patient is NWB (non-weight bearing/not able to walk) through RLE (right lower extremity) and has had a decline in ADL's (activities of daily living) and transfers. Observation of the dining room at 12:30 a.m., on September 30, 2013, revealed the resident was brought to lunch in a wheelchair. Interview with the Director of Nurses (DON) and concurrent review of the fall reports was conducted at 7:45 a.m., on October 2, 2013, in the MDS office. Interview verified a fall report for the fall on January 15, 2013, was missing, a fall investigation for January 12, 2013, was not completed until March 25, 2013, and did not include a root cause or contributing factors, a fall report for the March 6, 2013, fall had been completed by the DON on October 1, 2013, six months after the fall, and none of the falls had complete investigation identifying the root cause and contributing factors. Interview continued and confirmed the falls were not investigated (required to be completed by an interdisciplinary team within 72 hours of a fall) for the eight falls sustained by the resident from January through July of 2013. Interview confirmed an investigation of the fall with fracture in August 2013 had not been done by an interdisciplinary team to date. Interview confirmed the August 12, 2013, fracture to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323	(continued... from page 24) the right hip requiring surgery, resulted in the resident being unable to walk, a lower ability to transfer, and a decline in the ability to perform activities of daily living. Medical record review of an Interdisciplinary Progress Note dated August 19, 2013, revealed the resident was readmitted on this date following right hip surgery. Medical record review of the Re-admission nursing assessment dated [DATE], revealed the resident returned from a hospitalization due to a Urinary Tract Infection. Medical record review of the Fall Risk Evaluation dated October 7, 2013, revealed a score of 13, high risk for falls. Review of a fall report revealed the resident fell in the bathroom at 4:32 a.m., on October 9, 2013. Review of the resident's Care Plan and concurrent interview with the Director of Nurses (DON) in the conference room at 1:00 p.m., on October 28, 2013, confirmed the resident did not have individualized falls prevention interventions resumed upon returned to the facility October 7, 2013. Interview confirmed the Interdisciplinary Team did not investigate and develop new appoaches after the fall on August 12, 2013, resulting in the right hip fracture or after the October 9, 2013, fall. Resident #73 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Interdisciplinary Progress Notes dated October 19, 2012, at 1:00 p.m., revealed .activity tray in place d/t (due to) decreased safety awareness.low bed with pressure sensitive alarm while in bed. Medical record review of the Change of Condition Documentation dated December 8, 2012, revealed .pt (patient) lying on her L (left) side on safety mat.bed alarm noted to be off.no injury.bed now in lowest position.safety mat in place. Medical record review of the quarterly MDS (Minimum Data Set) dated January 9, 2013, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 2 (severe cognitive impairment). Further review of the MDS, revealed the resident was dependent on staff for bed mobility, transfers, bathing, dressing, toilet use, and personal hygiene. Medical record review of the Interdisciplinary Progress Notes dated December 9, 2012 for the fall occurring on December 8, 2012, revealed .bed in lowest position.safety mats.pressure alarm. Medical record review of the plan of care revealed no new interventions documented for the fall on December 8, 2012. Medical record review of the Change of Condition Documentation dated December 24, 2012, revealed .in dining room lying on left side.had removed lap buddy.assisted to chair and taken to room.bed alarm in use.bed in low position with mat at bedside. Medical record review of the plan of care revealed no new interventions documented for the fall on December 24, 2012. Medical record review of the Interdisciplinary Progress Notes dated December 28, 2012, revealed .removed activity tray.safety alarm to chair and bed. Medical record review of the care plan updated January 11, 2013, revealed Resident #73 was at risk for falls. Medical record review of the Change of Condition Documentation dated January 12, 2013, revealed .removed lap buddy.missed chair.replaced lap buddy with another lap buddy. Medical record review of the Pain Evaluation dated January 12, 2013, revealed the resident had pain in the right shoulder at an intensity of 3-4 (moderate pain). Medical record review of the plan of care revealed no new interventions documented for the fall on January 12, 2013. Medical record review of the Change of Condition Documentation dated, January 13, 2013, revealed .rolled out of bed.c/o (complains of) pain to rt (right) shoulder. Medical record review of the Pain Evaluation dated January 13 2013, revealed the resident had pain in the the right shoulder at an intensity of 1-2 (mild pain). Medical record review of the plan of care revealed no new interventions documented regarding the fall on January 13, 2013. Medical record review of the Interdisciplinary Progress Notes at 1:05 a.m., January 14, 2013, revealed .c/o (complains of) R (right) shoulder pain. Medical record review of the Interdisciplinary Progress Notes at 6:00 a.m., January 14, 2013, revealed, .large area of purple and blue/green bruising to R (right) posterior shoulder.guarding area. Medical record review of the Interdisciplinary Progres Notes at 8:00 a.m., January 14, 2013, revealed, c/o R shoulder pain.large amount bruising.send to hospital. Review of the hospital Discharge Summary dated January 18, 2013, revealed Resident #73 was admitted to the hospital with [REDACTED]. Review of the facility's policy titled 7.0 Falls Management dated September 15, 2001 and revised June 1, 2013, revealed .patients experiencing a fall will receive appropriate care.investigation of the cause.6.4 update care plan to reflect new interventions.6.5.3 document effectiveness of interventions. Interview with the ADON (Assistant Director of Nursing) on October 3, 2013, at 8:15 a.m. in the admissions office, confirmed the facility had failed to follow the facility's policy to investigate the cause of the resident's falls and had failed to implement new interventions after the falls on December 8, 2012, December 24, 2012, January 12, 2013 and January 13, 2013 which resulted in a fractured right clavicle. Resident #17 was admitted on [DATE], with [DIAGNOSES REDACTED]. Observation at 10:00 a.m., and 4:00 p.m., revealed the resident in the bed napping with shoes in wheelchair at bedside on October 30, 2013. Medical record review of facility documentation revealed the resident had seven falls in 2013 as follows: March 3, 2013, at 3:15 pm - fell out of the wheel chair (w/c) an investigation was initiated, unwitnessed without neuro checks being done, but no root cause or contributing factor determined and no new interventions to address the fall were developed. March 23, 2013 - Interview on October 30, 2013, with LPN #1 at 10:30 a.m., in the conference room, confirmed no report of the fall, other than what was in the Nurse's Notes, could be found and confirmed there had not been an investigation or any care plan interventions developed after the fall. April 8, 2013, at 1:20 p.m., - fell in their room, out of the w/c and struck head, no neuro checks were done. No investigation was initiated, no new interventions to address falls other than re-educate to call for help. May 5, 2013, at 2:00 p.m. - fell out of the w/c, reaching to floor. No neuro checks were done. An investigation was initiated, but no root cause or contributing factors determined and no new interventions to address the fall were developed. May 12, 2013, at 3:00 a.m. - fell as attempting to toilet self. An investigation was initiated, but no root cause or contributing factors determined and no new interventions to address the fall were developed. June 8, 2013, at 8:30 a.m. - Slipped out of the w/c onto floor. No investigation was initiated, no new interventions to address the fall. June 23, 2013, at 8:45 a.m. - An investigation was done and determined needs a reacher. Interview on October 30, 2013, with LPN #1 at 10:30 a.m., in the conference room, confirmed when the Interdisciplinary Team met and investigated the falls after the June 23, 2013, fall, the resident was provided a reacher and there had been no further falls. Resident #24 was admitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review revealed the resident was followed by Hospice and was able to return home on October 4, 2013. Review of the facility documentation revealed three falls had been reported and none of the falls had investigations initiated or completed. The three falls were reported as follows: April 14, 2013, at 11:45 a.m. - fell in the bathroom, swelling in the left elbow and pain left upper shoulder, xrays obtained at the facility with no fracture noted. A new intervention was care planned. July 7, 2013, at 8:10 a.m., Fall on the way to bathroom, the floor had been mopped and remained wet. The DON documented in the Intradisciplinary Team notes current interventions working and no new interventions to address falls were developed. September 18, 2013 - Sat on floor in front of the electric wheelchair on the way to the bathroom. Resident stated started to slide. Nursing provided non-skid socks. Interview with LPN #1, in the conference room, on October 30, 2013, at 3:30 p.m.,confirmed no investigation of any of the three falls was done and no new individualized interventions were developed to address the last two falls. Resident #42 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a quarterly Minimum Data Sets (MDS) dated [DATE], and May 25, 2013, revealed the resident was moderately impaired for daily decision making; required extensive assistance with bed mobility, transfers, and locomotion on unit; and required total dependence for locomotion off unit and toilet use. Medical record review of facility documentation revealed the resident had seven falls from January 2013 through August 2013 as follows: January 29, 2013, at 8:50 p.m. - fell from wheelchair (w/c) as reaching out as if to pick something off of the floor and hit head on the doorframe. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. March 3, 2013, at 5:00 a.m. - Had been gotten up into the w/c by staff due to agitation and then fell out of the w/c, no witness. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. March 3, 2013, at 12:15 p.m. - Found out of the w/c in dining room floor, lying on back. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. March 12, 2013, at 2:15 p.m. - The resident stated trying to get into bed and fell to floor. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. April 9, 2013, at 6:00 p.m. - Found lying on floor on the bedside floor mat, no mention of whether the resident had been in the bed or the w/c. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. July 15, 2013, at 1:45 p.m. - Found between the toilet and the wall on hands and knees after a CNA heard the pull away alarm. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. July 25, 2013, at 12:20 pm - Stood up and fell from w/c in solarium, witnessed. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. Interview at 2:20 p.m., on October 29, 2013, in the conference room, with LPN #1 confirmed the resident had one investigation completed for the seven falls from January 2013 through August 2013. Continued interview confirmed the resident did not have interventions developed to address the falls of March 12, 2013, and April 9, 2013. Resident # 119 was admitted to the facility on [DATE], with admitting [DIAGNOSES REDACTED]. Medical record review of facility Change of Condition Documentation fall dated January 5, 2013,

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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F 0323

(continued... from page 25)
.pressure alarm sounding, resident found sitting on floor complained of bilateral hip pain.Golf-ball sized bruise noted on crown, no bleeding noted .assisted to wheelchair; Nurse Practioner (NP) notified x-ray of bilateral hip. Medical record review of facility Change of Condition Documentation fall dated January 13, 2013, a facility report dated 1/15/13 . resident was trying to transfer self from bed to chair and fell on floor, landed on bottom. No injuries observed. Alarm on and sounding. Resident was educated on using call light to ask for assistance for transfers. Interview with the Administrator on October 29, 2013, at 3:30 p.m., in the conference room, with concurrent review of the resident's four falls, including a fall on February 10, 2013, and a fall on March 15, 2013, verified the following: The facility had a report completed immediately after the resident's four falls; the resident did not have injuries requiring transfer to the hospital; investigations were not completed to address the root cause and contributing factors to the four falls; and the resident was dismissed to home on May 5, 2013. Interview continued and the Administrator stated, It has already been acknowledged there were system problems with falls.

Resident #100 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the facility's fall report dated February 18, 2013, revealed .to room.found resident sitting on floor beside bed.no injury.re-educated to call light usage.call light within reach.bed in lowest position.safety alarm placed. Medical record review of the Care Plan dated February 18, 2013, revealed .poor coordination due to recent aka (above knee amputation) of right leg/foot.encourage.to use handrails.have commonly used articles within easy reach. Medical record review of the Change of Condition Documentation dated February 18, 2013, revealed .summoned to patient's room.sitting on the floor bedside bed.no injury.re-educated to call light usage and call light placed within reach.bed in lowest position.safety alarm placed. Medical record review of the Care Plan dated February 19, 2013, revealed .low bed.safety alarm in bed/chair.remove all objects near bed to prevent injury.when resident in bed place all necessary personal items within reach.reinforce need to call for assistance.PT (Physical Therapy) evaluation.place call light within easy reach.ensure environment is free of clutter. Medical record review of the facility's fall report dated February 21, 2013, revealed .responded to call light.laying in floor next to bed.stated was trying to change TV (television) station.forgot I don't (do not) have a right leg anymore. Medical record review of the Care Plan revealed no new interventions documented for the fall on February 21, 2013. Medical record review of the Change of Condition Documentation dated February 21, 2013, revealed .observed laying on floor next to bed.going to change TV (television).reinforce proper use of call light. Medical record review of the facility's fall report dated February 23, 2013, revealed .fell from wheelchair.found on floor.laying on chair alarm.bending over and fell out of wheelchair. Medical record review of the Care Plan dated February 23, 2013, revealed .teach resident to ask for help.bed in lowest position.safety mats. Medical record review of the Interdisciplinary Notes dated February 23, 2013, revealed .continues with therapy. Medical record review of the Change of Condition Documentation dated February 23, 2013, revealed .found laying in the floor on left side with bed alarm under (resident).stated that (resident) was bending over and went to far. Medical record review of an annual MDS (Minimum Data Set) dated February 25, 2013, revealed the resident was totally dependent for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. Further review of the MDS revealed, the resident had a BIMS (Brief Interview for Mental Status) score of 15 (no cognitive impairment). Medical record review of the Interdisciplinary Notes dated February 26, 2013, revealed .alert with confusion.several falls since admission.self-propels while up in wheelchair.confused to thinking.able to ambulate. Medical record review of Physician's Orders dated February 26, 2013, revealed .Physical Therapy for wheelchair mobility and strength training. Medical record review of the facility's fall report dated April 5, 2013, revealed .sitting on floor at bedside.no pain. Medical record review of the Care Plan dated April 5, 2013, revealed .encourage to verbalize needs.encourage to use call light. Medical record review of the Interdisciplinary Notes dated April 5, 2013, revealed .increased confusion.new order to obtain labs and infuse Normal Saline at 65 cc/hr (cubic centimeters/ per hour) times one. Medical record review of the Change of Condition Documentation dated April 5, 2013, revealed .witnessed the resident sitting upright on the bed at his bedside.continue to monitor.no new orders. Medical record review of the facility's fall report dated April 20, 2013, revealed .sitting in floor.no injury.safety alarm in place. Medical record review of the Care Plan addressing falls dated April 20, 2013, revealed .mats on floor next to bl (bilateral) side of bed.; dated April 23, 2013, revealed adjust level of care according to individual needs.allow sufficient time for dressing and undressing.baths and showers per schedule.encourage independence.encourage resident to do as much for self.ensure and assist with grooming needs.provide verbal cues.reinforce success for task accomplished. Medical record review of the Change of Condition Documentation dated April 20, 2013 revealed, .found sitting on floor.stated just rolled out of bed.safety alarm in place. Medical record review of the facility's fall report dated May 2, 2013, revealed .sitting on safety mat between bed and window holding trash can.nose bleeding.two raised areas on his forehead above each brow.to hospital for evaluation. Medical record review of the Care Plan revealed no documentation for new interventions for the fall on May 2, 2013. Medical record review of the Interdisciplinary Progress Notes dated May 2, 2013, revealed .slid forward and lowered self to mat. Medical record review of the Change of Condition Documentation dated May 2, 2013, revealed .bed alarm sounding.sitting on safety mat.holding trash can.nose was bleeding.had two raised areas on forehead above each brow.to the hospital for evaluation. Medical record review of the diagnostic imaging report dated May 2, 2013, revealed .no acute intracranial abnormality.no acute facial bone fracture. Medical record review of the MDS dated [DATE], revealed Resident #100 required extensive assistance from the staff with bed mobility and transfers, required limited assistance with locomotion and was totally dependent on the staff for dressing, toilet use, personal hygiene and bathing. Further review of the MDS revealed, the resident had a BIMS score of 7 (cognitive impairment). Interview with the DON (Director of Nursing) on November 6, 2013, at 8:30 a.m., in the business office, confirmed the facility failed to follow facility's policy to investigate the cause of the resident's falls and failed to implement new interventions after the falls on February 21, 2013, and May 2, 2013.

