DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391

X3) DATE SURVEY (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION STATEMENT OF COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA IDENNTIFICATION À. BUILDING B. WING \_\_\_\_ 11/07/2013 NUMBER 445319 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. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG 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 Administrator and Director of Nursing were informed or the Himitediate Jeopardy of November 6, 2015, at 2.50 p.lin. 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 no 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 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 revealed, open area to cocyx apply extuerm (cream to narden 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 bilaterial 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 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 .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 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, .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, .cleanse blister to left heel with wound cleanser.apply santyl (removes necrotic tissue). (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 dt (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 order dated April 8, 2013, revealed, .Wound care consult complex. Medical record review of a Physician Order dated April 8, 2013, revealed, .Wound care consult complex. Medical record review of a Physician Order dated April 8, 2013, revealed, .Wound care consult complex. Medical record review of a Physician Order dated April 8, 2013, revealed, .Wound care consult complex. Medical record review of a Physician Order dated April 10, 2013, revealed, .Wound care consult complex. Medical record review of a Physician Order dated April 10, 2013, revealed, .Wound care consult complex. Medical record review of a Physician Order dated April 10, 2013, revealed, .Wound care consult complex. Medical record review of a Physician Order dated April 10, 2013, revealed, .Wound care consult complex. Medical record review of a P

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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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.  Based on medical record review and interview, the facility failed to notify the physician of person or resident (95) of forther nesidents with pressure usees reviewed and interview. The facility failed to notify the physician of pressure ulcer progression for one resident (95) of fourther nesidents with pressure ulcers reviewed all to notify the physician of pressure ulcer progression for one resident (95) of fourther nesidents with pressure ulcers reviewed all to notify the physician of pressure ulcer progression for one resident (95) of fourther nesidents with pressure ulcers reviewed. He physician of the pressure ulcers are proposed to the physician of the physician of pressure ulcers. Administrator and Director of Nursing were informed of the Immediate Jeopardy on November 6, 2013, at 29, pm. in the conference room. The findings included. Resident #95 was admitted to a Trauma Genter on July 27, 2012, following an accident while burning brush in which there was an explosion. Two days late the family and friends were unable to conference room. The findings included. Resident #95 was admitted to a Trauma Genter on July 27, 2012, following an accident the resident was as Co quadrippel; (fratture 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 [July 20, 10, 20, 20, 20, 20, 20, 20, 20, 20, 20, 2		1.2 x 0.1, stage II; left lower leg May 1, 2013, revealed, send to on October 3, 2013, at 7:30 a.m measurements in the medical re at 11:35 a.m., on the A-Wing, for application and maintenance expected the facility to complet physician with changes. Intervistation, confirmed there was not and/or family were notified. Rewith [DIAGNOSES REDACTI 2103, revealed, Recommendate [MEDICATION NAME] 10 mg po 2 x day.3) [Nesychiatric Progress Note dated March 4, 2 [MEDICATION NAME] po 10 mg 2 x day.3) [MEDICATION NAME], DC [physician orders dated March 15, 2013, re 25 mg prn was discontinued, and [MEDIC with Licensed Practical Nurse 4 the physician was notified of the ph	g upper ulcer 2.0 x 1.0 x 0.1, stage II. Medical red (hospital) for direct admit. wound debridement. i., in the Medical Records Department, confirmed cord prior to December 27, 2012. Interview with onfirmed the physician expected the facility to of a multipodus boot (footdrop management). Good weekly skin assessments with wound measures the with the Director of Nursing (DON) on Octob physician order for [REDACTED]. Further intestident #62 was admitted to the facility on [DATI 2D]. Medical record review of a Psychiatric Progon :1) DC (discontinue) [MEDICATION NAMI AEDICATION NAME] 5 mg po 2 x day. Medical 1013, revealed, .Recommendation-1) DC [MEDICATION NAME] 5 mg po 2 x day. Information MEDICATION NAME] 5 mg po 2 x day. Information MEDICATION NAME] 10 mg twice wealed the [MEDICATION NAME] 10 mg twice wealed the [MEDICATION NAME] 10 mg twice at 10 n October 3, 2013, at 9:40 a.m., in the TV lot of [MEDICAL CONDITION] medication recommendation-10 mg	cord review of a Physician Order dated Interview with the Medical Records Director d there was no documentation of wound in the resident's physician on October 3, 2013, obtain an order with specific instructions Continued interview confirmed the physician ments for all pressure ulcers and notify the ber 3, 2013, at 12:50 p.m., at the Nurse's review confirmed no documentation the physician El, and readmitted to the facility on [DATE], gress Note dated January 17, 2013, and February 4, El non-use > (greater than) 30 days.2) DC all record review of the Comprehensive Non-CATION NAME] non-use > 30 days.2) DC ed consent for GDR (Gradual Dose Reduction) to be spoke with daughter. Medical record review of the ce a day was discontinued, [MEDICATION NAME] onths after the initial recommendation. Interview unge, confirmed there was no documentation mendations initiated January 2013, and continued in
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Medical record review of an admission by the pressure ulcers on admission. Medical record review of the staff responsible for monitoring the ADON) on November 5, 2012, to discharge on May 1, 2 thart revealed no information regarding the applit, and/or the staff responsible for monitoring the ADON) on November 5, 2012, to discharge on May 1, 2 thart revealed no information regarding the applit, and/or the staff responsible for monitoring the ADON) on November 5, 2013, at 7:58 a.m., in the ADON reveal of the staff revealed on information regarding the applit, and/or the staff responsible for monitoring the ADON reveal of the staff review of the Treatment Administripply exuderm (cream to harden skin and preven ontinued review of the November TAR revealed in assessments were documented. Medical record review of the Pressure Ulcer Documentation Forms date stageable left heel ulcer with the following: December 26, 2012, revealed, . 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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER / SUPPLIER STATEMENT OF (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA IDENNTIFICATION A. BUILDING 11/07/2013 NUMBER 445319 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. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (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 F 0157 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 day 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 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. 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. 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.

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: 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

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 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.

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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 applied to the property of the person of 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

[DATE], with [DIAGNOSES REDACTED]. Medical record review of two quarterly Minimum Data Sets (MDS) dated [DATE] 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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11

Facility ID: 445319

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE &				PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED 11/07/2013
	445319			
NAME OF PROVIDER OF SUI	PPLIER		STREET ADDRESS, CITY, STA	ATE, ZIP
WILLOWS AT WINCHESTE	R CARE & REHABILITATION		32 MEMORIAL DRIVE WINCHESTER, TN 37398	
For information on the nursing h	nome's plan to correct this deficien	cy, please contact the nursing hon	ne 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)			Y FULL REGULATORY	
F 0221 (continued from page 3) the re-assessment stated no longer in use) could not be determined from the medical record.				

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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 meadication).
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 fac
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
 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
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-
[MEDICATION NAME]/[MEDICATION NAME] 10/325 mg were removed from the facility and not administered to the resident.
#87 was admitted to the facility on [DATE], and readmitted [DATE], with [DIAGNOSES REDACTED]. Medical record review of
Physician's Recapitulation Orders dated June 2013, July 2013, and August 2013, revealed orders for [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
                                   ministered 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
 2013 and July 2013 revealed orders for [MEDICATION NAME] (antianxiety) 0.5 mg every six hours for Anxiety and
IMEDICATION
NAME] Sing 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]
              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,
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
                       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]
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
30, 2013, revealed orders for [MEDICATION NAME]-[MEDICATION NAME] 7.5/500 mg every four hours as needed for pain.
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
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
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
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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 are required. Molecular 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 all residents who received narcotics

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	445319			
NAME OF PROVIDER OF SUF	PPLIER		STREET ADDRESS, CITY, STA	ATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER  32 MEMORIAL DRIVE WINCHESTER, TN 37398				
For information on the nursing h	nome's plan to correct this deficien	cy, please contact the nursing hon	ne or the state survey agency.	
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			Y FULL REGULATORY
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 #			

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

of residents' property.

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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 readication).

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

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]-IMEDICATION

NAME] (pain medication) 10-325 mg every six hours as needed for pain and [MEDICATION NAME] (pain medication) 15 mg

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.

#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] 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,

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

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

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 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

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CORRECTION	NUMBER	D. WENG		11/07/2013
	445319			
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, ST.	ATE, ZIP
WILLOWS AT WINCHESTI	ER CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE WINCHESTER, TN 37398	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hor		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		ENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0224	facility investigated the medicatic Review of a facility e-mail from controlled substances by several entire card and declining the invesheet on medications when a new several residents (11) and not act must sign for delivery from couricount and verify discontinued mesheets. Interview with the Admin facility had completed pain asses been in pain. Continued interview medications. Interview with the I confirmed the facility had not fol	on diversion and no residents had the Consultant Pharmacist dated 3 different methods in order to avoientory sheet upon delivery by the 1 sheet had arrived from the pharmacily ally administering the pain medier; two nurses must sign to zero ods to be destroyed; and, facility visitrator on September 24, 2013, as ments on the residents and deter v confirmed the facility had not re DON on September 24, 2013, froi lowed the policy dated October 1	ion of pain medications. Further rebeen found to have experienced useptember 9, 2013, revealed a nurid detection. The nurse was diverticourier; taking the balance of the macy; and had also documented gications. The pharmacist recomme but a sheet from shift change reportion to the particular of the macy; and had also documented gications. The pharmacist recomme but a sheet from shift change reportion to the mind be made to the mind be mind be mind to resident had been without mind the mind to resident had been without mind the mind the mind in 2:11 p.m., until 3:00 p.m., in the 1, 2012, and had only required one otic cards, and remove the narcotic	incontrolled pain, see was diverting ing by taking the card and inventory ving PRN pain medications to endations were two nurses rts; two nurses must for declining inventory oom, confirmed the ut medications or had sappropriation of the e Conference Room, licensed nurse to sign
F 0225	Controlled Substance Card Coun narcotics enabled LPN #4 to dive 1) Hire only people with no lega residents; or 2) report and inve	t Sheet. The facility's failure to for ert narcotics for personal use from al history of abusing, neglecting	ollow policy and procedure for rectar residents living in the facility. C/ or mistreating	eipt and destruction of
	mistreatment of residents.  **NOTE-TERMS IN BRACKET Based on medical record review, the facility failed to follow policy failed to investigate an attempted findings included: Resident #77 v REDACTED]. Medical record re impaired for daily decision makin locomotion on unit; and needed I 2013, revealed, .inappropriate sest stay at the facility.alert and orien Review of a facility investigation #77's room where other staff mer enough to view resident #77 hold had no bottoms on and resident # pants and shoes on the floor. Res families of the residents were not transferred for further evaluation .transfer from a psych (psychiatric) issue and does not be revealed, .Suspected Sexual Alter Making: modified impaired-poor marked). Medical record review Capsule by mouth every 12 hours ordered to decrease the resident's August 15, 2013, revealed, .retur 2013, no issues have been noted. Medical record review of a physi admission for sexually inappropr revealed resident #77's stom reve 5:20 p.m., in the dining room rev #42 was admitted to the facility of Set (MDS) dated [DATE], reveal assistance with bed mobility, trar toilet use. Medical record review have sex with me touch along my Department records dated Augus notified.Course of Treatment no assault-unfounded. Review of fa prohibit abuse for all residents.pr Administrator.shall conduct an it to prevent further injury.assign a concerning the incident. The Adm investigation. Observation on Sep participating in physical therapy, #42's room, revealed the resident nurses' station, revealed resident nurses' stat	ITS HAVE BEEN EDITED TO PI review of facility investigation, of and procedures for a sexual abust removal of a pain patch for one a was admitted to the facility on [D view of a quarterly Minimum Dang; required no assistance with trainited assistance with trainited assistance with trainited assistance with dressing. Natual behaviors towards others at ted at times.self care deficit cognit dated August 2, 2013, revealed I mbers had gathered and were unal ling a wheelchair against the door 42 was lying on the bed in a fetal ident #42 was placed in the whee ified. The residents were kept sep. Medical record review of a hosp c) ward as he/she has only Deme helong on acute psy unit. Review reation. Medical record review of a severyday po (by mouth) BID (to libido). Medical record review on from Geropsych Unit for inappa alert with confusion. Medical record review on from Geropsych Unit for inappa alert with confusion. Medical record review on from Geropsych Unit for inappa alert with confusion Medical record review on from Geropsych Unit for inappa alert with confusion on Set (REDACTEL iate behaviors. Observation on Set on IDATE], with [DIAGNOSES I held the resident #77 sitting at a tab on IDATE], with [DIAGNOSES I held the resident was moderately in sfers, and locomotion on unit; an of a Triage from the hospital data vagina with his hand'.denied per 2, 2013, revealed, Stated Compevidence of sexual assault noted cility policy, Abuse Prohibition, devention of occurrences.investigat mediate and thorough investigat representative from social service inistrator shall take all necessary lember 26, 2013, at 10:10 a.m., i alert, and talking to staff. Observallying on the bed asleep. Observallying on t	ROTECT CONFIDENTIALITY** bbservation, review of facility polise investigation for two residents (resident (#33) of sixty-five resident ATE], and readmitted on [DATE] ta Set (MDS) dated [DATE], reveansfers, walking in room, walking Medical record review of the Care imes.explain behavior not acceptative impairment.ambulated with a Licensed Practical Nurse (LPN) #ble to open the door. The LPN was ble to open the door. The LPN was the Lohair and taken to his/her room. To barated and were monitored by the bital discharge record dated Augus ntia which was not considered as a of a facility investigation dated At a nursing assessment dated [DAT a nursing assessment dated Colober 10, 2013, revealed, Fluit and the search of the date	cy, and interview, (#77, #42) and tst reviewed. The , with [DIAGNOSES aled the resident was moderately in corridor, and/or Plan dated July 10, ble.may be unable to a rolling walker. 8 was called to resident s able to open the door nee and found resident #77 rief on, with the The physician and the e staff until both were at 3, 2013, revealed, an acute psy ugust 8, 2013, [TE], revealed, Decision cially inappropriate not utamide 250 mg (milligram) mide was a medication Note (IDT) dated 2013 through August 8, s notes [ReDACTED]. d no Psychiatric Notes since a the front lobby 1, 2013, at 8,35 on October 1, 2013, at ng supper. Resident iew of a quarterly Minimum Data; required extensive comotion off unit and ef Complaint: 'tried to review of Emergency artment has been alleged sexual acilities shall the efactors; interventions lent's feelings he results of the deld resident #42 a.m., in resident .m., in front of the autor on October 1, textive actions the review of Emergency artment was the lent sexual abuse. The coord review of Emergency artment was the lent sexual abuse. The coord review of Emergency artment was the lent sexual abuse. The lent sexual abuse are coord review of the quarterly ensive assistance with all and to sleep at night. DON) revealed, and attempted to remove ident on October 3, 2013, 1 Nurse Aide (CNA) was DON and the resident ministrator's office lent #33. Interview with the had failed to
F 0225	investigate and report to the appr # , # 1) Hire only people with no lega residents; or 2) report and inve mistreatment of residents.	opriate State Agency the attempte all history of abusing, neglecting stigate any acts or reports of ab	ed removal of a pain patch from a or mistreating	sleeping resident. C/O
1				

FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 6 of 39 Event ID: YL1O11 Facility ID: 445319

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED:4/7/2014 FORM APPROVED OMB NO 0938-0391

				OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	CTION	(X3) DATE SURVEY
DEFICIENCIES	/ CLIA	A. BUILDING		COMPLETED
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING		11/07/2013
CORRECTION				
VIA CE DE CUIDED CE	445319		hanness and honored court of	
NAME OF PROVIDER OF S			STREET ADDRESS, CITY, ST	I A I E, ZIP
WILLOWS AT WINCHES	TER CARE & REHABILITATIO	N CENTER	32 MEMORIAL DRIVE WINCHESTER, TN 37398	
For information on the nursir	ng homa's plan to correct this deficier	nov please contact the nursing ho		
	<u> </u>		, , ,	OVELLI DECLII ATODV
(A4) ID FREFIX TAG	OR LSC IDENTIFYING INFOR		IENC I MOST BE FRECEDED I	31 FULL REGULATOR I
F 0225	(continued from page 6)			
For information on the nursin (X4) ID PREFIX TAG  F 0225	OR LSC IDENTIFYING INFOR  (continued from page 6)  Based on medical record review, the facility failed to follow polic failed to investigate an attempter findings included: Resident #77  REDACTEDI. Medical record re impaired for daily decision maki locomotion on unit; and needed 2013, revealed, inappropriate se stay at the facility alert and orien Review of a facility investigation #77's room where other staff me enough to view resident #77 hole had no bottoms on and resident # pants and shoes on the floor. Res families of the residents were no transferred for further evaluation transfer from a psych (psychiatri (psychiatric) issue and does not I revealed, Suspected Sexual Alte Making: modified impaired-poor marked). Medical record review Capsule by mouth every 12 hour ordered to decrease the resident's August 15, 2013, revealed, retur 2013, no issues have been noted. Medical record review of a phys admission for sexually inapproprevealed resident #77's iroom reve 5:20 p.m., in the dining room re #42 was admitted to the facility. Set (MDS) dated [DATE], revea assistance with bed mobility, tratoilet use. Medical record review have sex with me.touch along m Department records dated Augus notified. Course of Treatment no assault-unfounded. Review of a prohibit abuse. for all residents, p Administrator. shall conduct an into prevent further injury. assign a concerning the incident. The Adrinvestigation. Observation on Se participating in physical therapy, #42's room, revealed the resident uses for all residents por Administrator of Treatment no Concerning the incident. The Adrinvestigation of a facility had failed to follow the president #33 was admitted to the Resident #33 was admitted to the Resident #33 was admitted to the Administrator of October 3, 201 investigate and report to the appring the property.  **NOTE TERMS IN BRACKE Based on medical record review. The resident's roomers and the endical record review. The indings Medical record review of a facility had Failed to follow the presidents reviewed. The	DEFICIENCIES (EACH DEFICITION)  Treview of facility investigation, y and procedures for a sexual about removal of a pain patch for one was admitted to the facility on [Deview of a quarterly Minimum Dang; required no assistance with trimited assistance with dressing. I sexual behaviors towards others at ted at times.self care deficit cogn dated August 2, 2013, revealed mbers had gathered and were unading a wheelchair against the doo #42 was lying on the bed in a feta sident #42 was placed in the wheeltified. The residents were kept sea. Medical record review of a hospicio ward as he/she has only Demobelong on acute psy unit. Review creation. Medical record review or, supervision required. Behaviora of a Physician Telephone Order or severyday po (by mouth) BID (ts. slibido). Medical record review or, supervision required. Behaviora of a Physician Telephone Order or severyday po (by mouth) BID (ts. slibido). Medical record review or from Geropsych Unit for inappalater with confusion. Medical record review or from Geropsych Unit for inappalater with confusion. Medical record review or from Geropsych Unit for inappalater with confusion. Medical record review or from Geropsych Unit for inappalater with confusion on the bed wealed resident #77 sitting at a tate on [DATE], with [DIAGNOSES] led the resident was moderately insfers, and locomotion on unit; at of a Triage from the hospital day y vagina with his hand. denied pest 2, 2013, revealed, .Stated Compevidence of sexual assault noted cility policy, Abuse Prohibition, a revention of occurrences. investig mmediate and thorough investigat representative from social servic ministrator shall take all necessary petember 26, 2013, at 10:10 a.m., a lert, and talking to staff. Obsert I tying on the bed asleep. Observe #42 self-propelling in the wheeled ce confirmed there were no causa the sexual altercation between removed and procedure for investigation of [DATE], with [DIAGNOSE] at 2:35 p.m., in the Administra topriate State Agency the attempt and the proper state Agency	observation, review of facility police investigation for two residents resident (#33) of sixty-five reside ATE], and readmitted on [DATE], revansfers, walking in room, walking Medical record review of the Caretimes, explain behavior not accept hit in the caretimes, explain behavior and a leichair and taken to his/her room, parated and were monitored by the pital discharge record dated Auguentia which was not considered as of a facility investigation dated A fa nursing assessment dated [DA di symptoms: none of the above (so dated August 8, 2013, revealed, Flwice daily) increased libido (Flut of an Interdisciplinary Department of an Interdisciplinary Department of all symptoms: none of the above (so dated August 8, 2013, at 9:50 a.m., iresidents, Observation on October I watching television. Observation ole with three female residents ear REDACTED], Medical record rempaired for daily decision making and required total dependence for 1 ted August 2, 2013, revealed, Chinetration by penis, Medical record rempaired for daily decision making and required total dependence for 1 ted August 2, 2013, revealed, Chinetration by penis, Medical record rempaired for daily decision making and required total dependence for 1 ted August 2, 2013, revealed, Chinetration by penis, Medical record rempaired for daily decision on occusions tion which shall focus on.causatives or designee to monitor the residents of incidents and allegations tion which shall focus on.causatives or designee to monitor the residents of the facility existence of the facility of facility customer concern, and existe	licy, and interview, (#77, #42) and Ints reviewed. The ], with [DIAGNOSES ealed the resident was moderately g in corridor, and/or Plan dated July 10, able.may be unable to a rolling walker. 8 was called to resident as able to open the door unce and found resident #77 orief on, with the The physician and the e staff until both were st 3, 2013, revealed, an acute psy ungust 8, 2013, TE], revealed, Decision ocially inappropriate not lutamide 250 mg (milligram) unide was a medication t Note (IDT) dated 2013 through August 8, is notes [REDACTED]. de no Psychiatric Notes since in the front lobby r 1, 2013, at 8:35 to 00 Cotober 1, 2013, at ing supper. Resident view of a quarterly Minimum Data g; required extensive ocomotion off unit and ief Complaint: 'tried to' d review of Emergency artment has been : alleged sexual Facilities shall s.the ve factors; interventions dent's feelings the results of the aled resident #42 b a.m., in resident p.m., in front of the trator on October 1, ective actions therview confirmed the dent sexual abuse, record review of the quarterly tensive assistance with all ard to sleep at night. (DON) revealed, the had attempted to remove sident on October 3, 2013, d Nurse Aide (CNA) was DON and the resident ministrator's office dent #33. Interview with the thad failed to' to sleeping resident, C/O  ** interview, the facility of of fifty-one ith [DIAGNOSES REDACTED]. tively intact, very important mee in transfers and place, time, and
	(Activities of Daily Living) due falls. Review of facility policy, A committed the act of abuse shall Concern revealed on July 7, 201. Aide (CNA) was going through Review of a police report dated 1 money from resident #10. The re revealed CNA #2 worked July 8, employee file revealed the emple Petty Cash Account Reimbursen Interview with the Administraton worked July 8, 2013, (7.33 hours	to decreased balance and pain; re Abuse Prohibition, dated October be immediately removed from du 3, (Sunday) resident #10 reported the resident's belongings when th July 7, 2013, revealed an officer resident named CNA #2 to the offi , 2013, 6:53 a.m. to 3:03 p.m., an oyee was suspended on July 9, 20 nent Request dated July 12, 2013, r on September 23, 2013, at 2:30 s) and July 9, 2013, (1 hour). Furt	113, revealed the resident had a sel quired assistance with toileting; a 1, 2008, revealed, the employee uty, pending investigation. Reviev I to Licensed Practical Nurse (LPI e resident woke up I had \$92.00 a responded to the facility to take a recer as the accused. Review of CN d July 9, 2013, 6:53 a.m. to 8:00 at 13 (two days after the incident way revealed the resident was reimbup m., in the conference room conduction thereinteries was reimbured to the resident was reimbured to	nd was at risk for alleged to have v of facility Customer N) #1 a Certified Nurse nd only \$2.00 was left. report of missing A #2's payroll record a.m. Review of CNA #2's as reported). Review of a rsed the missing \$90.00.
E 0226	the CNA from duty pending the	<u> </u>	-6	
F 0226	Develop policies that prevent mesident property.	nistreatment, neglect, or abuse of	of residents or theft of	
	**NOTE- TERMŠ IN BRACKE		ROTECT CONFIDENTIALITY* of facility customer concern, and	