Resident #62 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had short and long term memory problems; required extensive assistance with one person physical assist for transfers, walk in corridor, dressing, personal hygiene and bathing; required extensive assistance with two plus person physical assistance for bed mobility and toilet use; and was continent of bowel and bladder and had no falls. Review of facility's fall report revealed the resident had a fall on January 13, 2013, at 5:00 a.m., from the bed with no injury. Further review revealed the .bed was elevated. Further review of the documentation revealed no investigation to determine the cause of the fall and failed to add interventions to prevent future falls. Medical record review of the Change of Condition Documentation form, dated January 13, 2013, at 7:25 a.m., revealed, .bed alarm sounding and pt (patient) was lying on the floor beside the bed on.back with pillow between.knees. Pt has electric bed and the bed was in the highest position per pts (patient's) control.neuro (neurological) checks in place. Review of facility's fall report revealed the resident had a fall from the bed with a laceration and was sent to the emergency roiagnom on [DATE], at 3:30 p.m. Further review of the documentation revealed no investigation to determine the cause of the fall and failed to add interventions to prevent future falls. Medical record review of the Change of Condition Documentation form, dated January 13, 2013, at 15:30 (3:30) p.m., revealed, ZXX

F 0323

Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on review of facility policy, medical record review, review of the Fall Risk Evaluation forms, review of the facility fall reports, review of facility documentation, interview, and observation, the facility failed to investigate and develop new interventions to address falls for fourteen residents (#35, #73, #17, #24, #42, #119, #100, #62, #120, #26, #23, #113, #52, and #89) of twenty-two residents with falls reviewed. The facility's failure to investigate and develop new interventions to address falls placed residents #35 and #73 in Immediate Jeopardy (a situation in which the provider's non-compliance has caused or likely to cause serious injury, harm, impairment or death). The Immediate Jeopardy was effective on November 26, 2012, and is ongoing. The Regional Vice President, Director of Clinical Services, Administrator and Director of Nursing were informed of the Immedicate Jeopardy on November 6, 2013, at 2:30 p.m. in the conference room. The findings included: Review of the facility policy entitled Falls Management, effective on September 15, 2001, and revised on June 1, 2013, revealed, .If patient falls.Update care plan to reflect new interventions. Review of the facility

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F 0323	(continued... from page 26) policy entitled Falls Care Delivery Process, with revision date of June 1, 2013, revealed, .response to a Patient Fall: .Complete.Resident Incident report.to implement new interventions.Investigate fall circumstances.Implement immediate interventions after the fall.Complete Condition of Change Document.staff.Conduct interdisciplinary team meeting within 72 hours of patient fall to perform the following: .Update care plan with new interventions as appropriate.Communicate interventions to staff. Review of the facility policy entitled Falls Management, with revision date of June 1, 2013, revealed, .If patient falls:.Perform Neurological Assessment for all unwitnessed falls and witnessed falls with head injury. Review of the facility policy entitled Assessment: Neurological with revision date of October 1, 2012, revealed, Neurological assessment will be performed as indicated or ordered. When a patient sustains an injury to the head and/or unwitnessed fall, neurological assessment will be performed: every 30 minutes x (for) two hours, then every one hour x four hours, then every four hours x 24 hours. Resident #35 was admitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review revealed the resident was readmitted [DATE], after an Open Reduction and Internal Fixation of a Right Hip Fracture. Medical record review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Mental Status score of 14, indicating no cognitive impairment. Medical record review of the Fall Risk Evaluation completed on admission and at quarterly reviews on March 8, and June 8, 2013, revealed the resident was high risk for falls. Medical record review of the physical therapy (PT) notes from admission through June 13, 2013, revealed the resident received PT for transfers and gait training. Review of the PT notes dated June 3, 2013, revealed, .good progress with gait. However pt (patient) continues to demonstrate poor safety awareness and judgement.Patient continues to require minimal assist for sit to stand for transfers secondary to bilateral hip weakness. Pt's visual handicap will prevent gait independence. Further review revealed the resident was able to ambulate up to 300 feet with a rolling walker and began a restorative nursing program on June 15, 2013, to continue ambulation with the rolling walker. Medical record review of facility fall reports and Care Plans (from December 2012 through September 2013) revealed the resident had a history of [REDACTED]. January 12, 2013, at 4:20 a.m., fell on the way to bathroom, unwitnessed, no neuro (neurological) checks (to assess for head injury) were done, no root cause or contributing factors identified, Safety alarm. was added to the resident's care plan; January 15, 2013, no facility report provided for review, no neuro checks were done, no root cause or contributing factors identified, no new intervention developed; March 6, 2013 at 7:50 a.m., the fall report was initiated March 6, 2013 and completed six months later, on October 1, 2013, by the Director of Nurses. Review revealed the resident was found face down on the floor, complained of a headache, had a small skin tear of the right elbow, was seen in the emergency room , no neuro checks were done, no root cause or contributing factors identified, no new intervention developed; March 21, 2013, at 7:20 a.m., fall report related to the fall was not completed. Review revealed, .asked resident what happened.stated 'I just changed seats was trying to go to the bathroom and slid out of the bed onto my bottom, no root cause or contributing factors identified, no new intervention developed; April 1, 2013, at 11:55 p.m., facility fall report was not completed. Review revealed the resident was seen in the emergency room for a hematoma at the back of head the size of a baseball. No root cause or contributing factors identified. Review revealed a scoop mattress was care planned; May 21, 2013, at 4:15 p.m., facility fall report revealed this was a witnessed fall. An investigation of the falI was not completed. Review revealed the resident was assisted to the bathroom by a Certified Nurse Aide (CNA) who left the resident's side to assist the roommate and witnessed the resident stand, adjust clothing, tumble into the bathtub, and hit head. Review revealed the resident was not seen in the emergency room . No root cause or contributing factors were identified and no new intervention was developed; May 25, 2013, at 7:25 a.m., facility fall report revealed a CNA heard the safety alarm, saw the bathroom emergency call light blinking, and found the resident in the bathroom on the floor with bruises, a skin tear to the left arm. Review of subsequent facility documentation addressed a large bruise to the right hip, discovered on May 27, 2013, and the bruise was attributed to the fall of May 21, 2013. Review revealed the resident was seen in the emergency room . No neuro checks were done, no root cause or contributing factors identified, no new intervention developed; July 19, 2013, at 8:20 a.m., facility fall report was not initiated until October 1, 2013, by the DON. Review revealed the resident was found on the floor and old skin tear re-opened. No neuro checks completed, no root cause or contributing factors identified. Review of the Care Plan revealed, 7/19/13 fall.Intervention.Reacher/grabber. Review of a Nurse's Note revealed a bruise was reported on July 20, 2013, with bruising of the left hip and left lower leg noted and attributed to the fall of July 19, 2013; August 12, 2013, at 3:40 a.m., facility fall report revealed To resident room to answer call light, resident sitting in floor beside the bed.noted abrasion to right cheek and resident c/o (complained of) pain to right hip. Interview by telephone on October 3, 2013, at 7:12 a.m., with registered nurse (RN) #3 (the RN on duty the night of August 12, 2013) revealed when the resident fell and broke the right hip, on the night of August 12, 2013, there were two nurses on duty, who were both drawing blood and the two CNAs on duty were down another hall. Interview continued and revealed I heard (resident #35) way down at the end of B hall.found her on the floor. Medical record review of a History and Physical on admission to the hospital on August 12, 2013, revealed, .XXX[AGE] year-old.trying to get out of bed where a call light had been put on.did not get much help so.tried to get up by self and water spilled.slid and broke hip.Assessment and Plan: fall with right intertrochanteric fracture.still alert.wants surgery. Review of the occupational therapy (OT) note dated August 21, 2013, revealed, .patient is NWB (non-weight bearing/not able to walk) through RLE (right lower extremity) and has had a decline in ADL's (activities of daily living) and transfers. Observation of the dining room at 12:30 a.m., on September 30, 2013, revealed the resident was brought to lunch in a wheelchair. Interview with the Director of Nurses (DON) and concurrent review of the fall reports was conducted at 7:45 a.m., on October 2, 2013, in the MDS office. Interview verified a fall report for the fall on January 15, 2013, was missing, a fall investigation for January 12, 2013, was not completed until March 25, 2013, and did not include a root cause or contributing factors, a fall report for the March 6, 2013, fall had been completed by the DON on October 1, 2013, six months after the fall, and none of the falls had complete investigation identifying the root cause and contributing factors. Interview continued and confirmed the falls were not investigated (required to be completed by an interdisciplinary team within 72 hours of a fall) for the eight falls sustained by the resident from January through July of 2013. Interview confirmed an investigation of the fall with fracture in August 2013 had not been done by an interdisciplinary team to date. Interview confirmed the August 12, 2013, fracture to the right hip requiring surgery, resulted in the resident being unable to walk, a lower ability to transfer, and a decline in the ability to perform activities of daily living. Medical record review of an Interdisciplinary Progress Note dated August 19, 2013, revealed the resident was readmitted on this date following right hip surgery. Medical record review of the Re-admission nursing assessment dated [DATE], revealed the resident returned from a hospitalization due to a Urinary Tract Infection. Medical record review of the Fall Risk Evaluation dated October 7, 2013, revealed a score of 13, high risk for falls. Review of a fall report revealed the resident fell in the bathroom at 4:32 a.m., on October 9, 2013. Review of the resident's Care Plan and concurrent interview with the Director of Nurses (DON) in the conference room at 1:00 p.m., on October 28, 2013, confirmed the resident did not have individualized falls prevention interventions resumed upon returned to the facility October 7, 2013. Interview confirmed the Interdisciplinary Team did not investigate and develop new appoaches after the fall on August 12, 2013, resulting in the right hip fracture or after the October 9, 2013, fall. Resident #73 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Interdisciplinary Progress Notes dated October 19, 2012, at 1:00 p.m., revealed .activity tray in place d/t (due to) decreased safety awareness.low bed with pressure sensitive alarm while in bed. Medical record review of the Change of Condition Documentation dated December 8, 2012, revealed .pt (patient) lying on her L (left) side on safety mat.bed alarm noted to be off.no injury.bed now in lowest position.safety mat in place. Medical record review of the quarterly MDS (Minimum Data Set) dated January 9, 2013, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 2 (severe cognitive impairment). Further review of the MDS, revealed the resident was dependent on staff for bed mobility, transfers, bathing, dressing, toilet use, and personal hygiene. Medical record review of the Interdisciplinary Progress Notes dated December 9, 2012 for the fall occurring on December 8, 2012, revealed .bed in lowest position.safety mats.pressure alarm. Medical record review of the plan of care revealed no new interventions documented for the fall on December 8, 2012. Medical record review of the Change of Condition Documentation dated December 24, 2012, revealed .in dining room lying on left side.had removed lap buddy.assisted to chair and taken to room.bed alarm in use.bed in low position with mat at bedside. Medical record review of the plan of care revealed no new interventions documented for the fall on December 24, 2012. Medical record review of the Interdisciplinary Progress Notes dated December 28, 2012, revealed .removed activity tray.safety alarm to chair and bed. Medical record review of the care plan updated January 11, 2013, revealed Resident #73 was at risk for falls. Medical record review of the Change of Condition Documentation dated January 12, 2013, revealed .removed lap buddy.missed chair.replaced lap buddy with another lap buddy. Medical record review of the

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F 0323	(continued... from page 27)

Pain Evaluation dated January 12, 2013, revealed the resident had pain in the right shoulder at an intensity of 3-4 (moderate pain). Medical record review of the plan of care revealed no new interventions documented for the fall on January 12, 2013. Medical record review of the Change of Condition Documentation dated, January 13, 2013, revealed .rolled out of bed.c/o (complains of) pain to rt (right) shoulder. Medical record review of the Pain Evaluation dated January 13 2013, revealed the resident had pain in the the right shoulder at an intensity of 1-2 (mild pain). Medical record review of the plan of care revealed no new interventions documented regarding the fall on January 13, 2013. Medical record review of the Interdisciplinary Progress Notes at 1:05 a.m., January 14, 2013, revealed .c/o (complains of) R (right) shoulder pain. Medical record review of the Interdisciplinary Progress Notes at 6:00 a.m., January 14, 2013, revealed, .large area of purple and blue/green bruising to R (right) posterior shoulder.guarding area. Medical record review of the Interdisciplinary Progres Notes at 8:00 a.m., January 14, 2013, revealed, c/o R shoulder pain.large amount bruising.send to hospital. Review of the hospital Discharge Summary dated January 18, 2013, revealed Resident #73 was admitted to the hospital with [REDACTED]. Review of the facility's policy titled 7.0 Falls Management dated September 15, 2001 and revised June 1, 2013, revealed .patients experiencing a fall will receive appropriate care.investigation of the cause.6.4 update care plan to reflect new interventions.6.5.3 document effectiveness of interventions. Interview with the ADON (Assistant Director of Nursing) on October 3, 2013, at 8:15 a.m. in the admissions office, confirmed the facility had failed to follow the facility's policy to investigate the cause of the resident's falls and had failed to implement new interventions after the falls on December 8, 2012, December 24, 2012, January 12, 2013 and January 13, 2013 which resulted in a fractured right clavicle. Resident #17 was admitted on [DATE], with [DIAGNOSES REDACTED]. Observation at 10:00 a.m., and 4:00 p.m., revealed the resident in the bed napping with shoes in wheelchair at bedside on October 30, 2013. Medical record review of facility documentation revealed the resident had seven falls in 2013 as follows: March 3, 2013, at 3:15 pm - fell out of the wheel chair (w/c) an investigation was initiated, unwitnessed without neuro checks being done, but no root cause or contributing factor determined and no new interventions to address the fall were developed. March 23, 2013 - Interview on October 30, 2013, with LPN #1 at 10:30 a.m., in the conference room, confirmed no report of the fall, other than what was in the Nurse's Notes, could be found and confirmed there had not been an investigation or any care plan interventions developed after the fall. April 8, 2013, at 1:20 p.m., - fell in their room, out of the w/c and struck head, no neuro checks were done. No investigation was initiated, no new interventions to address falls other than re-educate to call for help. May 5, 2013, at 2:00 p.m. - fell out of the w/c, reaching to floor. No neuro checks were done. An investigation was initiated, but no root cause or contributing factors determined and no new interventions to address the fall were developed. May 12, 2013, at 3:00 a.m. - fell as attempting to toilet self. An investigation was initiated, but no root cause or contributing factors determined and no new interventions to address the fall were developed. June 8, 2013, at 8:30 a.m. - Slipped out of the w/c onto floor. No investigation was initiated, no new interventions to address the fall. June 23, 2013, at 8:45 a.m. - An investigation was done and determined needs a reacher. Interview on October 30, 2013, with LPN #1 at 10:30 a.m., in the conference room, confirmed when the Interdisciplinary Team met and investigated the falls after the June 23, 2013, fall, the resident was provided a reacher and there had been no further falls. Resident #24 was admitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review revealed the resident was followed by Hospice and was able to
return home on October 4, 2013. Review of the facility documentation revealed three falls had been reported and none of the falls had investigations initiated or completed. The three falls were reported as follows: April 14, 2013, at 11:45 a.m. - fell in the bathroom, swelling in the left elbow and pain left upper shoulder, xrays obtained at the facility with no fracture noted. A new intervention was care planned. July 7, 2013, at 8:10 a.m., Fall on the way to bathroom, the floor had been mopped and remained wet. The DON documented in the Intradisciplinary Team notes current interventions working and no new interventions to address falls were developed. September 18, 2013 - Sat on floor in front of the electric wheelchair on the way to the bathroom. Resident stated started to slide. Nursing provided non-skid socks. Interview with LPN #1, in the conference room, on October 30, 2013, at 3:30 p.m.,confirmed no investigation of any of the three falls was done and no new individualized interventions were developed to address the last two falls. Resident #42 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a quarterly Minimum Data Sets (MDS) dated [DATE], and May 25,
2013, revealed the resident was moderately impaired for daily decision making; required extensive assistance with bed mobility, transfers, and locomotion on unit; and required total dependence for locomotion off unit and toilet use. Medical record review of facility documentation revealed the resident had seven falls from January 2013 through August 2013 as follows: January 29, 2013, at 8:50 p.m. - fell from wheelchair (w/c) as reaching out as if to pick something off of the floor and hit head on the doorframe. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. March 3, 2013, at 5:00 a.m. - Had been gotten up into the w/c by staff due to agitation and then fell out of the w/c, no witness. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. March 3, 2013, at 12:15 p.m. - Found out of the w/c in dining room floor, lying on back. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. March 12, 2013, at 2:15 p.m. - The resident stated trying to get into bed and fell to floor. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. April 9, 2013, at 6:00 p.m. - Found lying on floor on the bedside floor mat, no mention of whether the resident had been in the bed or the w/c. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. July 15, 2013, at 1:45 p.m. - Found between the toilet and the wall on hands and knees after a CNA heard the pull away alarm. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. July 25, 2013, at 12:20 pm - Stood up and fell from w/c in solarium, witnessed. Record review revealed an investigation was not completed and no root cause or contributing factors were identified. Interview at 2:20 p.m., on October 29, 2013, in the conference room, with LPN #1 confirmed the resident had one investigation completed for the seven falls from January 2013 through August 2013. Continued interview confirmed the resident did not have interventions developed to address the falls of March 12, 2013, and April 9, 2013. Resident # 119 was admitted to the facility on [DATE], with admitting [DIAGNOSES REDACTED]. Medical record review of facility Change of Condition Documentation fall dated January 5, 2013, .pressure alarm sounding, resident found sitting on floor complained of bilateral hip pain.Golf-ball sized bruise noted on crown, no bleeding noted .assisted to wheelchair; Nurse Practioner (NP) notified x-ray of bilateral hip. Medical record review of facility Change of Condition Documentation fall dated January 13, 2013, a facility report dated 1/15/13 . resident was trying to transfer self from bed to chair and fell on floor, landed on bottom. No injuries observed. Alarm on and sounding. Resident was educated on using call light to ask for assistance for transfers. Interview with the Administrator on October 29, 2013, at 3:30 p.m., in the conference room, with concurrent review of the resident's four falls, including a fall on February 10, 2013, and a fall on March 15, 2013, verified the following: The facility had a report completed immediately after the resident's four falls; the resident did not have injuries requiring transfer to the hospital; investigations were not completed to address the root cause and contributing factors to the four falls; and the resident was dismissed to home on May 5, 2013. Interview continued and the Administrator stated, It has already been acknowledged there were system problems with falls.

Resident #100 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the facility's fall report dated February 18, 2013, revealed .to room.found resident sitting on floor beside bed.no injury.re-educated to call light usage.call light within reach.bed in lowest position.safety alarm placed. Medical record review of the Care Plan dated February 18, 2013, revealed .poor coordination due to recent aka (above knee amputation) of right leg/foot.encourage.to use handrails.have commonly used articles within easy reach. Medical record review of the Change of Condition Documentation dated February 18, 2013, revealed .summoned to patient's room.sitting on the floor bedside bed.no injury.re-educated to call light usage and call light placed within reach.bed in lowest position.safety alarm placed. Medical record review of the Care Plan dated February 19, 2013, revealed .low bed.safety alarm in bed/chair.remove all objects near bed to prevent injury.when resident in bed place all necessary personal items within reach.reinforce need to call for assistance.PT (Physical Therapy) evaluation.place call light within easy reach.ensure environment is free of clutter. Medical record review of the facility's fall report dated February 21, 2013, revealed .responded to call light.laying in floor next to bed.stated was trying to change TV (television) station.forgot I don't (do not) have a right leg anymore. Medical record review of the Care Plan revealed no new interventions documented for the fall on February 21, 2013. Medical record review of the Change of Condition Documentation dated February 21, 2013, revealed .observed laying on floor next to bed.going to change TV (television).reinforce proper use of call light. Medical record review of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER **WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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 0323	(continued... from page 28) facility's fall report dated February 23, 2013, revealed .fell from wheelchair.found on floor.laying on chair alarm.bending over and fell out of wheelchair. Medical record review of the Care Plan dated February 23, 2013, revealed .teach resident to ask for help.bed in lowest position.safety mats. Medical record review of the Interdisciplinary Notes dated February 23, 2013, revealed .continues with therapy. Medical record review of the Change of Condition Documentation dated February 23, 2013, revealed .found laying in the floor on left side with bed alarm under (resident).stated that (resident) was bending over and went to far. Medical record review of an annual MDS (Minimum Data Set) dated February 25, 2013, revealed the resident was totally dependent for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. Further review of the MDS revealed, the resident had a BIMS (Brief Interview for Mental Status) score of 15 (no cognitive impairment). Medical record review of the Interdisciplinary Notes dated February 26, 2013, revealed .alert with confusion.several falls since admission.self-propels while up in wheelchair.confused to thinking.able to ambulate. Medical record review of Physician's Orders dated February 26, 2013, revealed .Physical Therapy for wheelchair mobility and strength training. Medical record review of the facility's fall report dated April 5, 2013, revealed .sitting on floor at bedside.no pain. Medical record review of the Care Plan dated April 5, 2013, revealed .encourage to verbalize needs.encourage to use call light. Medical record review of the Interdisciplinary Notes dated April 5, 2013, revealed .increased confusion.new order to obtain labs and infuse Normal Saline at 65 cc/hr (cubic centimeters/ per hour) times one. Medical record review of the Change of Condition Documentation dated April 5, 2013, revealed .witnessed the resident sitting upright on the bed at his bedside.continue to monitor.no new orders. Medical record review of the facility's fall report dated April 20, 2013, revealed .sitting in floor.no injury.safety alarm in place. Medical record review of the Care Plan addressing falls dated April 20, 2013, revealed .mats on floor next to bl (bilateral) side of bed.; dated April 23, 2013, revealed adjust level of care according to individual needs.allow sufficient time for dressing and undressing.baths and showers per schedule.encourage independence.encourage resident to do as much for self.ensure and assist with grooming needs.provide verbal cues.reinforce success for task accomplished. Medical record review of the Change of Condition Documentation dated April 20, 2013 revealed, .found sitting on floor.stated just rolled out of bed.safety alarm in place. Medical record review of the facility's fall report dated May 2, 2013, revealed .sitting on safety mat between bed and window holding trash can.nose bleeding.two raised areas on his forehead above each brow.to hospital for evaluation. Medical record review of the Care Plan revealed no documentation for new interventions for the fall on May 2, 2013. Medical record review of the Interdisciplinary Progress Notes dated May 2, 2013, revealed .slid forward and lowered self to mat. Medical record review of the Change of Condition Documentation dated May 2, 2013, revealed .bed alarm sounding.sitting on safety mat.holding trash can.nose was bleeding.had two raised areas on forehead above each brow.to the hospital for evaluation. Medical record review of the diagnostic imaging report dated May 2, 2013, revealed .no acute intracranial abnormality.no acute facial bone fracture. Medical record review of the MDS dated [DATE], revealed Resident #100 required extensive assistance from the staff with bed mobility and transfers, required limited assistance with locomotion and was totally dependent on the staff for dressing, toilet use, personal hygiene and bathing. Further review of the MDS revealed, the resident had a BIMS score of 7 (cognitive impairment). Interview with the DON (Director of Nursing) on November 6, 2013, at 8:30 a.m., in the business office, confirmed the facility failed to follow facility's policy to investigate the cause of the resident's falls and failed to implement new interventions after the falls on February 21, 2013, and May 2, 2013. Resident #62 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident had short and long term memory problems; required extensive assistance with one person physical assist for transfers, walk in corridor, dressing, personal hygiene and bathing; required extensive assistance with two plus person physical assistance for bed mobility and toilet use; and was continent of bowel and bladder and had no falls. Review of facility's fall report revealed the resident had a fall on January 13, 2013, at 5:00 a.m., from the bed with no injury. Further review revealed the .bed was elevated. Further review of the documentation revealed no investigation to determine the cause of the fall and failed to add interventions to prevent future falls. Medical record review of the Change of Condition Documentation form, dated January 13, 2013, at 7:25 a.m., revealed, .bed alarm sounding and pt (patient) was lying on the floor beside the bed on.back with pillow between.knees. Pt has electric bed and the bed was in the highest position per pts (patient's) control.neuro (neurological) checks in place. Review of facility's fall report revealed the resident had a fall from the bed with a laceration and was sent to the emergency roiagnom on [DATE], at 3:30 p.m. Further review of the documentation revealed no investigation to determine the cause of the fall and failed to add interventions to prevent future falls. Medical record review of the Change of Condition Documentation form, dated January 13, 2013, at 15:30 (3:30) p.m., revealed, ZXX
F 0329	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure unnecessary medications were not administered to one resident (#62) of five residents reviewed for unnecessary medications. The findings included: Resident #62 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a Psychiatric Progress Note dated January 17, 2013, revealed .Current [MEDICAL CONDITION] Medications: Donepezil ([MEDICAL CONDITION] medication) 5 mg (milligrams) bed(time), [MEDICATION NAME] (Anti-depressant medication) 7.5 mg bed, [MEDICATION NAME] ([MEDICAL CONDITION] medication) 10 mg 2 x (times) day, Trazadone (Anti-depressant medication) 25 mg prn (as needed), [MEDICATION NAME] (Anti-anxiety medication) 0.5 mg prn.Alprazolom used nightly for anxiety (and) restlessness.Staff report.non-use of Trazadone.Recommendation:1) DC (discontinue) Trazadone non-use > (greater than) 30 days. 2) decrease [MEDICATION NAME] 5 mg po (by mouth) 2 x day. Medical record review of a Psychiatric Progress Note dated February 4, 2013, revealed .Current [MEDICAL CONDITION] Medications: Donepezil 5 mg 8P (8:00 PM), [MEDICATION NAME] 7.5 mg 8P, [MEDICATION NAME] 10 mg bid (2 times daily), Trazadone 25 mg prn, [MEDICATION NAME] 0.5 mg pm.not completed-previous recommendations F/U (follow-up) recommendations January 17, 2013, DC Trazadone, Decrease [MEDICATION NAME] report.non-use Trazadone.Recommendation-1) DC Trazadone non-use >30 days, 2) DC [MEDICATION NAME] 10 mg po 2 x day.3) [MEDICATION NAME] 5 mg po 2 x day. Medical record review of the Comprehensive Non-Psychiatric Progress Note dated March 4, 2013, revealed .Reason for Visit: Psych (psychiatric).F/U.Recommendations from February 4, 2013, not done as of now.Current [MEDICAL CONDITION] Medications: [MEDICATION NAME] (Donepezil) 5 mg [MEDICATION NAME] ([MEDICATION NAME]) 7.5 mg bed, [MEDICATION NAME] 10 mg 2 x day.Trazadone 25 mg prn, [MEDICATION NAME] 0.5 mg prn.Recommendation-1) DC Trazadone non-use >30 days.2) DC [MEDICATION NAME] po 10 mg 2 x day.3) [MEDICATION NAME] 5 mg po 2 x day.Informed consent for GDR (Gradual Dose Reduction) to [MEDICATION NAME], DC Trazadone NP (Nurse Practitioner) spoke with daughter. Medical record review of the physician orders [REDACTED]. Interview with Licensed Practical Nurse #1 on October 3, 2013, at 9:40 a.m., in the TV lounge confirmed there was no documentation the physician was notified of the [MEDICAL CONDITION] medication recommendations initiated January 2013 or February 2013. Further interview confirmed the physician was not notified until after the March 4, 2013 recommendation, and the resident continued to receive the medications recommended to be discontinued for approximately two months until an order for [REDACTED].