FORM CMS-2567(02-99) Event ID: YL1O11 Previous Versions Obsolete

STATEMENT OF DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/07/2013
CORRECTION	NUMBER 445319			11,0,,2010
NAME OF PROVIDER OF SUP			STREET ADDRESS, CITY, STA	ATE, ZIP
WILLOWS AT WINCHESTE.	R CARE & REHABILITATION	CENTER	32 MEMORIAL DRIVE WINCHESTER, TN 37398	
For information on the nursing by (X4) ID PREFIX TAG	nome's plan to correct this deficient SUMMARY STATEMENT OF D			FILL REGULATORY
. ,	OR LSC IDENTIFYING INFORM			T CDD REGUENTON 1
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 1 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			
F 0241	obtain permission prior to enterin findings included: Resident #29 w CONDITION] Disorder, [MEDIC Disorder, and [MEDICAL CONDITION] Disor revealed resident #29 was cognitively intac Observation on September 30, 20 Further observation revealed Cert obtaining the resident's permissio entered the resident's room, and p was readmitted to the facility on [Set, dated dated dated [DATE], reveal others, and had adequate hearing in the bed, and the door to the roo knocking on the closed door or as #1 entered the resident's room and facility policy, Treatment: Considerevealed, 1.6 Respect patient's pr Interview with CNA #9 on Octob	S HAVE BEEN EDITED TO PR observation, facility policy review g a resident's room for two residents are admitted to the facility on DCAL CONDITION], Paranoid [Mider. Medical record review of the ct, could make self understood, un 13, at 4:15 p.m., revealed resident iffied Nurse Aide (CNA) #10 known. Further observation revealed a roceeded to go to the trash can with DATE], with [DIAGNOSES REI ded resident #28 was moderately cand vision. Observation on Octob m was closed. Further observation king the resident's permission to of went to the resident's bathroom leration and Respect, effective dat ivate space and property. 1.6.2 Kier 1, 2013, at 3:25 p.m., in resider 1, 2013, at 3:25 p.m., in resider	•	to request and to request and to reviewed. The including [MEDICAL of Mood Disorder, Anxiety and the dated dated [DATE], the dated dated [DATE], the the door closed. The date of the room without door at 4:20 p.m., sion. Resident #28 of the Annual Minimum Data and the date of the Annual Minimum Data and the Ann
F 0241	obtain permission prior to enterin findings included: Resident #29 w CONDITION  Disorder, [MEDIC Disorder, and [MEDICAL CONDITION] Disor revealed resident #29 was cognitively intac Observation on September 30, 20 Further observation revealed Cert obtaining the resident's permissio entered the resident's room, and p was readmitted to the facility on [Set, dated dated dated [DATE], reveal others, and had adequate hearing in the bed, and the door to the roo knocking on the closed door or as #1 entered the resident's room and facility policy, Treatment: Consid revealed, 1.6 Respect patient's pr Interview with CNA #9 on Octob failed to knock on the closed door	S HAVE BEEN EDITED TO PR observation, facility policy review g a resident's room for two residents are admitted to the facility on DCAL CONDITION], Paranoid [Mider. Medical record review of the ct, could make self understood, un 13, at 4:15 p.m., revealed resident iffied Nurse Aide (CNA) #10 known. Further observation revealed a roceeded to go to the trash can with DATE], with [DIAGNOSES REI ded resident #28 was moderately cand vision. Observation on Octob mi was closed. Further observation with the resident's permission to c d went to the resident's bathroom leration and Respect, effective dat ivate space and property. 1.6.2 Kier 1, 2013, at 3:25 p.m., in resider 1, 2013, at 3:25 p.m., in resider	•	to request and to reviewed. The including [MEDICAL of Mood Disorder, Anxiety and the dated dated [DATE], the dated dated [DATE], the hearing and vision. When the door closed, and the room without door at 4:20 p.m., sion. Resident #28 of the Annual Minimum Data and the funderstood, understood resident #28 was awake, sident's room without nevealed housekeeper ission. Review of ember 1, 2013, ion to enter.  Land housekeeper had
F 0250	failed to provide social services for Resident #77 was admitted to the review of the quarterly Minimum decision making; required no assi and needed limited assistance wit inappropriate sexual behaviors to facility alert and oriented at times facility investigation dated Augus where other staff members had garesident #77 holding a wheelchain on and resident #42 was lying on the floor. Resident #42 was placed residents were notified. The reside further evaluation. Medical recorpsych (psychiatric) ward as he/she	S HAVE BEEN EDITED TO PR review of facility investigation, re or two residents (#77, #42) of sixt facility on [DATE], and readmitt Data Set (MDS) dated [DATE], it stance with transfers, walking in h dressing. Medical record review wards others at times.explain beh.self care deficit cognitive impair at 2, 2013, revealed Licensed Practhered and were unable to open the against the door. The LPN was at the bed in a fetal position with on d in the wheelchair and taken to hents were kept separated and were a review of a hospital discharge re has only Dementia which was not a supplemental which w	e e	iew, the facility dings included: S REDACTED]. Medical record ely impaired for daily locomotion on unit; 013, revealed, le to stay at the ker. Review of a o resident #77's room n the door enough to view nt #77 had no bottoms bants and shoes on e families of the were transferred for led, transfer from a chiatric) issue and does

			OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING	11/07/2013
CORRECTION	NUMBER		11/0//2015
NAME OF PROVIDER OF S	445319	CTREET ADDR	ESS, CITY, STATE, ZIP
	TER CARE & REHABILITATIO		L DRIVE
For information on the nursing	ng home's plan to correct this deficien	ncy, please contact the nursing home or the state sur	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE MATION)	PRECEDED BY FULL REGULATORY
F 0250	(milligram) Capsule by mouth e medication ordered to decrease t note dated August 15, 2013, rev. August 8, 2013, no issues have I [REDACTED]. Medical record Resident #42 was admitted to the review of a quarterly Minimum making; required extensive assis for locomotion off unit and toile. Chief Complaint: 'tried to have record review of an Emergency Department has been notified.Calleged sexual assault-unfounded. Facilities shall prohibit abuse. fr allegations. the Administrator. sh. interventions to prevent further if feelings concerning the incident the investigation. Interview with revealed the Social Worker had revealed the Social Worker had the Administrator's office, confinition of the state of the social worker had the Administrator's office, confinition of the state of the social worker had the Administrator's office, confinition of the state of the social worker had the Administrator's office, confinition of the state of	ew of a Physician Telephone Order dated August 8, very 12 hours everyday po (by mouth) BID (twice d he resident's libido). Medical record review of an Incaled, return from Geropsych Unit for inappropriate even noted.alert with confusion. Medical record review revealed no Psychiatric Notes since admissione facility on [DATE], and readmitted on [DATE], and task (MDS) dated [DATE], revealed the residentance with bed mobility, transfers, and locomotion of tuse. Medical record review of a Triage from the hosex with metouch along my vagina with his hand'd Department record dated August 2, 2013, revealed, ourse of Treatment no evidence of sexual assault not 1. Review of facility policy, Abuse Prohibition, date at all residents, prevention of occurrences, investigation njury, assign a representative from social services or The Administrator shall take all necessary corrective the Social Service (SS) Director on October 1, 2015 not followed up with the families or residents since to involvement with the situation. Interview with the med the facility had failed to provide medically relations.	aily) increased libido (Flutamide was a terdisciplinary Department Note (IDT) behavior, from August 2, 2013, through ew of a physician progress notes on for sexually inappropriate behaviors. iith [DIAGNOSES REDACTED]. Medical record at was moderately impaired for daily decision on unit; and required total dependence sospital dated August 2, 2013, revealed, enied penetration by penis. Medical Stated Complaint Alleged Assault. Police led on this exam. Primary Impression: d October 1, 2008, revealed, ons of incidents and a which shall focus on.causative factors; designee to monitor the resident's e actions depending on the results of 3, at 8:46 a.m., in the SS office the sexual altercation. Interview e Administrator on October 1, 2013, in
F 0250	possible quality of life.  **NOTE-TERMS IN BRACKE Based on medical record review failed to provide social services Resident #77 was admitted to th review of the quarterly Minimur decision making; required no as: and needed limited assistance w: inappropriate sexual behaviors i facility alert and oriented at time facility investigation dated Augt where other staff members had g resident #77 holding a wheelcha on and resident #42 was lying on the floor. Resident #42 was plac residents were notified. The resi further evaluation. Medical reco psych (psychiatric) ward as he/s not belong on acute psy unit. Re Altercation. Medical record revi (milligram) Capsule by mouth e medication ordered to decrease t note dated August 15, 2013, rev. August 8, 2013, no issues have t [REDACTED]. Medical record: Resident #42 was admitted to th review of a quarterly Minimum making; required extensive assis for locomotion off unit and toile. Chief Complaint: 'tried to have record review of an Emergency Department has been notified. C allegged sexual assault-unfounde. Facilities shall prohibit abuse.fc allegations.the Administrator.sh interventions to prevent further i feelings concerning the incident the investigation. Interview with revealed the Social Worker had revealed the Social Worker had	al services to help each resident achieve the higher achieve to help each resident achieve the higher TS HAVE BEEN EDITED TO PROTECT CONFILE, review of facility investigation, review of facility property for two residents (#77, #42) of sixty-five residents refacility on [DATE], and readmitted on [DATE], we had the residents achieve with transfers, walking in room, walking in the dressing. Medical record review of the Care Plan owards others at times, explain behavior not accepta as self care deficit cognitive impairment ambulated was 12, 2013, revealed Licensed Practical Nurse (LPN ir against the door. The LPN was able to gain entrain the bed in a fetal position with only a shirt and a brid in the wheelchair and taken to his/her room. The dents were kept separated and were monitored by the dreview of a hospital discharge record dated August has only Dementia which was not considered as a view of a facility investigation dated August 8, 2015 ewo of a Physician Telephone Order dated August 8, 2015 ewo of a Physician Telephone Order dated August 8, 2015 even of a price of the resident's libido). Medical record review of an Inealed, return from Geropsych Unit for inappropriate one noted. alert with confusion. Medical record reviewer eveled no Psychiatric Notes since admission facility on [DATE], and readmitted on [DATE], wo Data Set (MDS) dated [DATE], revealed the resident record dated August 2, 2013, revealed, ourse of Treatment no evidence of sexual assault not 1. Review of facility policy, Abuse Prohibition, date all residents, prevention of occurrences, investigation of use. Medical record review for a line and in the sidents and thorough investigation injury, assign a representative from social services or The Administrator shall take all necessary corrective the Social Service (SS) Director on October 1, 2015 not followed up with the families or residents since in oinvolvement with the situation. Interview with the med the facility had failed to provide medically related to provide medically related to provi	DENTIALITY**  bolicy, and interview, the facility eviewed. The findings included: ith [DIAGNOSES REDACTED]. Medical record ent was moderately impaired for daily corridor, and/or locomotion on unit; dated July 10, 2013, revealed, blbe.may be unable to stay at the with a rolling walker. Review of a ) #8 was called to resident #77's room I was able to open the door enough to view ace to find resident #77 had no bottoms rief on, with the pants and shoes on physician and the families of the e staff until both were transferred for st 3, 2013, revealed, transfer from a macute psy (psychiatric) issue and does 3, revealed, .Suspected Sexual 2013, revealed, Flutamide 250 mg ailty) increased libido (Flutamide was a sterdisciplinary Department Note (IDT) behavior.from August 2, 2013, through ew of a physician progress notes on for sexually inappropriate behaviors. ith [DIAGNOSES REDACTED]. Medical record at was moderately impaired for daily decision on unit; and required total dependence spital dated August 2, 2013, revealed, enied penetration by penis. Medical .Stated Complaint Alleged Assault.Police ted on this exam.Primary Impression: d October 1, 2008, revealed, ons of incidents and a which shall focus on.causative factors; designee to monitor the resident's e actions depending on the results of 3, at 8:46 a.m., in the SS office the sexual altercation. Interview e Administrator on October 1, 2013, in
F 0278	professional.  **NOTE- TERMS IN BRACKE Based on medical record review accurate assessment for pressure failed to accurately assess the de failure to assess the skin status a ulcer resulting in an amputation provider's non-compliance has c was effective on November 26, . Administrator and Director of N conference room. The facility pr November 26, 2013, revealed th Noncompliance for F-278 contir on [DATE], with [DIAGNOSES the resident had an open area on the sore/scabbed area to the coccyx, review of the Interim Care Plan integrity r/t (related to) Burn.rep 3:45 p.m., revealed, skin pink w (indicates very high risk). Medic Treatment Administration Recon	es an accurate assessment by a qualified health TS HAVE BEEN EDITED TO PROTECT CONFII, interview, and observation, and facility policy review ulcers for one resident, (#95) of fourteen residents and status for one resident (#28) of sixty-five reside that the status for one resident (#28) of sixty-five reside that the thippodus boot placement resulted in the debelow the knee, placed resident #95 in Immediate Jeaused or likely to cause serious injury, harm, impair 2012, and is ongoing. The Regional Vice President, ursing were informed of the Immediate Jeopardy on ovided and acceptable Allegation of Compliance on ecorrective actions implemented on November 25, in uses at an D level citation. The findings included: Rest REDACTED]. Medical record review of the admis left knee, open/abrasion on the right lower extremit reddened right lower extremity, and a reddened are dated October 5, 2012, revealed, potential for pain ort new open areas. Medical record review of a Nurarm, multiple red areas D/T (due to)[MEDICAL Coal record review of a physician's orders [REDACTE det (TAR) dated October 5-31, 2012, revealed, open 19, 2012). Medical record review of the admission	ew, the facility failed to complete an with pressure ulcers reviewed; and ents reviewed. The facility's velopment of an unstageable pressure copardy (a situation in which the ment, or death). The Immediate Jeopardy Diretor of Clinical Services, 1 November 6, 2013, at 2:30 p.m. in the November 22, 2013, and a revisit on 2013, removed the Immediate Jeopardy. esident #95 was admitted to the facility sion nursing assessment dated [DATE], revealed y, reddened area to the scrotum, a on the right side. Medical record related to wounds. alteration in skin se's Notes dated October 5, 2012, at DNDITION] total Norton plus score of 11 ED]. Medical record review of the area to coccyx apply exuderm change q