F 0329	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to ensure unnecessary medications were not administered to one resident (#62) of five residents reviewed for unnecessary medications. The findings included: Resident #62 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of a Psychiatric Progress Note dated January 17, 2013, revealed .Current [MEDICAL CONDITION] Medications: Donepezil ([MEDICAL CONDITION] medication) 5 mg (milligrams) bed(time), [MEDICATION NAME] (Anti-depressant medication) 7.5 mg bed, [MEDICATION NAME] ([MEDICAL CONDITION] medication) 10 mg 2 x (times) day, Trazadone (Anti-depressant medication) 25 mg prn (as needed), [MEDICATION NAME] (Anti-anxiety medication) 0.5 mg prn.Alprazolom used nightly for anxiety (and) restlessness.Staff report.non-use of Trazadone.Recommendation:1) DC (discontinue) Trazadone non-use > (greater than) 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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F 0329

(continued... from page 29)
days. 2) decrease [MEDICATION NAME] 5 mg po (by mouth) 2 x day. Medical record review of a Psychiatric Progress Note dated February 4, 2013, revealed .Current [MEDICAL CONDITION] Medications: Donepezil 5 mg 8P (8:00 PM), [MEDICATION NAME] 7.5 mg
8P, [MEDICATION NAME] 10 mg bid (2 times daily), Trazadone 25 mg prn, [MEDICATION NAME] 0.5 mg pm.not completed-previous
recommendations F/U (follow-up) recommendations January 17, 2013, DC Trazadone, Decrease [MEDICATION NAME] report.non-use
Trazadone.Recommendation-1) DC Trazadone non-use >30 days, 2) DC [MEDICATION NAME] 10 mg po 2 x day.3) [MEDICATION NAME] 5
mg po 2 x day. Medical record review of the Comprehensive Non-Psychiatric Progress Note dated March 4, 2013, revealed .Reason for Visit: Psych (psychiatric).F/U.Recommendations from February 4, 2013, not done as of now.Current [MEDICAL CONDITION] Medications: [MEDICATION NAME] (Donepezil) 5 mg [MEDICATION NAME] ([MEDICATION NAME]) 7.5 mg bed, [MEDICATION
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[MEDICATION NAME] po 10 mg 2 x day.3) [MEDICATION NAME] 5 mg po 2 x day.Informed consent for GDR (Gradual Dose Reduction)
to [MEDICATION NAME], DC Trazadone NP (Nurse Practitioner) spoke with daughter. Medical record review of the physician orders [REDACTED]. Interview with Licensed Practical Nurse #1 on October 3, 2013, at 9:40 a.m., in the TV lounge confirmed there was no documentation the physician was notified of the [MEDICAL CONDITION] medication recommendations initiated January 2013 or February 2013. Further interview confirmed the physician was not notified until after the March 4, 2013 recommendation, and the resident continued to receive the medications recommended to be discontinued for approximately two months until an order for [REDACTED].

F 0364

Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.

Based on observation of the resident tray-line service, food temperatures, tray distribution, and interview, the facility failed to serve hot food at or above 135 degrees Fahrenheit (F.) and cold food at or less than 41 degrees F. for two of two meal observations. The findings included: Observation on September 30, 2013, at 12:23 p.m., of the resident mid-day tray-line in the dining room revealed the dietary cook obtained food temperatures as follows: Hamburger patties 120 degrees F. Ground hamburger 112 degrees F. Pureed hamburger 104 degrees F. Tater tots 108 degrees F. Mashed potatoes 112 degrees F. Interview with the dietary cook obtaining the food temperatures on September 30, 2013, at 12:23 p.m., in the dining room confirmed the .food should be at least 140 degrees F. Interview with resident #28 on October 1, 2013, at 7:55 a.m., in the resident's room on the B wing regarding facility food temperature revealed .not always, usually at supper food cold. Sometimes in evening have to wait a long time to get meal. Observation of the resident evening meal service on October 1, 2013, revealed an overhead page at 5:22 p.m., for the A Hall resident trays were ready to be passed. Continued observation of the A Hall cart revealed it contained thirteen resident trays. Further observation revealed the last tray was removed from the A Hall cart at 5:49 p.m., a 27 minute timeframe. Observation of dinner on October 1, 2013, at 5:30 p.m., in the dining room revealed resident #47 received food and stated the pinto beans could have been a lot warmer. Continued dinner observation revealed resident #97 received food much later than the other residents at the table and the resident stated the pinto beans could have been warmer. Observation of the resident's evening tray-line service in in the dietary department, on October 1, 2013, at 5:25 p.m., revealed the following temperatures in degrees F.: Pinto beans 166 degrees F. Cubed potatoes 171 degrees F. Turnip greens 176 degrees F. (a new pan was placed on the tray-line at 5:36 p.m.) Mashed potatoes 201 degrees F. Pureed pinto beans 194 degrees F. Puree turnip greens were 163 degrees F. Milk, in a glass, 48 degrees F. Observation on October 1, 2013, revealed seven resident trays and one test tray left the dietary department at 5:39 p.m., for the B wing, the last resident tray was delivered and all residents were eating at 5:45 p.m. Further observation revealed the Certified Dietary Manager (CDM) obtained the following temperatures at 5:45 p.m., on the test tray: Pinto beans 138 degrees F., a loss of 28 degrees Cubed potatoes 107 degrees F., a loss of 64 degrees Turnip greens 136 degrees F., a loss of 40 degrees Mashed potatoes 119 degrees F., a loss of 82 degrees; Pureed pinto beans 149 degrees F., a loss of 45 degrees; Pureed turnip greens 129 degrees F., a loss of 34 degrees; and Milk, in a glass, 53 degrees F., an increase of 5 degrees. Interview with the CDM on October 1, 2013, at 5:45 p.m., on the B wing confirmed the test tray temperatures had fallen significantly for the hot food and the milk temperature had increased. C/O #

F 0364

Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.

Based on observation of the resident tray-line service, food temperatures, tray distribution, and interview, the facility failed to serve hot food at or above 135 degrees Fahrenheit (F.) and cold food at or less than 41 degrees F. for two of two meal observations. The findings included: Observation on September 30, 2013, at 12:23 p.m., of the resident mid-day tray-line in the dining room revealed the dietary cook obtained food temperatures as follows: Hamburger patties 120 degrees F. Ground hamburger 112 degrees F. Pureed hamburger 104 degrees F. Tater tots 108 degrees F. Mashed potatoes 112 degrees F. Interview with the dietary cook obtaining the food temperatures on September 30, 2013, at 12:23 p.m., in the dining room confirmed the .food should be at least 140 degrees F. Interview with resident #28 on October 1, 2013, at 7:55 a.m., in the resident's room on the B wing regarding facility food temperature revealed .not always, usually at supper food cold. Sometimes in evening have to wait a long time to get meal. Observation of the resident evening meal service on October 1, 2013, revealed an overhead page at 5:22 p.m., for the A Hall resident trays were ready to be passed. Continued observation of the A Hall cart revealed it contained thirteen resident trays. Further observation revealed the last tray was removed from the A Hall cart at 5:49 p.m., a 27 minute timeframe. Observation of dinner on October 1, 2013, at 5:30 p.m., in the dining room revealed resident #47 received food and stated the pinto beans could have been a lot warmer. Continued dinner observation revealed resident #97 received food much later than the other residents at the table and the resident stated the pinto beans could have been warmer. Observation of the resident's evening tray-line service in in the dietary department, on October 1, 2013, at 5:25 p.m., revealed the following temperatures in degrees F.: Pinto beans 166 degrees F. Cubed potatoes 171 degrees F. Turnip greens 176 degrees F. (a new pan was placed on the tray-line at 5:36 p.m.) Mashed potatoes 201 degrees F. Pureed pinto beans 194 degrees F. Puree turnip greens were 163 degrees F. Milk, in a glass, 48 degrees F. Observation on October 1, 2013, revealed seven resident trays and one test tray left the dietary department at 5:39 p.m., for the B wing, the last resident tray was delivered and all residents were eating at 5:45 p.m. Further observation revealed the Certified Dietary Manager (CDM) obtained the following temperatures at 5:45 p.m., on the test tray: Pinto beans 138 degrees F., a loss of 28 degrees Cubed potatoes 107 degrees F., a loss of 64 degrees Turnip greens 136 degrees F., a loss of 40 degrees Mashed potatoes 119 degrees F., a loss of 82 degrees; Pureed pinto beans 149 degrees F., a loss of 45 degrees; Pureed turnip greens 129 degrees F., a loss of 34 degrees; and Milk, in a glass, 53 degrees F., an increase of 5 degrees. Interview with the CDM on October 1, 2013, at 5:45 p.m., on the B wing confirmed the test tray temperatures had fallen significantly for the hot food and the milk temperature had increased. C/O #

F 0369

Provide special eating equipment and utensils for each resident who needs them.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, observation, and interview, the facility failed to provide eating equipment to address the visual impairment of one resident (#35) of sixty-five residents reviewed. The findings included: Resident #35 was admitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the [DIAGNOSES REDACTED]. Medical record review of the
initial Care Plan dated December 26, 2012, and last revised September 6, 2013, revealed the problem of impaired vision was identified. Review of the initial Care Plan revealed the intervention for the impaired vision was to Provide adaptive