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 445319 If continuation sheet Page 9 of 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:4/7/2014

CENTERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING		11/07/2013
NAME OF PROVIDER OF SU	445319 DDI IED		STREET ADDRESS, CITY, STA	ATE ZID
	FFLIER ER CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE	ATE, ZIF
For information on the avaning	homolo ulou to comport this deficien	av mlassa soutsat the mumaina ha	WINCHESTER, TN 37398	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D		ENCY MUST BE PRECEDED B	Y FULL REGULATORY
E 0279	OR LSC IDENTIFYING INFORM	MATION)		
F 0278	Living (ADL's); at risk for pressure sident was admitted to the hosp treatment of [REDACTED]. Med .Skin/Wound condition present: rarea (right forearm), (no areas on idated October 30, 2012, revealed open areas.10/30/12 coccyx sheat Stage II on coccyx. Medical record exuderm change q (every) 3 days order. Medical record review of a heel. Medical record review of a heel. Medical record review of a (IDT) dated December 11, 2012, of an IDT note dated December 131, 2012 2012).Cleanse blister to left heel. dated December 27, 2012, revealed 28, 2012, revealed, .wound care t 2013, revealed Left Heel Stage U Meintegrity r/t: foot ulcer (left heel) review of a quarterly MDS dated dependent for all ADL's; at risk for Interview with MDS nurse #1 on January 2013, did not include an Allegation of Compliance was ac documents, observations and intertaining with sign-in sheets for all record review revealed resident # observations of residents #73 and comprehensive skin assessments interventions were current on cert 2013, at the facility, and review of assessments on all residents curre confirmed the new Wound Care I Further interview with the Wound care intervied nursing staff related to scertified nursing staff related to scertified nursing staff ron Novemb policies. Interview with the Mini weekly, and had completed an au Administration Records confirme pressure ulcers. Interviews condu Operations confirmed the facility prevention, treatment and policy Scope and Severity level D a patt minimal harm, that is not Immedi	ure ulcers; and had no pressure ul vital October 24-29, 2012, for Alt lical record review of the Nursin; no.red area (coccyx).scabbed area heels noted). Norton Scale 12 (ve, potential for pain related to woring. Medical record review of the TAR reven Nurse's Note dated November 2 physician's orders [REDACTED revealed, open area to coccyx. as 2, 2012, revealed, wound care to crevel note. Open area to coccyx. as the tart date 11/26/2012. Medical red, Left Heel Stage U (unstagea of Left Heel Stagea Of L	making; totally dependent for all A cers on admission. Medical record ered Mental Status, Urinary Tract g Assessment Re-admitted d Octob a (right lower extremity) scab area rry high risk). Medical record reviewed as a start date of October 31, 201 ember 1-30, 2012, revealed, open aled a start date of October 9, 2012, decented a start date of October 9, 2012, at 10:00 a.m., revealed, .f. J. Medical record review of an Intend no documentation of the left he of L heel area to coccyx healed. Me apply exuderm change q (every) 3 coord review of a Pressure Ulcer Documentation Form ble). Medical record review of an I of a Pressure Ulcer Documentation Form Plan dated January 10, 2013, reveals: 10/29/12.Revision on: 1/10/2013, as moderately impaired for daily of one pressure ulcers. Validation of 5, 2013, through medical record retrative staff. The facility provided ulcer prevention and skin assessment facility on May 6, 2013. Medical ressure ulcers) confirmed the facility and the Mound Care Nurse had conswed treatments and interventions were interview with the new Wound Care the dressure ulcer Report log to the Adoministrator and Regional valued the Wound Care Nurse had conswed treatments currently in place, teted a Pressure Ulcer Report log to the Adoministrator and Regional valued the Wound Care such assessment needs. Review undit and were monitoring all reside the Meeting which included discurrector. The facility will remain out stitutes no actual harm with potent acceptable plan of correction. C/C teted to the facility on [DATE], with	review revealed the Infection, and for er 29, 2012, revealed, (top of right foot).red w of the Care Plan Burn.report new 2, revealed, .Skin (with) area to coccyx apply 2, for this treatment Blister noted to L (left) rdisciplinary Progress Note el. Medical record review dical record review dical record review of the days.(start date October 9, ocumentation Form DT note dated December 1 Form dated January 3, dated January 3, 2013, ed. Alteration in skin Medical record ecision making; totally eable pressure ulcers. DS dated [DATE], and the Credible view, review of facility evidence of in-service ents. Medical record review and ty had conducted n place, and preventative e Nurse on November 26, upleted comprehensive skin Continued interview the New Director of Nursing. to all licensed and the Incensed and the Incensed and the result of Clinical sisting of the Treatment ents with current vice-President of Clinical sisting of the property of compliance at a informer than 0.#
F 0278	Medical record review of the Quaresident was moderately impaired Therapy Quarterly Assessments s Medical Nutritional Therapy Ann. Oral/Dental: no pain, not edentul review of the Nursing Readmissic and April 30, 2013, revealed, .1. Medical record review of the Der for dentures. Observation on Sept observation revealed the resident on the patty and placed the patty member asked the resident if the the resident refused the assistance consumed. Interview with the resident refused the assistance consumed. Interview with the resident patty in the resident resident could not reinterview and observation revealed was not able to chew the hamburg on October 1, 2013, at 3:20 p.m., (resident) had false teeth. Interviex confirmed the facility failed to ac Make sure each resident receive professional.  **NOTE- TERMS IN BRACKET Based on medical record review, accurate assessment for pressure failed to accurately assess the der failure to assess the skin status an ulcer resulting in an amputation be provider's non-compliance has ca was effective on November 26, 20 Administrator and Director of Nuconference room. The facility pro November 26, 2013, revealed the	arterly Minimum Data Set (MDS) a cognitively and had no dental is signed by the Registered Dietitian and Assessment signed by the Relous, partial lower dentures, chevon assessment dated [DATE]; an Oral Problems: None. Teeth: upp tall Progress Note dated January tember 30, 2013, at 1:08 p.m., repicked up a hamburger patty on back on the hamburger patty on back on the hamburger bun. Furt resident needed assistance or wae and the alternative food. Further ident, in the resident's room, on on turners in another facility and was call if had told anyone in the faced the resident had a full upper deger on September 30, 2013. Interint in the resident's room, revealed the with MDS Coordinator #2 on curately assess the resident's dense an accurate assessment by a TS HAVE BEEN EDITED TO P interview, and observation, and sulcers for one resident, (#95) of intal status for one resident (#28) and the multipodus boot placemen below the knee, placed resident # used or likely to cause serious in 012, and is ongoing. The Region using were informed of the Immovided and acceptable Allegation corrective actions implemented	) dated [DATE], and the Annual Msuses. Medical record review of the n, dated November 1, 2012, and Jaegistered Dietitian and dated Auguving ability WNL (within normal ld the Nursing Quarterly Assessmeter right/left and lower right/left: Fa 6, 2012, revealed, Prosthesis: Upp vealed the resident was in the dinit two occasions with a hand and sucher observation at 1:18 p.m., reveanted something else to eat. Further observation revealed none of the October 1, 2013, at 7:58 a.m., and is having problems chewing food. Fillity of having difficulty chewing the nature in place. Further interview of the resident has real teeth that I kn October 1, 2013, at 4:14 p.m., in that status.	LDS dated [DATE], revealed the Medical Nutritional nuary 29, 2013, and the st 14, 2013, revealed, mits). Medical record this dated October 20, 2012, ir.Lower Dentures.  Ber. Other: No lower jaw the groom. Further ked or attempted to bite led a facility staff observation revealed hamburger patty was at 3:20 p.m., revealed urther interview ne food. Further onfirmed the resident Certified Nurse Aide #9 ow of I never knew ne MDS office,  ailed to complete an eres reviewed; and ne facility's unstageable pressure ion in which the The Immediate Jeopardy at Services, 113, at 2:30 p.m. in the 2013, and a revisit on he Immediate Jeopardy.

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 area 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

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 445319 Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF	(X1) PROVIDER / SUPPLIER			
DEFICIENCIES		(X2) MULTIPLE CONSTRUCT	HON	(X3) DATE SURVEY COMPLETED
AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		11/07/2013
CORRECTION	NUMBER			11/07/2013
	445319			
NAME OF PROVIDER OF SUP	PLIER		STREET ADDRESS, CITY, STA	ATE, ZIP
WILLOWS AT WINCHESTEI	R CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE	
			WINCHESTER, TN 37398	
For information on the nursing h	ome's plan to correct this deficient	cy, please contact the nursing hor	ne or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D	DEFICIENCIES (EACH DEFICIA	ENCY MUST BE PRECEDED BY	Y FULL REGULATORY
	OR LSC IDENTIFYING INFORM	MATION)		
F 0278	OR LSC IDENTIFYING INFORM (continued from page 10) (every) 3 days (start date October revealed the resident was modera Living (ADL's); at risk for pressu resident was admitted to the hosp treatment of [REDACTED]. Med .Skin/Wound condition present: n area (right forearm). (no areas on 1 dated October 30, 2012, revealed. open areas. 10/30/12 coccyx shear Stage II on coccyx. Medical record exuderm change q (every) 3 days order. Medical record review of a heel. Medical record review of a leel. dated December 1-31, 2012. 2012). Cleanse blister to left heel. dated December 27, 2012, revealed. Left Heel Stage U. Medintegrity r/t: foot ulcer (left heel) review of a quarterly MDS dated dependent for all ADL's; at risk for Interview with MDS nurse #1 on January 2013, did not include an allegation of Compliance was ac documents, observations and intervientions were current on cert 2013, at the facility, and review of assessments on all residents curre confirmed the new Wound Care Neutries with the Wound Care Further interview with the Wound Care Further interview with the Minit weekly, and had completed an aux Administration Records confirme pressure ulcers. Interviews condu Operations confirmed the facility revention, treatment and policy is revented and policy is record.	MATION)  19, 2012). Medical record review tely impaired for daily decision may be the property of the property of the Marsing to red area (coccyx). Scabbed area heels noted). Norton Scale 12 (verporter), potential for pain related to woring. Medical record review of the dreview of the TAR dated Nove. Record review of the TAR reversal Nurse's Note dated November 20, physician's orders [REDACTED] revealed, open area to coccyx. at start date 11/26/2012. Medical record review of the telephysician's orders [REDACTED] revealed, open area to coccyx a start date 11/26/2012. Medical record review of the telephysician's orders [REDACTED] revealed, open area to coccyx a start date 11/26/2012. Medical record review of J. Medical record review of a Predical record review of a Predical record review of a Predical record review of the Care Plshearing to coccyx. date initiated: [DATE], revealed the resident was or pressure ulcers; had one Stage October 3, 2013, at 8:00 a.m., in accurate assessment of the resided complished on-site November 26 rviews with nursing staff related to pressure 95 had been discharged from the #114 (in-house residents with proby the new Wound Care Nurse, the tified nursing assistant kardexs. In facility documentation confirmed the nurse kin assessments and reporting of part of the facility had conducted an aucted on November 26, 2013, confirmed the staff valum Data Set (MDS) Coordinato dit for pressure ulcers comprepeld the facility had conducted an acted on November 26, 2013, with had conducted a Quality Assurance with the new Medical Direction of the resident with the new Medical Direction with the new M	of the admission Minimum Data Sanaking; totally dependent for all Avers on admission. Medical recordered Mental Status, Urinary Tract I Assessment Re-admitted d Octob (right lower extremity) scab area (y high risk). Medical record review inds. alteration in skin integrity r/t to Care Plan dated October 31, 2012 mber 1-30, 2012, revealed, .open a led a start date of October 9, 2012, 5, 2012, at 10:00 a.m., revealed, .B. Medical record review of an Inte do documentation of the left her of th	Set (MDS) dated [DATE], ctivities of Daily review revealed the infection, and for er 29, 2012, revealed, (top of right foot).red wo fithe Care Plan Burn.report new 2, revealed, .Skin (with) urea to coccyx apply, .for this treatment clister noted to L (left) redisciplinary Progress Note 19. Medical record review dical record review of the lays. (start date October 9, ocumentation Form DT note dated December Form dated January 3, dated January 8, 2013, and .Alteration in skin Medical record ecision making; totally eable pressure ulcers. DS dated [DATE], and he Credible iew, review of facility evidence of in-service ents. Medical ecord review and ys had conducted in place, and preventative e Nurse on November 26, upleted comprehensive skin Continued interview the New Director of Nursing. to all licensed and hent and reporting e Pressure Ulcer Reports of the Treatment ints with current fice-President of Clinical sion of pressure ulcer of compliance at a
F 0280	minimal harm, that is not Immedi Resident #28 was admitted to the Medical record review of the Qua resident was moderately impaired Therapy Quarterly Assessments s Medical Nutritional Therapy Ann Oral/Dental: no pain, not edentul review of the Nursing Readmissic and April 30, 2013, revealed, .1. of Medical record review of the Den for dentures. Observation on Sept observation revealed the resident on the patty and placed the patty l member asked the resident if the the resident refused the assistance consumed. Interview with the resi the resident had lost the lower der revealed the resident could not re interview and observation reveale was not able to chew the hamburg on October 1, 2013, at 3:20 p.m., (resident) had false teeth. Intervie confirmed the facility failed to ac  Allow the resident the right to p care plan. **NOTE- TERMS IN BRACKET Based on medical record review, the facility failed to revise the care plan #114, #79) of fourteen residents (#35 falls; failed to revise the care staff to implement after a sexual failure to address interventions or staff unfamiliar with the care to b non-compliance has caused or lik revise the care plans addessing fa fractured clavicle for one resident on November 26, 2012, and is on Director of Nursing were informe findings included: Resident #35 v Minimum Data Set (MDS) dated [DATE], n	facility on [DATE], and readmitturerly Minimum Data Set (MDS) I cognitively and had no dental is igned by the Registered Dietitian unal Assessment signed by the Region assessment dated [DATE]; and Oral Problems: None. Teeth: uppe tall Progress Note dated January (tember 30, 2013, at 1:08 p.m., rev picked up a hamburger patty on t back on the hamburger patty on t back on the hamburger bun. Furthersident needed assistance or wan at and the alternative food. Further ident, in the resident's room, on Control of the compact of the properties of the compact	acceptable plan of correction. C/C ted to the facility on [DATE], with dated [DATE], and the Annual M sues. Medical record review of the dated November 1, 2012, and Jar gistered Dietitian and dated Augus ing ability WNL (within normal li the Nursing Quarterly Assessmer right/left and lower right/left: Fa 5, 2012, revealed, Prosthesis: Upp realed the resident was in the dinin wo occasions with a hand and such er observation at 1:18 p.m., reveated something else to eat. Further observation revealed none of the loctober 1, 2013, at 7:58 a.m., and a having problems chewing food. Fitty of having difficulty chewing thrure in place. Further interview criew with the resident's direct care he resident has real teeth that I kn October 1, 2013, at 4:14 p.m., in thal status.	[DIAGNOSES REDACTED]. DS dated [DATE], revealed the Medical Nutritional unary 29, 2013, and the st 14, 2013, revealed, mits). Medical record tast dated October 20, 2012, ir. Lower Dentures. er.Other: No lower jaw g room. Further ked or attempted to bite led a facility staff observation revealed hamburger patty was at 3:20 p.m., revealed urther interview the food. Further confirmed the resident Certified Nurse Aide #9 ow of. In ever knew the MDS office,  licy, and interview, ment to prevent tast reviewed with tar (#35, #73, and interventions for wed. The facility to for one resident (#35) and a Jeopardy was effective Administrator and the conference room. The cal record review of the mpairment. Medical record