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NAME OF PROVIDER OF SUPPLIER **WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP **32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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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F 0369	(continued... from page 30) equipment with meals as recommended. Adjust PRN (as needed). Record review of the Interdisciplinary Communication to Nutrition Services revealed the Registered Dietician (RD) had developed a plan to provide the resident with .Red Ware divided plate, spoon, fork, and cup.secondary to visual deficits. Red Ware divided plate to continue as pt (patient) is unable to see, recognize foods on plate.Staff should tell pt (patient) what foods are and place them in a specific location. Review revealed the plan was co-signed by a licensed practical nurse (LPN) on August 9, 2013. Observation of the resident eating lunch on September 30, 2013, at 1:00 p.m., in the dining room revealed the resident was served lunch on the regular dishes, not on the Red Ware. Observation of the resident eating supper on October 1, 2013, at 6:00 p.m., in the dining room revealed the resident had not been served with the Red Ware. Review of the supper meal ticket placed on the resident's tray on the evening of October 1, 2013, revealed the instructions included Adapt. (adaptive) equip (equipment): Red Ware Silverware; Red Ware Cup; Red Ware Plate. Interview on October 1, 2013, at 6:00 p.m., in the dining room with Certified Nurse Aide (CNA #12), confirmed the Red Ware had not been provided for the resident and the CNA stated there was none available to use. Interview with the Director of Nurses in the office adjacent to the nursing station on October 2, 2013, at 8:00 a.m., confirmed there was Red Ware stocked in the kitchen, ready for use. C/O #
F 0369	**Provide special eating equipment and utensils for each resident who needs them.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, and interview, the facility failed to provide eating equipment to address the visual impairment of one resident (#35) of sixty-five residents reviewed. The findings included: Resident #35 was admitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the [DIAGNOSES REDACTED]. Medical record review of the initial Care Plan dated December 26, 2012, and last revised September 6, 2013, revealed the problem of impaired vision was identified. Review of the initial Care Plan revealed the intervention for the impaired vision was to Provide adaptive equipment with meals as recommended. Adjust PRN (as needed). Record review of the Interdisciplinary Communication to Nutrition Services revealed the Registered Dietician (RD) had developed a plan to provide the resident with .Red Ware divided plate, spoon, fork, and cup.secondary to visual deficits. Red Ware divided plate to continue as pt (patient) is unable to see, recognize foods on plate.Staff should tell pt (patient) what foods are and place them in a specific location. Review revealed the plan was co-signed by a licensed practical nurse (LPN) on August 9, 2013. Observation of the resident eating lunch on September 30, 2013, at 1:00 p.m., in the dining room revealed the resident was served lunch on the regular dishes, not on the Red Ware. Observation of the resident eating supper on October 1, 2013, at 6:00 p.m., in the dining room revealed the resident had not been served with the Red Ware. Review of the supper meal ticket placed on the resident's tray on the evening of October 1, 2013, revealed the instructions included Adapt. (adaptive) equip (equipment): Red Ware Silverware; Red Ware Cup; Red Ware Plate. Interview on October 1, 2013, at 6:00 p.m., in the dining room with Certified Nurse Aide (CNA #12), confirmed the Red Ware had not been provided for the resident and the CNA stated there was none available to use. Interview with the Director of Nurses in the office adjacent to the nursing station on October 2, 2013, at 8:00 a.m., confirmed there was Red Ware stocked in the kitchen, ready for use. C/O #
F 0371	**Store, cook, and serve food in a safe and clean way.** Based on observation and interview, the facility failed to maintain a clean hand sink area; maintain sanitary food preparation equipment; ensure pots, pans and utensils were appropriately sanitized in the three compartment sink; sanitize the food thermometer between food items; serve food in a sanitary manner; appropriately wash and sanitize serving utensils prior to use; maintain a sanitary dish room; and maintain a sanitary dietary department. The findings included: Observation on September 30, 2013, at 9:55 a.m., in the dietary department revealed the only dietary department hand sink, towel dispenser, and soap dispenser were on the soiled side of the dish machine. Further observation revealed the interior of the hand sink, faucet and handles, and the towel and soap dispensers had an accumulation of food debris. Further observation revealed the two foil lined range top spill pans had a heavy accumulation of food and blackened debris on and under the foil. Interview with dietary employee #1 and the facility Administrator, on September 30, 2013, at 9:55 a.m., present during the observations confirmed the hand sink, faucet, handles, and the towel and soap dispensers were soiled. Further interview confirmed the two spill pans for the range top had an accumulation of food and blackened debris on and under the foil. Observation on September 30, 2013, at 11:45 a.m., revealed dietary employee #3 working at the three compartment sink for processing soiled pots, pans and utensils. Further observation revealed the sanitizer sink contained a third size pan, sauce pan, stainless steel bowl, and a cutting board. Further observation revealed none of the items in the sanitizer sink were submerged into the sanitizing water solution per the manufacturer's recommendation. Interview with dietary employee #3, and the Certified Dietary Manager (CDM), on September 30, 2013, at 11:45 a.m., at the three compartment sink confirmed the items in the sanitizer sink were not submerged into the sanitizer water solution. Further interview revealed the sanitizer test strips could not be found. Further interview confirmed the facility could not ensure the appropriate level of sanitizer in the three compartment sink. Observation on September 30, 2013, beginning at 12:23 p.m., of the resident mid-day meal service in the dining room revealed dietary employee #1 obtained food temperatures. Further observation revealed dietary employee #1 used the same cloth to wipe the thermometer between each food item: hamburger patties, ground hamburger, pureed hamburger, tater tots, and mashed potatoes. Further observation revealed the food was removed from the dining room tray line at 12:26 p.m., and taken to the dietary department to reheat. Further observation revealed the thermometer was rinsed under running water in the sink and the temperature was taken for the reheated food without sanitizing the thermometer between each food item. Further observation revealed the food was returned to the dining room steam table at 12:49 p.m. Further observation at 12:51 p.m., revealed the CDM touched the tomato slices, lettuce leaves, and onion slices with the same gloved hand at the dining room steam table. Further observation revealed the dining room steam table was concluded at 1:20 p.m., and all food and utensils were transported to the dietary department steam table for meal service to residents eating in their rooms. Further observation revealed dietary employee #2 took the soiled serving utensils to a sink, ran water over the utensils, used a cleaning cloth to wipe the utensils, stored the utensils on a plate, and took the plate of utensils to the dietary department steam table. Further observation revealed the plate the utensils were stored on contained ground meat, mashed potatoes, and a twist tie. Further observation revealed the CDM took the utensils stored on the plate, at the dietary department steam table, to the three compartment sink, used a cleaning cloth to wash the utensils, rinsed the utensils in running water, activated the sanitizer pump and held the utensils in contact with 100 percent sanitizer solution, then returned the utensils to the dietary steam table. Further observation revealed the CDM removed the utensils from the steam table and dipped the utensils into and out of the sanitizer solution in the sanitizer sink. Interview on September 30, 2013, at 12:23 p.m., in the dining room with dietary employee #1 confirmed the same cloth was used to wipe the thermometer between foods. Further interview revealed dietary employee #1 was aware alcohol wipes were to be used to sanitize the thermometer. Interview on September 30, 2013, at 1:20 p.m., in the dietary department with dietary employee #2 confirmed the employee had not washed, rinsed, or sanitized the serving utensils. Further interview confirmed the utensils were stored on a soiled plate. Interview on September 30, 2013, at 1:20 p.m., in the dietary department with the CDM confirmed the thermometer was not sanitized between each food item being reheated. Further interview confirmed the serving utensils had not been washed, rinsed, or sanitized appropriately. Further interview confirmed the utensils were stored on a soiled plate. Further interview confirmed the CDM had not submerged the utensils in the sanitizer solution for one minute as recommended by the the manufacturer. Further interview confirmed the sanitizer level could not be tested to verify the appropriate level per the manufacturer's recommendation of 200 parts per million. Further interview confirmed the CDM used the same gloved hand to touch the tomato slices, onion slices, and lettuce leaves on the dining room tray line. Observation on October 1, 2013, at 9:30 a.m., in the dish room and interview with the CDM present during the observation confirmed the wall under the soiled side of the dish machine table had a build-up of blackened debris by the base board. Further observation and interview confirmed the ceiling tiles and tile grid in the vicinity of the food preparation area and dietary department steam table had an accumulation of debris and rust. Observation on October 1, 2013, at 9:45 a.m., in the dietary department, and interview with the CDM, present during the observation, confirmed eleven inverted full size steam table pans were stored under the steam table and were ready for use. Further observation and interview confirmed the exterior surfaces of the eleven pans had a heavy accumulation of blackened debris.
F 0371	**Store, cook, and serve food in a safe and clean way.** Based on observation and interview, the facility failed to maintain a clean hand sink area; maintain sanitary food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**
NAME OF PROVIDER OF SUPPLIER **WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **32 MEMORIAL DRIVE WINCHESTER, TN 37398**	

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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F 0371

(continued... from page 31)
preparation equipment; ensure pots, pans and utensils were appropriately sanitized in the three compartment sink; sanitize the food thermometer between food items; serve food in a sanitary manner; appropriately wash and sanitize serving utensils prior to use; maintain a sanitary dish room; and maintain a sanitary dietary department. The findings included: Observation on September 30, 2013, at 9:55 a.m., in the dietary department revealed the only dietary department hand sink, towel dispenser, and soap dispenser were on the soiled side of the dish machine. Further observation revealed the interior of the hand sink, faucet and handles, and the towel and soap dispensers had an accumulation of food debris. Further observation revealed the two foil lined range top spill pans had a heavy accumulation of food and blackened debris on and under the foil. 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F 0425

Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, and interview, the facility failed to provide pharmaceutical services to relieve pain and anxiety for one resident (#33), of sixty-five residents reviewed. This failure resulted in harm to resident #33 The findings included: Resident #33 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of
the Nurse's Admission Note dated May 3, 2013, at 8:10 p.m., revealed .C/O (complained of) pain/anxiety. Medical record review of the Admission Physician order [REDACTED].-325 mg (5 mg of Hydrocodone and 325 mg of Acetaminophen per each tablet) 1 tab every 6 hours as needed. Medical record review of the Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED] Interview with the resident on September 25, 2013, at 8:00 a.m., in the resident's
room, revealed the resident had a short stay in the hospital and when the resident returned in May 2013, the resident could not get pain medications until the next morning. Continued interview revealed the resident stated, I was miserable; I finally got my medicine about 6:00 a.m. Interview with the Director of Nursing (DON) on September 26, 2013, at 10:35 a.m., in the conference room, revealed the resident complained of pain and anxiety on admission. Continued interview confirmed the facility failed to provide the resident's pain and anxiety medications for six hours and twenty minutes after the resident's complaint of pain and anxiety. C/O #

F 0425

Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist.
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F 0431

Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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F 0431

(continued... from page 32)

Based on review of facility documentation, review of facility policy, interview, and observation, the facility failed to manage controlled drugs for thirteen of forty-three residents receiving narcotics and failed to follow a systematic approach for receipt and destruction of narcotics for all residents receiving narcotics; failed to dispose of controlled substances properly for one (#16) of fifty-one residents; and failed to store medications properly on one of three carts. The findings included: Review of the facility Allegations Report dated August 28, 2013, revealed the facility reported Licensed Practical Nurse (LPN) #4 to the Office of Investigations for a significant narcotic theft. Review of the facility Controlled Drug Records dated June through August, 2013, identified by the Administrator and the Director of Nursing (DON) as the Controlled Drug Records removed from Licensed Practical Nurse (LPN) #4's truck by a police officer on August 27, 2013, revealed a total of 586 doses of controlled substances was diverted from thirteen residents from June 2013, through August 2013. Review of the facility's policy Management of Controlled Drugs revised October 1, 2012, revealed, .Storage: Two licensed nurses are required to document placement of controlled drugs into inventory.Destruction: Two licensed professionals are required to destroy and document destruction of controlled drugs.Centers will use the 'controlled Substances Book' a bound books system from which the pages cannot be removed, for ongoing tracking of all controlled drugs on each medication cart.Storage and Maintenance of Controlled Drugs.Two licensed nursing staff are required to immediately log the received medication into the 'Controlled Substances Book'.One licensed nursing staff will log the required information for each entry and sign the entry.The second licensed nursing staff will witness the documentation and sign the entry.To store drugs awaiting destruction.Perform count of drugs to be stored. Count to be done by DON or designee and licensed nursing staff.Signatures of two licensed nursing staff are required.document on Index Page date drug removed, by whom and highlight 'off' the Index Page.Two licensed nursing staff must sign the highlighted removed drug entry line on the Index Page.Document the disposition to storage in the bound destruction book located in the storage area.Signatures of two licensed nursing staff are required. Review of the facility investigation revealed Licensed Practical Nurse (LPN) #4 reported on August 27, 2013, LPN #4 had been taking the residents' discontinued medications and signing as needed (prn) medications as administered to residents, but keeping the medications. Further review revealed the facility investigated all residents who received narcotics (pain medications) to determine all residents who had been victims of the misappropriation of pain medications. Further review revealed the facility investigated the medication diversion and no residents had been found to have experienced uncontrolled pain. Review of a facility e-mail from the Consultant Pharmacist dated September 9, 2013, revealed a nurse was diverting controlled substances by several different methods in order to avoid detection. The nurse was diverting by taking the entire card and declining the inventory sheet upon delivery by the courier; taking the balance of the card and inventory sheet on medications when a new sheet had arrived from the pharmacy; and had also documented giving PRN pain medications to several residents (11) and not actually administering the pain medications. The pharmacist recommendations were two nurses must sign for delivery from courier; two nurses must sign to zero out a sheet from shift change reports; two nurses must count and verify discontinued meds to be destroyed; and, facility will begin using hard bound books for declining inventory sheets. Interview with the Administrator on September 24, 2013, at 10:38 p.m., in the Conference Room, revealed on August 27, 2013, the facility was informed by an employee a large amount of controlled substances had been diverted from the facility for personal use. Continued interview revealed the facility had controlled drug records from thirteen residents with a known amount of the drugs diverted. Continued interview confirmed the facility had not identified a diversion before LPN #4 had reported the drug diversion to the facility. Interview with the Consultant Pharmacist on September 23, 2013, at 12:20 p.m., by telephone, revealed the pharmacy had a technician who checked for narcotic diversion on a regular basis and none had been detected. Interview with the DON on September 24, 2013, from 2:11 p.m., until 3:00 p.m., in the Conference Room, revealed the facility had not followed the policy dated October 1, 2012, and had only required one licensed nurse to sign for controlled substances from the courier, destroy the empty narcotic cards, and remove the narcotic count sheets from the Controlled Substance Card Count Sheet. The facility's failure to follow policy and procedure for receipt and destruction of narcotics enabled LPN #4 to divert narcotics for personal use from residents living in the facility. Interview with LPN #2 on September 23, 2013, at 1:00 p.m., at the Nurse's Station, revealed resident #16's Fentanyl (pain) Patch came off while the resident was bathing. Continued interview revealed LPN #2 disposed of the pain patch in the sharps container. Review of the facility policy Medication Administration: Transdermal dated November 1, 2007, revealed .Follow any specific instructions for removal and destruction of medication patches.fold patch sticky side to sticky side and flush down the toilet. Interview with the Director of Nursing (DON) on September 24, 2013, at 3:00 p.m., in the conference room, confirmed the facility failed to follow the correct procedure for disposal of controlled pain patches. Observation on September 30, 2013, at 9:55 a.m., on the A-Wing Medication Cart, revealed a one cc (cubic centimeter) vial of B-12 (vitamin for injection) stored on top of the unattended medication cart, in a plastic bag. Review of the facility policy Storage and Expiration dated May 16, 2011, revealed .drugs and biologicals, are securely stored in a locked cabinet/cart.inaccessible to visitors/patients. Interview with Licensed Practical Nurse (LPN) #2 on September 30, 2013, at 9:55 a.m., on the A-Wing, confirmed the B-12 was not stored properly. Interview with the Director of Nursing (DON) on October 2, 2013, at 10:14 a.m., in the Nurse's Station, confirmed all medications should be stored in the locked medication carts.

Observation of the A wing medication cart on October 1, 2013, at 9:10 a.m., with Licensed Practical Nurse (LPN #2) on the A-wing, revealed a basket in the right top drawer containing three Doxycycline Hydrate (antibiotic) tablets along with prefilled saline syringes, scissors, and other medical items. Continued observation revealed the medication was not labeled for any particular resident. Interview with LPN #2, in the A-wing, on October 1, 2013, at 9:10 a.m., confirmed the three tablets of Doxcycline Hydrate were not stored properly and were not labeled for a resident. C/O # , #

F 0431

Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.