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 445319 If continuation sheet Page 11 of 39

	TH AND HUMAN SERVICES E & MEDICAID SERVICES		PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391
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 S	UPPLIER	STREET ADDRES	SS, CITY, STATE, ZIP
VILLOWS AT WINCHES	TER CARE & REHABILITATION	CENTER 32 MEMORIAL D WINCHESTER, T	
For information on the nursing	ng home's plan to correct this deficience	cy, please contact the nursing home or the state survey	y agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIENCY MUST BE PI MATION)	RECEDED BY FULL REGULATORY
F 0280	interventions care planned; Marcl interventions care planned; Marcl interventions care planned; Marcl April 1, 2013, at 11:55 p.m., fall I intervention for a scoop mattress; interventions were implemented; bathroom emergency call light bit the left arm. Review of the Care F report was not initiated until Octor evealed the resident was found of fall. Intervention 7/19/13 Reacher, call light, resident sitting in floor right hip. Medical record review of the Assessment and Plan: fall with rithe an Interdisciplinary Progress I following the surgery of the right the resident returned from a hospi Evaluation dated October 7, 2013 the resident fell in the bathroom a resident did not have the individue the Director of Nurses (DON) in the Interventions were not resumed w Interdisciplinary Team did not corecord review of the Nursing Asses have a pressure ulcer, indicated the August 30, 2013, as a Deep Tissu skin intact with Appearance. deep resident at intervals on October 1, the right heel pressure ulcer restincertified nurse aide (CNA) #9 revareview of the resident's Kardex/ resident had a pressure ulcer of the ulcer of the right heel and had not telephone on October 3, 2013, at 4 until September 20, 2013, Interview of the pressure ulcer of the Ucer, and the RD verified nutritic and concurrent review of the Skin a.m., on October 2, 2013, confirm but the pressure ulcer had not bee unstageable due to deep tissue injuot the hospital on October 1, 2013 heel ulcer was identified on Augu the heels off of the bed had not be with the Director of Nurses at 11: not have a pressure ulcer on admiresident's Care Plan and Kardex definition of the resident #73 was care ple Documentation, revealed resident 2013, revealed resident #73 was care ple Documentation, revealed resident effective on Septen felect new interventions. Review 2013, revealed, Implement imme	as care planned; January 15, 2013, no fall report proving, 16, 2013 at 7:50 a.m., fall report revealed fell on the vince of 21, 2013, at 7:20 a.m., fall report was not completed eport revealed resident on the way to the bathroom, the vince of 21, 2013, at 7:20 a.m., fall report revealed its will way 25, 2013, at 7:25 a.m., fall report revealed at CN. nking, and found the resident in the bathroom on the Plan revealed no new interventions were implemented beer 1, 2013, by the DON, during the annual survey, non the floor and old skin tear re-opened. Review of the Grabber. August 12, 2013, at 3:40 a.m., fall report revealed to the bed. noted abrasion to right cheek and reside at History and Physical on admission to the hospital ght intertrochanteric (hip) fracture. still alert. wants survote dated August 19, 2013, revealed on this date the hip. Medical record review of the Re-admission nursitalization due to a Urinary Tract Infection. Medical revealed a score of 13, high risk for falls. Review of the 4:32 a.m., on October 9, 2013. Review of the reside alizade interventions previously put into place resume the conference room at 1:00 p.m., on October 28, 201 hen the resident returned to the facility October 7, 20 method to the resident returned to the facility October 7, 20 method to the resident returned to the facility October 7, 20 method to the resident review of the weekly skin checks recorded on the last 20, 2013. Medical record review of the physician's order stream to make the conference was identified on August 25, 2013, and e Injury measuring 3 cm (centimeters) Legnth, 4 cm value purple. Medical record review of the physician's order and the CNA had cared for the resident during the provided for the CNA staff) and revealed the graph theel. Interview on October 2, 2013, at 9:00 a ealed the CNA had cared for the resident during the provided for the CNA staff) and revealed the resident band and the Unit Manager/Wound Cared the following: the right heel pressure ulcer had be not interventions were not develope	way to the bathroom, new I, no new interventions care planned; In Care Plan recorded a new was a witnessed fall, no new A heard the safety alarm, saw the floor with bruises, a skin tear to I; July 19, 2013, at 8:20 a.m., fall Io investigation done. Review E Care Plan revealed, 7/19/13 vealed To resident room to answer lent c/o (complained of) pain to I on August 12, 2013, revealed, regry. Medical record review of resident returned from the hospital ing assessment dated [DATE], revealed ecord review of the Fall Risk facility documentation revealed int's Care Plan revealed the d on re-admission. Interview with 3, confirmed previous individualized 113. Interview confirmed the er the October 9, 2013, fall. Medical 2013, revealed the resident did not e treatment record revealed the rity Report, initiated for a right initially staged and measured on Width, and undetermined Depth due to the ers [REDACTED]. Observation of the resident remained in the bed with, in the resident's room with Drevious two weeks. Interview included the Kardex did not indicate the ent told the resident had a pressure el off of the bed. Interview by d the RD had worked at the facility e RD to the resident's pressure ight heel pressure ulcer. Interview e Nurse in the conference room at 10:30 en identified on August 25, 2013, 3, the pressure wound was assessed as nge until the resident was admitted anager stated from the time the right nued interview confirmed floating Plan as a new intervention. Interview ce room, confirmed the resident tid ure ulcer in the facility; the f a pressure ulcer. Resident #73 was f review of the quarterly MDS (Minimum Da tatal Status) score of 2 (severe not staff for bed mobility, transfers, lan updated January 11, 2013, he Change of Condition 2012, December 24, 2012, January 12, loos to address the resident's falls view of the facility's policy titled Falls Jif patient falls. Update care plan to wit

landed 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]. 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

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

			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/07/2013
	445319		
NAME OF PROVIDER OF SUP	PLIER	STREET ADDRESS, CITY, ST	ATE, ZIP

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 12)

WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER

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

32 MEMORIAL DRIVE WINCHESTER, TN 37398

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 two physical assistance for transfers, walk in corridor, dressing, personal hygiene and bathing; required extensive assistance of two physical assistance for transfers, walk in corridor, dressing, personal hygiene and bathing; required extensive assistance of two physical assistance for bed mobility and to left the service of the control of the problems of the service of the service

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

CENTERS FOR WEDICHKE	a wiedie/tid bekviees		OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING	11/07/2013
CORRECTION	NUMBER		11/0//2013
	445319	kan yan i na na	
NAME OF PROVIDER OF ST			ESS, CITY, STATE, ZIP
WILLOWS AT WINCHEST	TER CARE & REHABILITATION	N CENTER 32 MEMORIAL WINCHESTER,	
For information on the nursing	g home's plan to correct this deficien	ncy, please contact the nursing home or the state surv	vey agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE LIMATION)	PRECEDED BY FULL REGULATORY
F 0280	(continued from page 13)	,	
	report, revealed resident #93 had February 15, 2013, and February and April 22, 2013, revealed resicondition. Further review of the February 11, 2013, February 13, Nursing) on November 5, 2013, to reflect new interventions to at 15, 2013, and February 25, 2013 [DIAGNOSES REDACTED]. Moreident was dependent for bed of the MDS revealed, the resident Medical record review of a quarm and transfers, required limited as hygiene and bathing. Further revimpairment. Medical record review of the Care Plan updated #100 was care planned for at risl pain, and decreased safety aware resident's falls on February 21, 2 at 8:30 a.m., in the business offic address the resident's falls occur Resident #52 was admitted to the	I falls/incidents documented on January 23, 2013, Fe z 25, 2013. Medical record review of the Care Plan up dient #93 was care planned as being at risk for falls r Care Plan, revealed no new interventions had been a 2013, February 15, 2013, and February 25, 2013. In at 12:20 p.m., in the conference room, confirmed the Idress the resident's falls occurring on February 11, 23. Resident #100 was admitted to the facility on [DAT dedical record review of an annual MDS (Minimal D mobility, transfer, locomotion, dressing, toilet use, and thad a BIMS (Brief Interview for Mental Status) sceterly MDS dated [DATE], revealed the resident requissistance from for locomotion and was totally dependition of the MDS revealed, the resident had a BIMS sew of the facility's fall reports, revealed Resident #14 2013, February 23, 2013, April 5, 2013, April 26, 2018 for falls related to bilateral aka (above knee amputateness. Further review of the care plan, revealed no ne 2013, and May 2, 2013. Interview with the DON (Direc, confirmed the facility failed to revise the Care Plaring on February 21, 2013 and May 2, 2013.  e facility on [DATE], with [DIAGNOSES REDACT	pdated January 31, 2013, April 16, 2013 /t (related to) unstable health dded to address the resident's falls on terview with the DON (Director of facility failed to revise the Care Plan 2013, February 13, 2013, February FEJ, and readmitted on [DATE], with ata Set) dated February 25, 2013, revealed the dd personal hygiene. Further review ore of 15 (no cognitive impairment). ired extensive assistance for bed mobility lent for dressing, toilet use, personal core of 7 indicating severe cognitive 00 had falls/incidents documented on 1013, and May 2, 2013. Medical record 13, and July 31, 2013, revealed resident tition), unstable health condition, winterventions to address the ector of Nursing) on November 6, 2013, in to reflect new interventions to
F 0280	(MDS) dated [DATE], revealed the resi assistance of one person for bath and bladder; and had a fall since record review of the facility fall past 30 days, and had no issues of revealed an entry dated August 8 self from w/c (wheelchair) to an- This is an inappropriate inv/terv- impaired decision-making. Revi- attempting to ambulate independent	dent had short and long term memory problems; had ling, dressing, and grooming; required assistance with the last assessment. Medical record review of the ph report dated July 3, 2013, which was incorrect, rever contributing to falls. Medical record review of Interdia, 2013, reviewed d/t (due to) recent fall on August 4 other chair and fell in floor. Pt re-educated to ask for ention considering the resident had long and short ter ew of a facility fall report dated June 4, 2013 (incorrelently in the solarium from the wheelchair to another participate in the planning or revision of the resident participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision where the participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate in the planning or revision of the resident wheelchair to another participate the participate in the planning or revision where the participate in the planning or partic	impaired decision-making; required h transfers; was incontinent of bowel hysician's orders [REDACTED]. Medical led the resident had a fall in the isciplinary Team Progress Notes 1, 2013. Pt. was trying to transfer assistance before transferring. In memory deficits as well as ect date), revealed the resident was chair. Continued review of the docu
	Based on medical record review the facility failed to revise the ca future falls for nine residents (#2 falls; failed to revise the care pla #114, #79) of fourteen residents staff to implement after a sexual failure to address interventions of staff unfamiliar with the care to non-compliance has caused or li revise the care plans addessing four fractured clavicle for one resident on November 26, 2012, and is on Director of Nursing were inform findings included: Resident #35 Minimum  Data Set (MDS) dated [DATE],	TS HAVE BEEN EDITED TO PROTECT CONFID, review of facility documentation, observation, revie re plan following falls to include interventions for th \$5, #73, #62, #120, #26, #93, #100, #52, #119) of twe maddressing pressure ulcers for staff to implement c reviewed with pressure ulcers; and failed to revise that extraction for two residents (#77, #42) of sixty-five on the care plan for pressure ulcers for three residents be provided placing residents in Immediate Jeopardy kely to cause serious injury, harm, impairment, or de alls with new interventions resulted in a [MEDICAL at (#73) placing the residents in Immediate Jeopardy. Immediate Jeopardy on November 6, 2013, was admitted on [DATE], with [DIAGNOSES RED. revealed a Brief Mental Status score of 14, indicating on completed on admission and at quarterly reviews on completed on admission and at quarterly reviews.	we of facility policy, and interview, the staff to implement to prevent entry-two residents reviewed with are plans for four (#35, #73, the care plan with interventions for residents reviewed. The facility's (#35, #73, and #114) resulted in (a situation in which the provider's ath). The failure of the facility to CONDITION] for one resident (#35) and a The Immediate Jeopardy was effective nical Services, Administrator and at 2:30 p.m. in the conference room. The ACTED]. Medical record review of the g no cognitive impairment. Medical record
	the resident was high risk for fal through October 2013) revealed the bathroom and Safety alarm v interventions care planned; Marcinterventions care planned; Marcinterventions care planned; Marcinterventions care planned; Marcintervention for a scoop mattress interventions were implemented bathroom emergency call light be the left arm. Review of the Care report was not initiated until Oct revealed the resident was found fall. Intervention 7/19/13 Reache call light, resident sitting in floor right hip. Medical record review. Assessment and Plan: fall with the an Interdisciplinary Progress following the surgery of the righ the resident fell in the bathroom resident did not have the individ the Director of Nurses (DON) in interventions were not resumed Interdisciplinary Team did not crecord review of the Nursing As have a pressure ulcer. Medical resident's skin was intact on Aug beel pressure ulcer, indicated the August 30, 2013, as a Deep Tiss skin intact with Appearance. deep resident at intervals on October 1.	Is. Medical record review of facility falls reports and the resident had a history of [REDACTED]. January vas care planned; January 15, 2013, no fall report proch 6, 2013 at 7:50 a.m., fall report revealed fell on the ch 21, 2013, at 7:20 a.m., fall report revealed fell on the ch 21, 2013, at 7:20 a.m., fall report revealed fell on the ch 21, 2013, at 7:20 a.m., fall report revealed the stationary of the propert revealed the propert revealed the stationary of the stationary o	Care Plans (from December 2012 12, 2013, at 4:20 a.m., fell on the way to voided for review and no new et way to the bathroom, new ed, no new interventions care planned; the Care Plan recorded a new s was a witnessed fall, no new NA heard the safety alarm, saw the lee floor with bruises, a skin tear to ed; July 19, 2013, at 8:20 a.m., fall, no investigation done. Review he Care Plan revealed, 7/19/13 hevealed To resident room to answer dident c/o (complained of) pain to all on August 12, 2013, revealed, surgery. Medical record review of the resident returned from the hospital rising assessment dated [DATE], revealed record review of the Fall Risk of facility documentation revealed dent's Care Plan revealed the led on re-admission. Interview with 13, confirmed previous individualized 2013. Interview confirmed the free the October 9, 2013, fall. Medical 9, 2013, revealed the resident did not the treatment record revealed the grity Report, initiated for a right ind initially staged and measured on the Width, and undetermined Depth due to the ders [REDACTED]. Observation of the e resident remained in the bed with 1a.m., in the resident's room with
	resident had a pressure ulcer of t ulcer of the right heel and had no	x/Care Card (provided for the CNA staff) and reveale he right heel. Interview confirmed the CNA had not by been given any instructions to maintain the right he 19:45 a.m., with the Registered Dietician (RD) reveal	been told the resident had a pressure eel off of the bed. Interview by

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE &				PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 11/07/2013
	445319			
NAME OF PROVIDER OF SUI	PPLIER		STREET ADDRESS, CITY, STA	ATE, ZIP
WILLOWS AT WINCHESTE	R CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE WINCHESTER, TN 37398	
For information on the nursing l	nome's plan to correct this deficien	cy, please contact the nursing hor	me or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	Y FULL REGULATORY
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			

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 quality of the depote 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 Decumentation, revealed resident #73 had falls/incidents documented on December 8, 2012, December 24, 2012, January 12, 2013 and January 13, 2013. Fur

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 on October 1, 2013, of the sacran/coccyx pressure under October 16, 2013, when the sacran/coccyx under 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, [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 layage saline to wound. Santyl (wound debrider) to coccyx wound when dressing. Start 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 # 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

CENTERS FOR WEDICARE	x WEDIC/ ND SER VICES			OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY
DEFICIENCIES AND PLAN OF	CLIA IDENNTIFICATION	A. BUILDING B. WING		COMPLETED 11/07/2013
CORRECTION	NUMBER			11/0//2013
NAME OF PROVIDER OF SU	445319 PPI IER		STREET ADDRESS, CITY, STA	TF ZIP
	ER CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE	112, 211
E i C d d i i	1 1 1	1	WINCHESTER, TN 37398	
	home's plan to correct this deficient		, , ,	V EULL DECLUATORY
(A4) ID TREFIX TAG	OR LSC IDENTIFYING INFOR		ENCT MOST BET RECEDED B	T TULL REGULATOR I
F 0280	OR LSC IDENTIFYING INFOR  (continued from page 15) resident had a fall from the bed v record review of the Resident Fa the facility fall report revealed th and was sent to the emergency revealed no documentation of a f Note dated January 21, 2013, at of the Care Plan initiated on Febrelated to: unstable health condit February 10, 2013. Further revie the fall on January 20, 2013. Revealed care.review and revise care plan witnessed falls with head injury. reflect new interventions. Docum fall. The Administrator and Direc Delivery Process. Review of the Fall. Evaluate and monitor patien and witnessed falls with head inj identify any causes that may hav Fall Risk Factors to implement n immediate interventions after the staff Conduct Interdisciplinary T complete.investigation form. Det as indicated by investigation. Cor will: Complete the follow-up rec 2013, at 11:00 a.m., in the confer December 4, 2012, was the only 2013. Interview on October 3, 20 confirmed the Care Plan followin been updated with new intervent Care Plans after falls. Resident # REDACTED]. Review of facility March 3, 12 and 22, 2013, and A 2013, revealed a focus of Risk fo initiated on February 6, 2013, of Further review of the care plan r transferring needs. Further revier falls on February 25, 2013, Marc Administrator's office, with the facility failed to revise the care palon in the care plan revealed 2013, and April 10, 2013. Reside [DATE], with [DIAGNOSES R following dates: July 4, 2013, ar record review of the care plan vi unsteady gait Further review rever reach. Resident to wear non-slip review of the care plan revealed 2013, and April 10, 2013. Reside (DATE], with [DIAGNOSES R following dates: July 4, 2013, in Regional Vice President, on Not the care plan to include any new  Resident #93 was admitted to the MDS (Minimal Data Set) dated April 1 indicating severe cognitive impain mobility, transfer, locomorion, du report, revealed resident #93 had February 15, 2013, and February 13, 2013, and February 25, 2013, to reflect new interventio	with a laceration, was sent to the e ll Evaluation revealed the residente resident had a fall from the bed born due to complaints of a headar fall evaluation after the fall on Jan 2:00 a.m., revealed there resident ruary 28, 2010, and updated on Dion, unsteady gait, history of falls we revealed no additional intervenciew of the facility's policy titled Id. communicate patient's fall risk a regularly. If the patient falls: Perfe Complete the Change of Conditional Evaluation of Nursing will conduct a post Falls Care Delivery Process, revit for 72 hours after the fall. Investigate we interventions or remove envire fall. Update care plan with new if earmien need for additional action/nmunicate information to staff an ommendations within five workir 3, 2013, at 7:45 a.m., revealed the wheel chair beside the bed. Intervence room, confirmed the Care P Care Plan used during January 20, 113, at 1:55 p.m. in the business on the falls on January 13, 2013, at 7:45 a.m., revealed the wheel chair beside the bed. Intervence room, confirmed the Care P Care Plan used during January 20, 113, at 1:55 p.m. in the business on the falls on January 13, 2013, at 7:45 a.m., revealed the wheel chair beside the bed. Intervence room, confirmed the Care P Care Plan used during January 20, 113, at 1:55 p.m. in the business on the falls on January 13, 2013, at 7:45 a.m., revealed the facility of falls report revealed the resident piral 10, 2013. Medical record revortalls report revealed the resident piral 10, 2013, and April 10, 2013. Interview with the Director of Clinical alan with new interventions after the facility failed to include new iterview with the Director of Nurs vember 6, 2013, at 10:35 a.m., in the interventions after the facility failed to include new iterview with the Director of Nurs vember 6, 2013, and Fel and Falls on January 13, 2013, and Fel at 12:20 p.m., in the conference of the facility failed to include new iterview with the Director of Nurs vember 6, 2013, and Fel at 12:20 p.m., in the conference of the facility fa	mergency roiagnom on [DATE], at experienced two falls on January with no injury on January 20, 201; then. Medical record review of the luary 20, 2013. Medical record reviews readmitted to the facility from ecember 4, 2012, revaled a proble. Goal: No significant injury with the tions following the two falls on Jaralls Management Policy dated Segratus to caregivers. develop individual mount of the care policy dated Segratus to caregivers. develop individual mount of the caregivers of the conduct Interdisciplinary Team in tall review. Further review reveal seed on June 1, 2013, revealed Resgran Neurological Assessment for unterdisciplinary Team in tall review. Further review reveal from the commental risk factors to prevent funterventions as appropriate following interventions. Add additional interdisciplinary as a propriate following interventions. Add additional interdisciplinary as a following intervention of the factory	t 3:30 p.m. Medical 13, 2013. Review of 3, at 10:00 p.m., Resident Fall Evaluation iew of the Nursing the hospital. Review m for Risk for falls the target date of uary 13, 2013, or for otember 15, 2001 and dualized plan of inwitnessed falls and orm. Update care plan to neeting within 72 hours of ed Refer to Falls Care ponse to a Patient ill unwitnessed falls cord and assessments to DICATION NAMEJ/Extrinsic ture falls. Implement unicate interventions to g: Review and ventions to.care plan fursing (or designee) bservations on October 2, ttached, the call ctor on October 3, and updated on yoal date on February 10, Director of Nursing, mary 20, 2013, had not olicy to revise the TEJ, with [DIAGNOSES es: February 25, 2013, date of February 6, the approaches on-slip footwear. ance with tions after the c15 p.m., in the sing confirmed the ch 3, 12 and 22, ted to the facility on lent had five falls on the r 19, 2013. Medical related to: sed articles within easy roperly. Further y 4, 2013; July 8, nical Services, and the facility failed to revise betoater 4, 2013. cord review of the quarterly ttal Status) score of 4 dependent for bed the facility failed to revise betoater 4, 2013, revealed resident for bed on [DAT [D], with ebruary 25, 2013, revealed the ene. Further review gnitive impairment). sistance for bed mobility to idle use, personal ting severe cognitive dents documented on 2013, Rebruary tted on [DATEJ], with ebruary 25, 2013, revealed the ene. Further review gnitive impairment). sistance for bed mobility to idle use, personal ting severe cognitive dents documented on 2013, revealed resident nealth condition, to address the 2) on November 6, 2013, interventions to  the annual Minimum Data Set on-making: required inconting: revealed resid
F 0281	quality.	the nursing facility meet profes	ooronin suman us vi	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER / SUPPLIER (X3) DATE SURVEY STATEMENT OF (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA IDENNTIFICATION À. BUILDING B. WING \_\_\_\_ 11/07/2013 NUMBER 445319 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. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG 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 resident was alert; had no mood or behavior problems; had clear speech; was oriented to person, place and time; was resident was alert; nad no mood or benavior 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.
\*\*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 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. 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) F 0309 [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 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 lying on back in an large. 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)

[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 Sentenber 25.