Based on review of facility documentation, review of facility policy, interview, and observation, the facility failed to manage controlled drugs for thirteen of forty-three residents receiving narcotics and failed to follow a systematic approach for receipt and destruction of narcotics for all residents receiving narcotics; failed to dispose of controlled substances properly for one (#16) of fifty-one residents; and failed to store medications properly on one of three carts. The findings included: Review of the facility Allegations Report dated August 28, 2013, revealed the facility reported Licensed Practical Nurse (LPN) #4 to the Office of Investigations for a significant narcotic theft. Review of the facility Controlled Drug Records dated June through August, 2013, identified by the Administrator and the Director of Nursing (DON) as the Controlled Drug Records removed from Licensed Practical Nurse (LPN) #4's truck by a police officer on August 27, 2013, revealed a total of 586 doses of controlled substances was diverted from thirteen residents from June 2013, through August 2013. Review of the facility's policy Management of Controlled Drugs revised October 1, 2012, revealed, .Storage: Two licensed nurses are required to document placement of controlled drugs into inventory.Destruction: Two licensed professionals are required to destroy and document destruction of controlled drugs.Centers will use the 'controlled Substances Book' a bound books system from which the pages cannot be removed, for ongoing tracking of all controlled drugs on each medication cart.Storage and Maintenance of Controlled Drugs.Two licensed nursing staff are required to immediately log the received medication into the 'Controlled Substances Book'.One licensed nursing staff will log the required information for each entry and sign the entry.The second licensed nursing staff will witness the documentation and sign the entry.To store drugs awaiting destruction.Perform count of drugs to be stored. Count to be done by DON or designee and licensed nursing staff.Signatures of two licensed nursing staff are required.document on Index Page date drug removed, by whom and highlight 'off' the Index Page.Two licensed nursing staff must sign the highlighted removed drug entry line on the Index Page.Document the disposition to storage in the bound destruction book located in the storage area.Signatures of two licensed nursing staff are required. Review of the facility investigation revealed Licensed Practical Nurse (LPN) #4 reported on August 27, 2013, LPN #4 had been taking the residents' discontinued medications and signing as needed (prn) medications as administered to residents, but keeping the medications. Further review revealed the facility investigated all residents who received narcotics (pain medications) to determine all residents who had been victims of the

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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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F 0431	(continued... from page 33) misappropriation of pain medications. Further review revealed the facility investigated the medication diversion and no residents had been found to have experienced uncontrolled pain. Review of a facility e-mail from the Consultant Pharmacist dated September 9, 2013, revealed a nurse was diverting controlled substances by several different methods in order to avoid detection. The nurse was diverting by taking the entire card and declining the inventory sheet upon delivery by the courier; taking the balance of the card and inventory sheet on medications when a new sheet had arrived from the pharmacy; and had also documented giving PRN pain medications to several residents (11) and not actually administering the pain medications. The pharmacist recommendations were two nurses must sign for delivery from courier; two nurses must sign to zero out a sheet from shift change reports; two nurses must count and verify discontinued meds to be destroyed; and, facility will begin using hard bound books for declining inventory sheets. Interview with the Administrator on September 24, 2013, at 10:38 p.m., in the Conference Room, revealed on August 27, 2013, the facility was informed by an employee a large amount of controlled substances had been diverted from the facility for personal use. Continued interview revealed the facility had controlled drug records from thirteen residents with a known amount of the drugs diverted. Continued interview confirmed the facility had not identified a diversion before LPN #4 had reported the drug diversion to the facility. Interview with the Consultant Pharmacist on September 23, 2013, at 12:20 p.m., by telephone, revealed the pharmacy had a technician who checked for narcotic diversion on a regular basis and none had been detected. Interview with the DON on September 24, 2013, from 2:11 p.m., until 3:00 p.m., in the Conference Room, revealed the facility had not followed the policy dated October 1, 2012, and had only required one licensed nurse to sign for controlled substances from the courier, destroy the empty narcotic cards, and remove the narcotic count sheets from the Controlled Substance Card Count Sheet. The facility's failure to follow policy and procedure for receipt and destruction of narcotics enabled LPN #4 to divert narcotics for personal use from residents living in the facility. Interview with LPN #2 on September 23, 2013, at 1:00 p.m., at the Nurse's Station, revealed resident #16's Fentanyl (pain) Patch came off while the resident was bathing. Continued interview revealed LPN #2 disposed of the pain patch in the sharps container. Review of the facility policy Medication Administration: Transdermal dated November 1, 2007, revealed .Follow any specific instructions for removal and destruction of medication patches.fold patch sticky side to sticky side and flush down the toilet. Interview with the Director of Nursing (DON) on September 24, 2013, at 3:00 p.m., in the conference room, confirmed the facility failed to follow the correct procedure for disposal of controlled pain patches. Observation on September 30, 2013, at 9:55 a.m., on the A-Wing Medication Cart, revealed a one cc (cubic centimeter) vial of B-12 (vitamin for injection) stored on top of the unattended medication cart, in a plastic bag. Review of the facility policy Storage and Expiration dated May 16, 2011, revealed .drugs and biologicals, are securely stored in a locked cabinet/cart.inaccessible to visitors/patients. Interview with Licensed Practical Nurse (LPN) #2 on September 30, 2013, at 9:55 a.m., on the A-Wing, confirmed the B-12 was not stored properly. Interview with the Director of Nursing (DON) on October 2, 2013, at 10:14 a.m., in the Nurse's Station, confirmed all medications should be stored in the locked medication carts. Observation of the A wing medication cart on October 1, 2013, at 9:10 a.m., with Licensed Practical Nurse (LPN #2) on the A-wing, revealed a basket in the right top drawer containing three Doxycycline Hydrate (antibiotic) tablets along with prefilled saline syringes, scissors, and other medical items. Continued observation revealed the medication was not labeled for any particular resident. Interview with LPN #2, in the A-wing, on October 1, 2013, at 9:10 a.m., confirmed the three tablets of Doxcycline Hydrate were not stored properly and were not labeled for a resident. C/O # , #
F 0441	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and review of the facility policy, the facility failed to separate clean and dirty items and contain dirty linen on one of three wings; failed to complete [DIAGNOSES REDACTED] (TB) screenings for five of five employee health records; and failed to contain dirty razors for one of three shower rooms. The findings included: Observation on September 23, 2013, at 10:05 a.m., on the A-wing, revealed a soiled linen cart with a black and white print bag lying on the shelf with the soiled bags. Interview with Certified Nurse Aide (CNA) #4 on September 23, 2013, at 10:08 a.m., on the A-Wing, confirmed the black and white bag contained clean items used for resident personal care and was stored with soiled items. Observation on September 23, 2013, at 10:10 a.m., on the A-Wing, revealed a box of gloves and clean, unused wipes stored on the soiled linen cart. Interview with Licensed Practical Nurse (LPN) #4 on September 23, 2013, at 10:10 a.m., on the A-Wing, confirmed clean items used for resident care had been stored on the soiled linen cart. Interview with the Director of Nursing (DON) on October 2, 2013, at 10:14 a.m., at the Nurse's Station, confirmed clean items were not to be stored with soiled items. Observation on October 1, 2013, at 5:30 p.m., revealed four dirty linen carts, each with two bags of dirty linen, on A-Wing during meal tray pass. Further observation revealed the lid of one of the eight dirty linen bags was raised with dirty linen exposed. Interview with CNA #11 on October 1, 2013, at 5:35 p.m., on A-Wing, confirmed the dirty linen carts were not normally left on the hallway during meal service. Further interview with CNA #11 confirmed the dirty linen bag with the raised lid was overfilled and should have been emptied. Review of the facility policy [DIAGNOSES REDACTED] (TB) Screening dated March 21, 2013, revealed, .if result is negative, (less than) 10 mm (millimeter) induration), repeat test in one to three weeks after first test was read. Review of five personnel files revealed no second [MEDICATION NAME] Skin Test. Interview with Registered Nurse (RN) #1 on September 23, 2013, at 2:40 p.m., in the conference room, revealed RN #1 was responsible for employee health screening. Continued interview confirmed no second TB test was performed on the five employees. Observation on September 24, 2013, at 12:10 p.m., in the A-Wing shower room, revealed a sharps container on the counter with safety razors spilling over onto the counter. Review of the facility policy Sharps Injury Prevention dated March 1, 2012, revealed Purpose to prevent.transmission of infectious disease.safety razors.must be placed in sharps disposal containers.replaced routinely when ? full. Interview with RN #1 on September 24, 2013, at 12:12 p.m., in the A-Wing shower room, confirmed the sharps container was full and needed to be replaced. .
F 0441	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and review of the facility policy, the facility failed to separate clean and dirty items and contain dirty linen on one of three wings; failed to complete [DIAGNOSES REDACTED] (TB) screenings for five of five employee health records; and failed to contain dirty razors for one of three shower rooms. The findings included: Observation on September 23, 2013, at 10:05 a.m., on the A-wing, revealed a soiled linen cart with a black and white print bag lying on the shelf with the soiled bags. Interview with Certified Nurse Aide (CNA) #4 on September 23, 2013, at 10:08 a.m., on the A-Wing, confirmed the black and white bag contained clean items used for resident personal care and was stored with soiled items. Observation on September 23, 2013, at 10:10 a.m., on the A-Wing, revealed a box of gloves and clean, unused wipes stored on the soiled linen cart. Interview with Licensed Practical Nurse (LPN) #4 on September 23, 2013, at 10:10 a.m., on the A-Wing, confirmed clean items used for resident care had been stored on the soiled linen cart. Interview with the Director of Nursing (DON) on October 2, 2013, at 10:14 a.m., at the Nurse's Station, confirmed clean items were not to be stored with soiled items. Observation on October 1, 2013, at 5:30 p.m., revealed four dirty linen carts, each with two bags of dirty linen, on A-Wing during meal tray pass. Further observation revealed the lid of one of the eight dirty linen bags was raised with dirty linen exposed. Interview with CNA #11 on October 1, 2013, at 5:35 p.m., on A-Wing, confirmed the dirty linen carts were not normally left on the hallway during meal service. Further interview with CNA #11 confirmed the dirty linen bag with the raised lid was overfilled and should have been emptied. Review of the facility policy [DIAGNOSES REDACTED] (TB) Screening dated March 21, 2013, revealed, .if result is negative, (less than) 10 mm (millimeter) induration), repeat test in one to three weeks after first test was read. Review of five personnel files revealed no second [MEDICATION NAME] Skin Test. Interview with Registered Nurse (RN) #1 on September 23, 2013, at 2:40 p.m., in the conference room, revealed RN #1 was responsible for employee health screening. Continued interview confirmed no second TB test was performed on the five employees. Observation on September 24, 2013, at 12:10 p.m., in the A-Wing shower room, revealed a sharps container on the counter with safety razors spilling over onto the counter. Review of the facility policy Sharps Injury Prevention dated March 1, 2012, revealed Purpose to prevent.transmission of infectious disease.safety razors.must be placed in sharps disposal containers.replaced routinely when ? full. Interview with RN #1 on September 24, 2013, at 12:12 p.m., in the A-Wing shower room, confirmed the sharps container was full and needed to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445319	A. BUILDING ______ B. WING _____	**11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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 0441

(continued... from page 34)
replaced. .

F 0490

Be administered in an acceptable way that maintains the well-being of each resident .
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, facility policy review, observation, interview and facility document review, the facility administration failed to ensure staff provided the necessary care to prevent pressure ulcers and prevent pressure ulcers from worsening. The facility's failure resulted in amputation of resident #95's left leg and resulted in the need for surgery on the resident's right leg to remove necrotic (dead) tissue. The facility's failure to ensure systems and processes were in place and consistently followed by staff for the provision of necessary care and services to prevent development of avoidable pressure ulcers and worsening of identified pressure ulcers placed Resident #95, #114, #35, and #73 and potentially any resident at risk for pressure ulcers in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The facility administration failed to ensure residents were safe in the facility by not investigating accidents; not determining causes of falls; not devising new interventions to prevent future falls; and not evaluating the new interventions. The facility failed to provide a system for management of falls and failed to follow the facility's fall policy, resulting in 22 residents experiencing 93 falls in 2013. This failure placed Resident #35 in Immediate Jeopardy who, after multiple falls, no investigation of the cause of the falls, and no new interventions, sustained a [MEDICAL CONDITION]. This failure placed Resident #73 in Immediate Jeopardy who, after several falls with no investigation of the cause of the falls, and no new interventions, sustained a clavicle fracture. The facility's failure placed all residents at risk for falls in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The facility Administrator failed to ensure a systematic approach was followed by nursing staff for receipt and destruction of medications which provided an environment to allow Licensed Practical Nurse #4 to potentially divert narcotics from any resident who was receiving narcotics. The Administrator's failure to implement a system to prevent diversion of narcotics constitutes Substandard Quality of Care. The Regional Vice President, Director of Clinical Services, Administrator, and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m., in the conference room. The Immediate Jeopardy was effective November 26, 2012. Substandard Quality of Care was cited under F224-F, F314-K and F323-K. The facility provided an acceptable Allegation of Compliance on November 22, 2013, and a revisit on November 26, 2013, revealed the corrective actions implemented on November 25, 2013, removed the Immediate Jeopardy. Noncompliance for F-490 continues at a E level citation. The findings included: Interview with the Administrator on October 3, 2013, at 12:30 p.m., in the Administrator's office, confirmed care plans were not updated to reflect changing needs of residents; measures were not implemented to prevent pressure ulcers or falls; falls were not investigated completely; and interventions not implemented to prevent further falls. Interview with the Administrator on October 3, 2013, at 4:10 p.m., in the Administrator's office, confirmed the facility had not identified issues with receipt and destruction of medications or possible drug diversion until Licensed Practical Nurse #4 self-reported to the facility a history of drug diversion. Interview with the Administrator on November 6, 2013, at 2:10 p.m., in the Administrator's office, confirmed three residents (#95, #35, #114) developed pressure ulcers which worsened in the facility. Continued interview confirmed two residents (#35, #73) had falls with significant injury, and the facility had not followed the facility's policy for falls. Continued interview with the Administrator revealed the Administrator stated did not feel there was a problem with falls or pressure ulcers. Refer to F224, F280, F314, F323 Validation of the Credible Allegation of Compliance was accomplished on-site November 26, 2013, by medical record review, review of facility documents, observation and interview with nursing and administrative staff. The facility provided evidence of new policy and procedures related to Fall Prevention, Pressure Ulcers, and Quality Assessment and Assurance activities and evidence the new policies were reviewed and approved by the facility administration and the new medical director. The facility provided evidence the survey findings were reviewed and shared with the facility leadership group and staff members. In-service training records including sign in sheets for all staff members related to the new policies and procedures were provided, including abuse. Review of facility documents revealed, the leadership group was involved in daily review of facility operations, and implementation of corrective measures to prevent falls and pressure ulcers. Observation at the facility on November 26, 2013, revealed, all fall related interventions were in place for residents (#17, #23, #26, #42, #52, #62). Medical record review of resident #35 revealed the resident was discharged from the facility on October 29, 2013. Medical record review of resident #73 revealed the fall risk assessment was completed, and the care plan was reviewed and updated with individualized interventions. Medical record review revealed resident #95 had been discharged from the facility on May 6, 2013. Medical record review and observations of residents #73 and #114 (in-house residents with pressure ulcers) confirmed the facility had conducted comprehensive skin assessments by the new Wound Care Nurse, treatments and interventions were in place, and preventative interventions were current on certified nursing assistant kardexs. Interview with the new facility Administrator (interim as of November 8, 2013, and new Administrator as of November 21, 2013) on November 26, 2013, at the facility, revealed the facility leadership group, the new Director of Nursing (as of October 29, 2013), and the new Medical Director (as of November 20, 2013), reviewed the findings of the survey and implemented follow up audit measures to assure compliance with corrective actions during a Quality Assessment and Assurance meeting. The facility will remain out of compliance at a Scope and Severity level E a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy, until it provides an acceptable plan of correction.