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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Event ID: YL1O11

Facility ID: 445319

If continuation sheet Page 17 of 39

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(V2) MIII TIDI E CONSTRUIO	TION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES	/ CLIA	(X2) MULTIPLE CONSTRUC A. BUILDING	TION	COMPLETED
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING		11/07/2013
	445319		L	
NAME OF PROVIDER OF WILLOWS AT WINCH	F SUPPLIER ESTER CARE & REHABILITATION	N CENTER	STREET ADDRESS, CITY, ST. 32 MEMORIAL DRIVE	ATE, ZIP
For information on the sur	sing home's alon to come at this deficien	ary mlasses contact the municipa he	WINCHESTER, TN 37398	
(X4) ID PREFIX TAG	sing home's plan to correct this deficien		IENCY MUST BE PRECEDED B	V EIILL DECLII ATODV
(A4) ID I KEFIA TAG	OR LSC IDENTIFYING INFOR		IENC I MOST BETRECEDED B	T TOLE REGULATOR I
F 0309	(continued from page 17) failure to follow physician's orde	rs [REDACTED].#33 who expen	rienced unrelieved pain and anxiety	<i>/</i> .
	the manufacturer's instructions for use for more than 29 consecu patients who have [MEDICAL C stool.the following adverse event anal mucosa; Peri-anal skin breal Perforation of the bowel. Medica Elimination.Rectal tube to BSB (review of the Minimum Data Set urine, bowel continence not rated dated October 29, 2013, revealed Observation on October 31, 2013 with son at the bedside. Interview and the son stated (Resident) has the Unit Manager/Registered Numanufacturer's instructions for the hospital had not been determinot been developed. Interview or tube had been in place since Sept continued and confirmed the man days and the resident's had been in determined the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been in place since Sept continued and confirmed the man days and the resident's had been since Sept continued and confirmed the man days and the resident's had been since Sept continued and confirmed the man days and the resident's had s	or the use of the rectal tube reveative days. Precautions 1. Close at ONDTITON] bowel conditions. 4 s could occur. Rectal/anal bleedicdown; Temporary loss of anal s 1 record review of the admission bedside bag). Medical record review (MDS) dated [DATE], revealed (had a rectal tube in place from Resident out to wound care per at 10:40 a.m., in the resident's with the son, during the observ not had any stool from the tube (RN) #1, on October 31, 201:e rectal tube. Interview revealed ned by the nursing home staff. In October 31, 2013, at 1:30 p.m., ember 3, 2013. Interview confirmufacturer's instructions indicated used continuously for 58 days. If	eptember 14, 2013, with [DIAGNC led, .Contraindications.1. This protention should be exercised with the .The use of the device is not indicing due to pressure necrosis or ulcer phincter muscle tone; Infection; Be nursing assessment dated [DATE] view of the physician orders [RED. cognitive skills severely impaired, admission). Medical record review ambulance. Will also have a new room revealed the resident lying or ation, revealed the resident lying or two days now. Interview at the 3, at 11:00 a.m., revealed the facilit the original date the rectal tube hanterview verified a plan of care for in the nursing station with RN #1, med the resident had a [DIAGNOS] the rectal tube sudterview confirmed the nursing station the nursing station of the used the review confirmed the nursing station with stationary stations.	duct is not intended he use of the device in ated for solid or soft-formed ration of rectal or owel Obstruction; , revealed, Bowel ACTED]. Medical record , always incontinent of or of a Nurse's Note rectal seal placed. h back in an air bed octal tube in place nursing station, with ty did not have the d been placed at the rectal tube had revealed the rectal ES REDACTED]. Interview continuously beyond 29 If had requested the
	rectal tube be replaced while at the	ne hospital's Wound Care Center the Wound Care Physician on N	on October 29, 2013, due to disloc ovember 4, 2013, at 10:50 a.m., re	lging on the same day.
F 0314	Give residents proper treatmen			
	sores. **NOTE- TERMS IN BRACKET	TS HAVE BEEN EDITED TO P	ROTECT CONFIDENTIALITY*	*
	Based on medical record review,	review of facility policy, observ	ation, and interview, the facility fa #114, #35, #73) of fourteen reside	iled to prevent the
	ulcers reviewed. The facility's fai	lure to perform accurate assessn	nents and obtain physician's orders er's non-compliance caused or is li	placed residents #95,
	injury, harm, impairment, or deat	h). The systemic failure to ensur	e orders physician's orders for a m	edical device was
			cers were assessed accurately; and at risk for pressure ulcers in Immed	
			is ongoing. The Regional Vice Pre of the Immediate Jeopardy on Nove	
	in the conference room. The find	ings included: Resident #95 was	admitted to a Trauma Center on Ju	ıly 27, 2012, following an
	the resident and a neighbor found	which there was an explosion. To the resident in the house, mining	wo days later the family and friends nally responsive and lethargic. As a	s were unable to contact a result of the
			above shoulders leaving resident u y, including face, right arm, left ar	
	extremities. Resident #95 was ad	mitted to the facility on [DATE]	, with [DIAGNOSES REDACTED	)]. Review of the discharge
	anti-contracture devices were app	olied to patient: Multipodus boot	lated August 20, 2012, revealed .the s BLEs (bilateral lower extremities	continuously when
	supine. Interview with the Direct	or of Nursing (DON) on October	r 3, 2013, at 12:50 p.m., at the nurs 5, 2012, with a multipodus boot (f	es station, revealed the
	footdrop) in place on the left foot	. Medical record review of the In	nterim Care Plan dated October 5,	2012, revealed,
	potential for pain related to wour record review of the admission n	nds.alteration in skin integrity r/t ursing assessment dated [DATE]	(related to) Burn.report new open l, revealed the resident had an open	areas. Medical area on the left knee,
	open/abrasion on the right lower	extremity, reddened area to the s	scrotum area, sore/scabbed over are	ea to the coccyx,
	orders dated October 5, 2012, rev	ealed, .float heels.pressure reduce	de. Medical record review of the A cing mattress to bed.weekly skin cl	neck by licensed nurse.
			at 3:45 p.m., revealed, .skin pink wa 11) (indicates very high risk). Med	
			12, revealed, .open area to coccyx a	
			ontinued review of the October TA admission Minimum Data Set (M	
	resident was moderately impaired	for daily decision making; total	lly dependent for all Activities of I	Daily Living (ADL's);
			on. Medical record review revealed tal Status, Urinary Tract Infection,	
	[REDACTED]. Medical record r	eview of the Nursing Assessmen	t Re-admitted d October 29, 2012,	revealed .Skin/Wound condition
			) scab area (top of right foot).red at of the Care Plan dated October 30	
			Burn.report new open areas.10/30	
			evealed .Skin (with) Stage II (parti nt Administration Records (TAR)	
			applied to coccyx and change every being administered on November	
	review of the TAR revealed an or	rder to apply skin prep to bilatera	al heels each shift. Further review of	of the TAR revealed no
			aber 26, 29, and 30, 2012. Medical noted to L (left) heel possibly cause	
	wears to prevent foot drop. Medi	cal record review of a Nurse Pra	ctitioner (NP) note on November 2	6, 2012, revealed .Skin:
			nission on October 5, 2012, to disc at's chart revealed no information re	
	application of the boot, the sched	ule of the boot, and/or the staff r	responsible for monitoring the boot	. Medical record
	bilateral heels q (every) shift. Me	dical record review of a Physicia	, .Skin prep (strengthen skin to pre an's order dated November 26, 201	2, revealed, .cleanse
	blister to left heel. Medical record	d review of an Interdisciplinary l	Progress Note (IDT) dated Decemb	er 11, 2012, revealed,
	18, 2012, revealed, .wound care t	o L heel.area to coccyx healed. I	<ul> <li>Medical record review of an IDT Medical record review of Nutrition</li> </ul>	notes dated December
	21, 2012, revealed .gradual weigh	nt trending down. Remains on fo	rtified food with meals; refused ho measurements for the left heel doo	use shakes repeatedly;
	2012 (thirty-one days after disco	very). Medical record review of	a Pressure Ulcer Documentation Fo	orm dated December 27,
	2012, revealed, .Left Heel Stage	U (unstageable - base of ulcer co	overed with slough or eschar). Would be remining, no tunneling, no odor, no	nd Measurements length 2
	Review of the TAR dated Decem	ber 2012, revealed an order to c	leanse blister to left heel with wour	nd cleanser; apply
	documentation the treatment was	administered on December 6, 12	ned review of the TAR for Decemb 2, 20, 21, 23, and 30, 2012, on the elember TAR revealed the order for	day shift, and December 3,
	11, 23, and 27, 2012, on the fligh	comment in the Dec	Amout 1/11 it vealed the bluef lor	okin prop onatorai