F 0490

Be administered in an acceptable way that maintains the well-being of each resident .
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, facility policy review, observation, interview and facility document review, the facility administration failed to ensure staff provided the necessary care to prevent pressure ulcers and prevent pressure ulcers from worsening. The facility's failure resulted in amputation of resident #95's left leg and resulted in the need for surgery on the resident's right leg to remove necrotic (dead) tissue. The facility's failure to ensure systems and processes were in place and consistently followed by staff for the provision of necessary care and services to prevent development of avoidable pressure ulcers and worsening of identified pressure ulcers placed Resident #95, #114, #35, and #73 and potentially any resident at risk for pressure ulcers in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The facility administration failed to ensure residents were safe in the facility by not investigating accidents; not determining causes of falls; not devising new interventions to prevent future falls; and not evaluating the new interventions. The facility failed to provide a system for management of falls and failed to follow the facility's fall policy, resulting in 22 residents experiencing 93 falls in 2013. This failure placed Resident #35 in Immediate Jeopardy who, after multiple falls, no investigation of the cause of the falls, and no new interventions, sustained a [MEDICAL CONDITION]. This failure placed Resident #73 in Immediate Jeopardy who, after several falls with no investigation of the cause of the falls, and no new interventions, sustained a clavicle fracture. The facility's failure placed all residents at risk for falls in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The facility Administrator failed to ensure a systematic approach was followed by nursing staff for receipt and destruction of medications which provided an environment to allow Licensed Practical Nurse #4 to potentially divert narcotics from any resident who was receiving narcotics. The Administrator's failure to implement a system to prevent diversion of narcotics constitutes Substandard Quality of Care. The Regional Vice President, Director of Clinical Services, Administrator, and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m., in the conference room. The Immediate Jeopardy was effective November 26, 2012. Substandard Quality of Care was cited under F224-F, F314-K and F323-K. The facility provided an acceptable Allegation of Compliance on November 22, 2013, and a revisit on November 26, 2013, revealed the corrective actions implemented on November 25, 2013, removed the Immediate Jeopardy. Noncompliance for F-490 continues at a E level citation. The findings included: Interview with the Administrator on October 3, 2013, at 12:30 p.m., in the Administrator's office, confirmed care plans were not updated to reflect changing needs of residents; measures were not implemented to prevent pressure ulcers or falls; falls were not investigated completely; and interventions not implemented to prevent further falls. Interview with the Administrator on October 3, 2013, at 4:10 p.m., in the Administrator's office, confirmed the facility had not identified issues with receipt and destruction of medications or possible drug diversion until Licensed Practical Nurse #4 self-reported to the facility a history of drug diversion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0490

(continued... from page 35)
Interview with the Administrator on November 6, 2013, at 2:10 p.m., in the Administrator's office, confirmed three residents (#95, #35, #114) developed pressure ulcers which worsened in the facility. Continued interview confirmed two residents (#35, #73) had falls with significant injury, and the facility had not followed the facility's policy for falls. Continued interview with the Administrator revealed the Administrator stated did not feel there was a problem with falls or pressure ulcers. Refer to F224, F280, F314, F323 Validation of the Credible Allegation of Compliance was accomplished on-site November 26, 2013, by medical record review, review of facility documents, observation and interview with nursing and administrative staff. The facility provided evidence of new policy and procedures related to Fall Prevention, Pressure Ulcers, and Quality Assessment and Assurance activities and evidence the new policies were reviewed and approved by the facility administration and the new medical director. The facility provided evidence the survey findings were reviewed and shared with the facility leadership group and staff members. In-service training records including sign in sheets for all staff members related to the new policies and procedures were provided, including abuse. Review of facility documents revealed, the leadership group was involved in daily review of facility operations, and implementation of corrective measures to prevent falls and pressure ulcers. Observation at the facility on November 26, 2013, revealed, all fall related interventions were in place for residents (#17, #23, #26, #42, #52, #62). Medical record review of resident #35 revealed the resident was discharged from the facility on October 29, 2013. Medical record review of resident #73 revealed the fall risk assessment was completed, and the care plan was reviewed and updated with individualized interventions. Medical record review revealed resident #95 had been discharged from the facility on May 6, 2013. Medical record review and observations of residents #73 and #114 (in-house residents with pressure ulcers) confirmed the facility had conducted comprehensive skin assessments by the new Wound Care Nurse, treatments and interventions were in place, and preventative interventions were current on certified nursing assistant kardexs. Interview with the new facility Administrator (interim as of November 8, 2013, and new Administrator as of November 21, 2013) on November 26, 2013, at the facility, revealed the facility leadership group, the new Director of Nursing (as of October 29, 2013), and the new Medical Director (as of November 20, 2013), reviewed the findings of the survey and implemented follow up audit measures to assure compliance with corrective actions during a Quality Assessment and Assurance meeting. The facility will remain out of compliance at a Scope and Severity level E a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy, until it provides an acceptable plan of correction.

F 0501

Choose a doctor to serve as the medical director to create resident care policies and coordinate medical care in the facility.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, facility policy review, review of facility fall reports, observation and interview, the Medical Director failed to ensure the facility's fall policy and procedures were implemented and failed to coordinate the medical care provided to residents. The medical director's failure to ensure staff provided the necessary care to prevent pressure ulcers and prevent pressure ulcers from worsening ultimately resulting in amputation of resident #95's left leg and resulting in the need for surgery on the resident's right leg to remove necrotic (dead) tissue. The facility medical director's failure to ensure systems and processes were in place and consistantly followed by staff for the provision of necessary care and services to prevent development of avoidable pressure ulcers and worsening of identified pressure ulcers placed Resident #95, #114, #35, and #73 and potentially any resident at risk for pressure ulcers in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The medical director failed to ensure the facility implemented the facility's fall policy, resulting in 22 residents experiencing 93 falls. This failure placed Resident #35 in Immediate Jeopardy who, after multiple falls, no investigation of the cause of the falls, and no new interventions, sustained a [MEDICAL CONDITION]. This failure placed Resident #73 in Immediate Jeopardy who, after several falls with no investigation of the cause of the falls, and no new interventions, sustained a clavicle fracture. The facility's failure placed all residents at risk for falls in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The Regional Vice President, Director of Clinical Services, Administrator, and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m., in the conference room. The Immediate Jeopardy was effective November 26, 2012, and is ongoing. Substandard Quality of Care was cited under F314-K and F323-K. The findings included: Telephone interview with the Medical Director on November 6, 2013, at 11:10 a.m. revealed .most of the falls occur at night due to short staffing. Continued interview revealed at the monthly QA (Quality Assurance) meeting they review patient and family concerns; review pressure ulcers and falls. Interview with the Administrator on November 6, 2013, at 1:30 p.m., in the conference room, revealed .if the Medical Director is not present at the Quality Meetings the Administrator would walk over to the Medical Director's office with the minutes for the Medical Director to review. Continued Interview revealed the administrator stated .reviewed info (information) with the medical director but never offered any suggestions. Refer to F280, F314, F323

F 0501

Choose a doctor to serve as the medical director to create resident care policies and coordinate medical care in the facility.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, facility policy review, review of facility fall reports, observation and interview, the Medical Director failed to ensure the facility's fall policy and procedures were implemented and failed to coordinate the medical care provided to residents. The medical director's failure to ensure staff provided the necessary care to prevent pressure ulcers and prevent pressure ulcers from worsening ultimately resulting in amputation of resident #95's left leg and resulting in the need for surgery on the resident's right leg to remove necrotic (dead) tissue. The facility medical director's failure to ensure systems and processes were in place and consistantly followed by staff for the provision of necessary care and services to prevent development of avoidable pressure ulcers and worsening of identified pressure ulcers placed Resident #95, #114, #35, and #73 and potentially any resident at risk for pressure ulcers in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The medical director failed to ensure the facility implemented the facility's fall policy, resulting in 22 residents experiencing 93 falls. This failure placed Resident #35 in Immediate Jeopardy who, after multiple falls, no investigation of the cause of the falls, and no new interventions, sustained a [MEDICAL CONDITION]. This failure placed Resident #73 in Immediate Jeopardy who, after several falls with no investigation of the cause of the falls, and no new interventions, sustained a clavicle fracture. The facility's failure placed all residents at risk for falls in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The Regional Vice President, Director of Clinical Services, Administrator, and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m., in the conference room. The Immediate Jeopardy was effective November 26, 2012, and is ongoing. Substandard Quality of Care was cited under F314-K and F323-K. The findings included: Telephone interview with the Medical Director on November 6, 2013, at 11:10 a.m. revealed .most of the falls occur at night due to short staffing. Continued interview revealed at the monthly QA (Quality Assurance) meeting they review patient and family concerns; review pressure ulcers and falls. Interview with the Administrator on November 6, 2013, at 1:30 p.m., in the conference room, revealed .if the Medical Director is not present at the Quality Meetings the Administrator would walk over to the Medical Director's office with the minutes for the Medical Director to review. Continued Interview revealed the administrator stated .reviewed info (information) with the medical director but never offered any suggestions. Refer to F280, F314, F323

F 0514

Keep accurate, complete and organized clinical records on each resident that meet professional standards.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, interview, and review of facility policy, the facility failed to maintain accurate and complete medical records for three residents (#73, #113, #62) of sixty-five residents reviewed. The findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445319	A. BUILDING ______ B. WING _____	**11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0514

(continued... from page 36)

Resident #73 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the facility's Skin Integrity Report dated June 27, 2013, revealed a suspected deep tissue injury pressure ulcer was identified on the side of the left great toe. Medical record review of the facility's Wound Management Tracking Tool dated June 27, 2013, revealed a suspected deep tissue injury pressure ulcer was identified on the side of the left great toe and also on the side of the left lateral foot. Medical record review of the Interdisciplinary Progress Notes dated July 2, 2013, revealed, .DTI (deep tissue injury) to right lateral aspect of foot. Medical record review of the physician's treatment orders dated July 8, 2013, revealed, .skin prep left lateral foot and left great toe. Medical record review of the facility's Medical Nutrition Therapy assessment dated [DATE], revealed the resident had no pressure ulcers and .(L) (left) toe tx (treatment) noted. Medical record review of the Interdisciplinary Progress Notes revealed on August 2, 2013, .DTI to left lateral foot and side of left great toe. and on August 8, 2013, .side of left lateral foot resolved. Medical record review of the physician's treatment orders dated August 11, 2013, revealed, .skin prep outer part of right foot. Medical record review of the weekly bath and skin report revealed open areas on the right inner and left outer feet on September 2, 4, 6, and 11, 2013. Medical record review of the Interdisciplinary Progress Notes revealed on October 22, 2013, .Stage II to side of left foot. and on October 29, 2013, .Stage II to left outer foot area. Interview with the Wound Care Nurse on October 29, 2013, at 10:20 a.m., revealed revealed the resident had two wounds on the left foot and no wound on the right foot. Interview with the DON (Director of Nursing) and the Wound Care Nurse on October 30, 2013, at 10:15 a.m., in the dining room, confirmed the documentation in the medical record regarding the locations of the pressure ulcers for Resident #73 was inaccurate.

Resident #113 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of facility policy Falls Management
dated June 1, 2013, revealed, .complete change of condition form.update care plan to reflect new interventions.document notification of family/physician.condition of patient.effectiveness of interventions. Interview with a family member on September 30, 2013, at 3:37 p.m., in the resident's room, revealed the facility had notified the family the resident fell out of the wheelchair since the admission to the facility. Interview with the Assistant Director of Nursing (ADON) on October 1, 2013, at 8:30 a.m., at the Nurse's Station, confirmed there was no documentation in the medical record regarding a fall since the resident's admission on September 26, 2013. Interview with the ADON on October 1, 2013, at 2:35 p.m., in the Nurse's Station, revealed the facility contacted Registered Nurse (RN) #2 regarding a fall since admission for the resident. Further interview confirmed the resident had a fall on September 27, 2013, at 8:15 a.m., and the facility failed to complete documentation of the fall until October 1, 2013 (when requested by the surveyor). Medical record review of the Situation, Background, Assessment/Appearance and Request (SBAR) form (to assess change of condition) dated September 27, 2013, revealed, .CNA (Certified Nurse Aide) walked resident room and found resident sitting on floor next to B bed. Interview with the DON on October 28, 2013, at 2:45 p.m., in the conference room, after reviewing the SBAR form dated September 27, 2013, confirmed the DON had instructed the RN to date the SBAR as a late entry, but the RN inaccurately dated the SBAR as completed on September 27, 2013. Medical record review revealed no nursing documentation from the resident's admission on September 26, 2013, until October 2, 2013. Review of the facility policy entitled Policy Clinical Record: Charting and Documentation revised on January 1, 2013, revealed, .New Admissions/Re-admissions Chart on all three shifts for a minimum of 72 hours. Interview with the DON on October 28, 2013, at 2:45 p.m., in the conference room, confirmed the medical record was incomplete and failed to contain the first three days (72 hours) of nursing notes after the admission on September 26, 2013. Resident #62 was admitted to the facility on [DATE], and readmitted to Review of facility fall report revealed the resident had a fall from the bed with no injury and was sent to the emergency room due to complaints of a headache on January 20, 2013, at 10:00 p.m. Medical record review of the Change of Condition Documentation form, dated January 20, 2013, at 10:50 p.m., revealed, .Resident attempting to get out of bed when alarm sounding and then slid in floor on butt in front of w/c (wheel chair).CNAs (Certified Nurse Aides) assisted (resident) to get up in w/c and go to bathroom to urinate.(resident) states.has bad head ache.house shoes were on, floor dry, alarm sounding, resident continues to refuse to use call light for assistance and refuses to wait till assistance arrives before (resident) gets out of bed in w/c.goes to bathroom approx. (approximately) every 30 to 40 minutes, then comes back to bed and drinks large amount of water, very weak,. Review of the Neurological Evaluation form revealed no neurological checks after the fall on January 20, 2013. Interview on October 3, 2013, at 12:55 p.m., with the Medical Records Director, in the conference room, confirmed the facility failed to maintain a complete medical record regarding the lack of neurological checks documentation following the January 20, 2013, fall.

F 0514

Keep accurate, complete and organized clinical records on each resident that meet professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on medical record review, interview, and review of facility policy, the facility failed to maintain accurate and complete medical records for three residents (#73, #113, #62) of sixty-five residents reviewed. The findings included:

Resident #73 was admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the facility's Skin Integrity Report dated June 27, 2013, revealed a suspected deep tissue injury pressure ulcer was identified on the side of the left great toe. Medical record review of the facility's Wound Management Tracking Tool dated June 27, 2013, revealed a suspected deep tissue injury pressure ulcer was identified on the side of the left great toe and also on the side of the left lateral foot. Medical record review of the Interdisciplinary Progress Notes dated July 2, 2013, revealed, .DTI (deep tissue injury) to right lateral aspect of foot. Medical record review of the physician's treatment orders dated July 8, 2013, revealed, .skin prep left lateral foot and left great toe. Medical record review of the facility's Medical Nutrition Therapy assessment dated [DATE], revealed the resident had no pressure ulcers and .(L) (left) toe tx (treatment) noted. Medical record review of the Interdisciplinary Progress Notes revealed on August 2, 2013, .DTI to left lateral foot and side of left great toe. and on August 8, 2013, .side of left lateral foot resolved. Medical record review of the physician's treatment orders dated August 11, 2013, revealed, .skin prep outer part of right foot. Medical record review of the weekly bath and skin report revealed open areas on the right inner and left outer feet on September 2, 4, 6, and 11, 2013. Medical record review of the Interdisciplinary Progress Notes revealed on October 22, 2013, .Stage II to side of left foot. and on October 29, 2013, .Stage II to left outer foot area. Interview with the Wound Care Nurse on October 29, 2013, at 10:20 a.m., revealed revealed the resident had two wounds on the left foot and no wound on the right foot. Interview with the DON (Director of Nursing) and the Wound Care Nurse on October 30, 2013, at 10:15 a.m., in the dining room, confirmed the documentation in the medical record regarding the locations of the pressure ulcers for Resident #73 was inaccurate.

Resident #113 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of facility policy Falls Management
dated June 1, 2013, revealed, .complete change of condition form.update care plan to reflect new interventions.document notification of family/physician.condition of patient.effectiveness of interventions. Interview with a family member on September 30, 2013, at 3:37 p.m., in the resident's room, revealed the facility had notified the family the resident fell out of the wheelchair since the admission to the facility. Interview with the Assistant Director of Nursing (ADON) on October 1, 2013, at 8:30 a.m., at the Nurse's Station, confirmed there was no documentation in the medical record regarding a fall since the resident's admission on September 26, 2013. Interview with the ADON on October 1, 2013, at 2:35 p.m., in the Nurse's Station, revealed the facility contacted Registered Nurse (RN) #2 regarding a fall since admission for the resident. Further interview confirmed the resident had a fall on September 27, 2013, at 8:15 a.m., and the facility failed to complete documentation of the fall until October 1, 2013 (when requested by the surveyor). Medical record review of the Situation, Background, Assessment/Appearance and Request (SBAR) form (to assess change of condition) dated September 27, 2013, revealed, .CNA (Certified Nurse Aide) walked resident room and found resident sitting on floor next to B bed. Interview with the DON on October 28, 2013, at 2:45 p.m., in the conference room, after reviewing the SBAR form dated September 27, 2013, confirmed the DON had instructed the RN to date the SBAR as a late entry, but the RN inaccurately dated the SBAR as completed on September 27, 2013. Medical record review revealed no nursing documentation from the resident's admission on September 26, 2013, until October 2, 2013. Review of the facility policy entitled Policy Clinical Record: Charting and Documentation revised on January 1, 2013, revealed, .New Admissions/Re-admissions Chart on all three shifts

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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 0514	(continued... from page 37) for a minimum of 72 hours. Interview with the DON on October 28, 2013, at 2:45 p.m., in the conference room, confirmed the medical record was incomplete and failed to contain the first three days (72 hours) of nursing notes after the admission on September 26, 2013. Resident #62 was admitted to the facility on [DATE], and readmitted to Review of facility fall report revealed the resident had a fall from the bed with no injury and was sent to the emergency room due to complaints of a headache on January 20, 2013, at 10:00 p.m. Medical record review of the Change of Condition Documentation form, dated January 20, 2013, at 10:50 p.m., revealed, .Resident attempting to get out of bed when alarm sounding and then slid in floor on butt in front of w/c (wheel chair).CNAs (Certified Nurse Aides) assisted (resident) to get up in w/c and go to bathroom to urinate.(resident) states.has bad head ache.house shoes were on, floor dry, alarm sounding, resident continues to refuse to use call light for assistance and refuses to wait till assistance arrives before (resident) gets out of bed in w/c.goes to bathroom approx. (approximately) every 30 to 40 minutes, then comes back to bed and drinks large amount of water, very weak,. Review of the Neurological Evaluation form revealed no neurological checks after the fall on January 20, 2013. Interview on October 3, 2013, at 12:55 p.m., with the Medical Records Director, in the conference room, confirmed the facility failed to maintain a complete medical record regarding the lack of neurological checks documentation following the January 20, 2013, fall.
F 0520	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical record review, facility policy review, review of fall reports, observation and interview, the facility Quality Assurance (QA) Committee failed to identify the facility staff failure to follow facility policy and procedure for receipt and destruction of medications to prevent diversion of narcotics; failed to identify the facility's failure to prevent pressure ulcers or the facility's failure to provide treatment to prevent pressure ulcers from worsening as a problem; failed to identify the facility was not following the facility's fall policy; and failed to implement any action plans to address the issues. The facility QA Committee's failure to ensure staff provided the necessary care to prevent pressure ulcers and prevent pressure ulcers from worsening resulting in amputation of resident #95's left leg and resulting in the need for surgery on the resident's right leg to remove necrotic (dead) tissue. The facility QA committee's failure to ensure systems and processes were in place and consistently followed by staff for the provision of necessary care and services to prevent development of avoidable pressure ulcers and worsening of identified pressure ulcers placed Resident #95, #114, #35, and #73 and potentially any resident at risk for pressure ulcers in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The facility's QA Committee failed to ensure a system for management of falls and failed to identify the facility's failure to follow the facility's fall policy, resulting in 22 residents experiencing 93 falls in 2013. This failure placed Resident #35 in Immediate Jeopardy who, after multiple falls, no investigation of the cause of the falls, and no new interventions, sustained a [MEDICAL CONDITION]. This failure placed Resident #73 in Immediate Jeopardy who, after several falls with no investigation of the cause of the falls, and no new interventions, sustained a clavicle fracture. The facility's failure placed all residents at risk for falls in Immediate Jeopardy. The facility QA Committee's failure to ensure a systematic approach was followed by nursing staff was followed for receipt and destruction of medications provided an environment to allow Licensed Practical Nurse #4 to potentially divert narcotics from any resident who was receiving narcotics. The facility's failure to implement a system to prevent diversion of narcotics constitutes Substandard Quality of Care. The Regional Vice President, Director of Clinical Services, Administrator, and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m., in the conference room. The Immediate Jeopardy was effective November 26, 2012, and is ongoing. Substandard Quality of Care was cited under F224-F, F314-K and F323-K. The facility provided an acceptable Allegation of Compliance on November 25, 2013, and a revisit on November 26, 2013, revealed the corrective actions implemented on November 25, 2013, removed the Immediate Jeopardy. Noncompliance for F-520 continues at an E level citation The findings included: Interview with the Director of Quality Assurance, who was also the Administrator, on October 3, 2013, at 4:10 p.m., in the Administrator's office, revealed the committee looked at incidents, falls, grievances, and put plans into place when issues were identified. Continued interview with the Administrator revealed the committee had not identified any problems with tracking falls, missing incident reports, and/or care plan revisions. Further interview with the Administrator revealed the committee had not identified any problems with tracking or identifying pressure ulcers, or any problems with the measurement of wounds. Further interview with the Administrator confirmed the facility had not identified issues with receipt and destruction of medications or possible drug diversion until Licensed Practical Nurse #4 self-reported to the facility a history of drug diversion. Interview with the Administrator on October 3, 2013, at 12:30 p.m., in the Administrator's office, confirmed care plans were not updated to reflect changing needs of residents; measures were not implemented to prevent pressure ulcers or falls; falls were not investigated completely; and interventions not implemented to prevent further falls. Interview with the administrator/Director of QA on November 6, 2013 at approximately 9:30 a.m., in the conference room, stated the former Director of Nursing had not brought all the info (information) to the meetings so the whole picture was incomplete. Further interview revealed the fall QA was not in depth as it needed to be and did not review the specifics of the falls in the meeting. Further interview revealed .the meetings did not necessarily result in action taken (to address fall). Refer to F224, F280, F314, F323 Validation of the Credible Allegation of Compliance on-site November 26, 2013, was accomplished by medical record review, review of facility documents, observation and interview with nursing and administrative staff. The facility provided evidence of new policy and procedures related to Fall Prevention, Pressure Ulcer, and Quality Assessment and Assurance activities and evidence the new policies were reviewed and approved by the facility Administration and the new Medical Director (as of November 20, 2013). Interview with the Director of Clinical Services revealed the facility administration was in-serviced by the Regional Vice President, Director of Clinical Services, and/or new Director of Nursing (as of October 29, 2013) of the survey findings, and corrective actions to identify and prevent fall risks and pressure ulcers in addition to department head specific roles in Quality Assessment and Assurance duties relevant to monitoring the implementation of the new policies and procedures. In-service training records including sign in sheets for all staff members related to the new policies and procedures were provided. A review of the facility documentation revealed the measures contained in the Allegation of Compliance were in place, and ongoing monitoring was in progress. A review of the facility Audit Tools revealed the facility was involved in ongoing monitoring of the implementation of corrective actions as specified in the Allegation of Compliance. Interview with the Director of Clinical Services on November 26, 2013, at the facility, confirmed the facility leadership team had met with the new Medical Director on November 20, 2013, and discussed new policies and procedures to reduce falls and pressure ulcers in the facility, the role of the Medical Director, and the Quality Assessment and Assurance Meeting was scheduled for November 24, 2013, at 2:30 p.m. at the facility. Continued interview with the Director of Clinical Services revealed the new Medical Director was to meet with the Quality Assessment and Assurance Committee monthly to provide ongoing monitoring and evaluation of the facility's implementation of corrective actions to reduce falls, pressure ulcers and review audit of [MEDICAL CONDITION] medication usage. Review of the November 24, 2013 Quality Assurance Meeting minutes revealed the new Administrator (as of November 21, 2013), new Director of Nursing, new Medical Director and facility staff were in attendance and the Allegation of Compliance was discussed, in addition to the new policies and procedures implemented. Interviews with nursing staff members revealed the nursing staff were aware of the new interventions in place to address the falls, and pressure ulcers and observation of the residents revealed the specific interventions noted in the medical record were in place. The facility will remain out of compliance at a Scope and Severity level E a pattern of deficient practice that constitutes no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy, until it provides an acceptable plan of correction and the facility's corrective measures could be reviewed and evaluated by the Quality Assessment/Performance Improvement Committee.
F 0520	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER	**32 MEMORIAL DRIVE WINCHESTER, TN 37398**

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 0520	(continued... from page 38) Based on review of medical record review, facility policy review, review of fall reports, observation and interview, the facility Quality Assurance (QA) Committee failed to identify the facility staff failure to follow facility policy and procedure for receipt and destruction of medications to prevent diversion of narcotics; failed to identify the facility's failure to prevent pressure ulcers or the facility's failure to provide treatment to prevent pressure ulcers from worsening as a problem; failed to identify the facility was not following the facility's fall policy; and failed to implement any action plans to address the issues. The facility QA Committee's failure to ensure staff provided the necessary care to prevent pressure ulcers and prevent pressure ulcers from worsening resulting in amputation of resident #95's left leg and resulting in the need for surgery on the resident's right leg to remove necrotic (dead) tissue. The facility QA committee's failure to ensure systems and processes were in place and consistently followed by staff for the provision of necessary care and services to prevent development of avoidable pressure ulcers and worsening of identified pressure ulcers placed Resident #95, #114, #35, and #73 and potentially any resident at risk for pressure ulcers in Immediate Jeopardy (a situation in which the provider's noncompliance has caused or is likely to cause serious injury, harm, impairment, or death). The facility's QA Committee failed to ensure a system for management of falls and failed to identify the facility's failure to follow the facility's fall policy, resulting in 22 residents experiencing 93 falls in 2013. This failure placed Resident #35 in Immediate Jeopardy who, after multiple falls, no investigation of the cause of the falls, and no new interventions, sustained a [MEDICAL CONDITION]. This failure placed Resident #73 in Immediate Jeopardy who, after several falls with no investigation of the cause of the falls, and no new interventions, sustained a clavicle fracture. The facility's failure placed all residents at risk for falls in Immediate Jeopardy. The facility QA Committee's failure to ensure a systematic approach was followed by nursing staff was followed for receipt and destruction of medications provided an environment to allow Licensed Practical Nurse #4 to potentially divert narcotics from any resident who was receiving narcotics. The facility's failure to implement a system to prevent diversion of narcotics constitutes Substandard Quality of Care. The Regional Vice President, Director of Clinical Services, Administrator, and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 2:30 p.m., in the conference room. The Immediate Jeopardy was effective November 26, 2012, and is ongoing. 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