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		1		OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		
CORRECTION	NUMBER			11/07/2013
	445319			
NAME OF PROVIDER OF S			STREET ADDRESS, CITY, ST.	ATE, ZIP
WILLOWS AT WINCHEST	TER CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE	
			WINCHESTER, TN 37398	
For information on the nursing	g home's plan to correct this deficien	cy, please contact the nursing ho	me or the state survey agency.	
(X4) ID PREFIX TAG			ENCY MUST BE PRECEDED B	Y FULL REGULATORY
E 0214		WITTION)		
	g home's plan to correct this deficien SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR (continued from page 18) heels each shift was not documer 23, 24, and 27, 2012, on nights. It revealed, Left Heel Stage U.Wo tunneling, no odor, no exudate, n record review of a Pressure Ulcel length 1.5 cm. width 1 cm, (no de Continued review of nutrition no snack BID; [MEDICATION NA preferences.  Review of the TAR for January 2 purachol; wrap with roll gauze. Cadministered on January 13, 18, 2 the TAR for January revealed an resident was moderately impaired had one Stage 1 pressure ulcer ar 2013, revealed, Alteration in ski 10/29/12. Revision on: 1/10/2013 revealed, Left Heel Stage U.Wo tunneling, no odor, no exudate, n 23, 2013, revealed, Left Heel Stage U.Wo tunneling, no on odor, no exudate, n 23, 2013, revealed, Left Heel Stage U.Wo tunneling, no on omount of the commentation form dated February 1, 2013, revealed Documentation Form dated February 1, 2013, revealed Documentation Form dated February 1, 2013, revealed Contentation Form dated February 1, 2013, revealed Documentation Form dated February 1, 2013, revealed To the full of the	cy, please contact the nursing hor DEFICIENCIES (EACH DEFICE MATION)  atted as being administered on De Medical record review of a Pressund Measurements length 1.5 cm or order change. Medical record repode decided a feed of repode decided for appetite; [MEDIo 2013, revealed an order to cleans continued review of the January 10, 2013, revealed ME] started for appetite; [MEDIo 2013, revealed an order for [REDACTED]. Medical for daily decision making; total did no unstageable pressure ulcers integrity r/t (related to): foot ul. Medical record review of a Presund Measurements length 2 cm. to order change. Medical record rege U. Wound Measurements length 2 cm. to order change. Medical record review of a Presund Measurements length 1.5 cm. width care with positive resuluary 5, 2013, revealed, Left Hee easurements length 1.5 cm. width care for the decided of the wide of a presuluary 5, 2013, revealed and for the decided feed of the wound Measurements, no tunned for the decided record review of a Press of Wound Measurements, no tunned for the decided record review of a Press of the wound Measurements, no tunned for the pressure of the form of the feed of the wound of the feed of t	WINCHESTER, TN 37398  me or the state survey agency.  IENCY MUST BE PRECEDED B  cember 14, 20, and 30, 2012, on da  the Ulcer Documentation Form data, width 1.5 cm, (no depth documer  eview of a physician progress note  uary 8, 2013, revealed, .Left Heel;  ning, no tunneling, no odor, no exi-  ed, left heel ulcer; protein powder  CATION NAME] 2.7 (normal ranger  e blister to left heel with wound cle  FAR revealed no documentation the locember 29 and 30, 2012, on ni  al record review of a quarterly MD  ly dependent for all ADL's; at risk.  Medical record review of a Care  cer (left heel) shearing to coccyx. desure Ulcer Documentation  width 1 cm, (no depth documentation  width 1 cm, (no depth documentation  seview of a Pressure Ulcer Docume  gth 1.5 cm. width .5 cm, (no depth  Medical record review of a Pressu  d Measurements length 1.5 cm. with  te, no order change. Medical record  s. Medical record review of a Pressu  d Measurements length 1.5 cm. with  te, no order change. Medical record  s. Medical record review of repressure Ulcer Documentation Form da  sure Ulcer Documentation Form da  sure Ulcer Documentation Form da  seling, no odor, exudate sm type se  (to physician or family). Continue  tes dated February 15, 2013, revealed, .Le  condition of a pressure under the decommentation  seling, no odor, exudate sm type se  (to physician or family). Continue  tes dated February 15, 2013, revealed, .Le  condition of a pressure under the decommentation  seling, no odor, exudate sm type se  (to physician or family). Continue  tes dated February 15, 2013, revealed, .Le  condition of a pressure under the decommentation  and a pressure under the decommentation  seling, no odor, exudate sm type se  (to physician or family). Continue  tes dated February 15, 2013, revealed, .Le  condition of a pressure under the decommentation  seling, no odor, exudates  condition of a pressure under the decommentation  seling no odor, exudate on skin concern  seling no odor, exudates  condition of a pressure under the decommentation  s	ays and December 3, 11, 17, ed January 3, 2013, atation), no undermining, no s [REDACTED]. Medical Stage U.Wound Measurements adate, no order change. BID (twice daily); ge 3.4 - 4.5); update food anser; apply hydrogel, et reatment was ghts. Continued review of S dated [DATE], revealed the for pressure ulcers; Plan dated January 10, ate initiated: atated January 16, 2013, on), no undermining, no atation Form dated January documentation, no re Ulcer Documentation did review of an IDT note sure Ulcer ulcer ulcer area of intact skin o odor, exudates smer change.no notification of the width of the ulcer had ated February 12, 2013, r., 100% eschar, [MEDICAL dreview revealed the wound led milk TID (three ulant); hydration encouraged is. Medical record review ff Heel Stage DTI.no Wound to present, no order change.no complete with no wound 13, revealed, .Left Heel Stage is m type ser, 25% slough ation of change (to physician drainage; and 13, 2013, revealed, ord review of a Measurements Length 2 cm, order change.no in size; still had in prep bilateral heels 21, 23, 24, 25, 27, r for [REDACTED]. Medical the April 3, 2013 ep to bottom of left ote dated March 21, foot board d/t (due ED]. Medical record review of po (by mouth) bid (twice daily) no documentation of skin in tx (treatment) (with) meals; received un's order days wound. Medical dical record review of a slough; left lower II. Continued cumentation of the wir of the word of the wir of the word of th
	wound on anterior aspect of ankl	e joint; ulceration over heel 5 x 5	ne wound. Left foot with ulceration cm with black necrotic tissue on l	ateral side and
	necrosis on medial side, lateral si	de with track going down to calc	aneous with foul odor. I explained  Medical record review of the pre-	I would not be able
	dated [DATE], revealed .osteo[D	IAGNOSES REĎACTED] left o	calcaneous, left talus; stage IV (full	skin loss with bone, tendon,
	subcutaneoue fat visible) pressur	e ulcer right posterior leg. Medic	left ankle joint; stage III (full skin al record review of the operative re	eport dated May 5,
	2013, revealed .left [MEDICAL] posterior leg, 6 x 1.5 cm. Review continually observes and monitor	CONDITION] was performed all of facility policy, Skin Integrity is patients for changes and imple	ong with excision and closure of st Management, dated October 1, 20 ments revisions to the plan of care.	age III ulcer to right 10, revealed, .Staff to prevent the
	comprehensive, interdisciplinary	plan of care.document appearance	easurements and complete skin into ce and condition of the wound wee	kly.assure all skin

DEPARTMENT OF HEALT CENTERS FOR MEDICARI	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	ON	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING		11/07/2013
NAME OF PROVIDER OF C	445319	l c	TREET ADDRESS CITY OF	ATE ZID
NAME OF PROVIDER OF S			TREET ADDRESS, CITY, STA	ATE, ZIP
WILLOWS AT WINCHEST	TER CARE & REHABILITATION		2 MEMORIAL DRIVE VINCHESTER, TN 37398	
	g home's plan to correct this deficien		, , ,	
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIEN MATION)	ICY MUST BE PRECEDED B'	Y FULL REGULATORY
F 0314	27, 2012. Interview with MDS na and November 2012, did not inch confirmed the Care Plan had not 12, 2013. Interview with Register measurements prior to late Februs 11:35 a.m., on the A-Wing, confi application and maintenance of a expected the facility to complete physician with changes. Interview Station, confirmed there was no p by the multipodus boot and no do 2012. Telephone interview with t consulted on the resident .about a Wound Care Physician revealed t of the leg where the calf meets the debrided (removed dead tissue to physician felt the area was regres the Wound Care Physician could from the pressure ulcers it had to observed the multipodus boot in 1 the resident. Interview with the U revealed the resident had ulcers o 2 on back of left leg which were the only wound noted on the right a.m., in the conference room, reve ADON revealed the resident was not revealed. I can't remember exact! resident's attending physician on remembered the resident as being physician revealed the physician properly; make sure the boot was not appli physician revealed the physician specifically to care for the wound Practitioner first with problems as summary this fifty-eight year old neighbor; and transferred to a traufracture which rendered the resident ersident developed two decubitus pressure ulcer on the back of the itransferred to the hospital after the Stage III; and the left leg ulcer also had osteo[DIAGNOSES RE so the resident underwent [REDA 2. perform accurate assessments of heel blister in a timely manner. 4. 5. follow physician orders as evic to coccyx; application of skin pre on the heel ulcer for thirty-one dathe right leg. 8. recognize a stage resident #114 was admitted to the hosp amputation.  Predicting Pressure Sore Risk con Resident #114 was admitted to the record review of the admission mare, black areas of the left and rierals.	s Department, confirmed there was in the street of the control of	a.m., in the MDS Office, confirithe resident's pressure ulcers. Cs pressure ulcer treatments or as 13, at 9:00 a.m., on the A-Wing with the resident's physician on ility to obtain an order with spement). Continued interview cond measurements for all pressure N) on October 3, 2013, at 12:50 Further interview confirmed the sed until the blister was discovered the test of the hopedic consult because the wondened and on both shins, describe with the Wound Care Physician reveal the Wound Care Nurse revealed the interview of Nursing (ADON) on the Soots from the hospital. Further, and the word of the word	ned the MDS dated [DATE], ontinued interview sessments until March, revealed RN #1 had no October 3, 2013, at cific instructions for firmed the physician ruleers and notify the p.m., at the Nurse's left heel ulcer was caused red on November 26, aled the physician was interview with the d as the lateral side revealed the physician facility but the unds were deeper than led the foot was so gone vealed he/she had not not not physician visited in the conference room, ght great toe, right heel wound was November 5, 2013, at 7:58 her interview with the therview with the therview with the ethe boot was applied with the physician linterview with the ethe boot was applied with the physician therview with the ethe boot was applied with the physician linterview with the ethe boot was applied with the physician linterview with the ethe boot was applied with the physician linterview with the ethe boot was found by a 15% of the body and a neck multipodus boot on ultipodus boot on ultipodus boot on ultipodus boot the left heel on became a pressure ulcer and the lent developed a resident was right leg ulcer to DITION] in the wounds and here was no way to save the foot of the multipodus boot the left heel on the resident's foot. The physician of exuderm ent wound measurements e discovered on until the uiring a below knee

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 dvt (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 Scin 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 Duode

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

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

F 0314

	TH AND HUMAN SERVICES E & MEDICAID SERVICES		PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391
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 S	SUPPLIER	STREET ADDRESS, CIT	Y, STATE, ZIP
WILLOWS AT WINCHES	TER CARE & REHABILITATION	N CENTER 32 MEMORIAL DRIVE WINCHESTER, TN 373	
For information on the nursing	ng home's plan to correct this deficien	cy, please contact the nursing home or the state survey agenc	y.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECED MATION)	ED BY FULL REGULATORY
F 0314	Based on medical record review, development of avoidable pressur ulcers reviewed. The facility's fai #114, #35 in Immediate Jeopardy injury, harm, impairment, or deat obtained; skin assessments were the physician were documented. Immediate Jeopardy was effectives reviewes, Administrator, and Dire in the conference room. The findiaccident while burning brush in we the resident and a neighbor found accident the resident was a C6 queck down) [MEDICAL CONDI' extremities. Resident #95 was ads recommendations from Physical' anti-contracture devices were app supine. Interview with the Direct resident was admitted to the facilifootdrop) in place on the left foot potential for pain related to wour record review of the admission mopen/abrasion on the right lower reddened right lower extremity, a orders dated October 5, 2012, rev Medical record review of a Nurse D/T (due to) [MEDICAL CONDI' Treatment Administration Record (every) 3 days (start date October assessments documented in Octol resident was moderately impaired at risk for pressure ulcers; and ha admitted to the hospital on Octob [REDACTED]. Medical record represent: no.red area (coccyx).scal forearm).Norton Score 12 (very h.potential for pain related to wour Medical record review of the Car shallow open ulcer) on coccyx. M the resident was ordered Exudern review of the TAR revealed an ordocumentation this was administ Note dated November 26, 2012, a wears to prevent foot drop. Medical record review of the TAR revealed an ordocumentation this was administ Note dated November 26, 2012, a wears to prevent foot drop. Medical record review of the Car shallow open ulcer) on coccyx. M the resident was ordered Exudern review of the TAR revealed an ordocumentation this was administ Note dated November 26, 2012, a wears to prevent foot drop. Medical record review of the Car shallow open ulcer) on coccyx. M the resident was ordered Exudern review of the TAR revealed an ordocumentation this was administ Note dated November 26, 2012, a wears to prevent foot drop. Medical rec	TS HAVE BEEN EDITED TO PROTECT CONFIDENTIAL review of facility policy, observation, and interview, the faci re ulcers for four residents (#95, #114, #35, #73) of fourteen: ulcre to perform accurate assessments and obtain physician's of (a situation in which the provider's non-compliance caused on). The systemic failure to ensure orders physician's orders for erformed correctly; pressure ulcers were assessed accurately was likely to place any resident at risk for pressure ulcers in I e from November 26, 2012, and is ongoing. The Regional Vi orgs included: Resident #95 was admitted to a Trauma Center which there was an explosion. Two days later the family and the resident in the house, minimally responsive and lethargic adriplegic (fracture of neck just above shoulders leaving resistion) 15% (percent) of the body, including face, right arm, mitted to the facility on [DATE], with [DIAGNOSES REDA Therapy at an outside hospital, dated August 20, 2012, reveal blied to patient: Multipodus boots BLEs (bilateral lower extreor of Nursing (DON) on October 3, 2013, at 12:50 p.m., at the otty from the hospital on October 5, 2012, with a multipodus be Medical record review of the Interim Care Plan dated October Musing assessment dated [DATE], revealed the resident had an extremity, reddened area to the scrotum area, sore/scabbed on dreddened area on the right side. Medical record review of an extremity, reddened area to the scrotum area, sore/scabbed on dreddened area on the right side. Medical record review of for all dated October 5, 2012, at 3:45 p.m., revealed, .skin p TION] total Norton plus score (11) (indicates very high risk) (1 (TAR) dated October 5, 2012, at 3:45 p.m., revealed, .skin p TION] total Norton plus score (11) (indicates very high risk) (1 (TAR) dated October 5, 2012, revealed, .open area to cope 10 (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	lity failed to prevent the residents with pressure orders placed residents #95, or is likely to cause serious or a medical device was; and treatments ordered by mmediate Jeopardy. The ce President, Director of Clinical a November 6, 2013, at 2:30 p.m., ron July 27, 2012, following an friends were unable to contact c. As a result of the dent unable to move from the left arm, and bilateral lower CTEDI. Review of the discharge led .the following mities) continuously when e nurses station, revealed the boot (for management of her 5, 2012, revealed, open areas. Medical no pen area on the left knee, wer area to the coccyx, the Admission Physician skin check by licensed nurse. ink warm, multiple red areas. Medical record review of the cyx apply exuderm change q her TAR revealed no weekly skin set (MDS) dated [DATE], revealed the es of Daily Living (ADL's); realed the resident was exciton, and for treatment of 2012, revealed. 3.10/30/12 coccyx shearing. (partial loss of skin as TAR) dated November 2012, revealed every three days. Continued ember 20, 23, and 29, 2012. Further view of the TAR revealed no modical record review of a Nurse's caused by boot resident not regarding the eboot. Medical record to prevent or a Nurse's caused by boot resident not regarding the eboot. Medical record to prevent breakdown) 6, 2012, revealed, .cleanse ecember 11, 2012, revealed, in IDT note dated December 27, ion Form dated December 12, ion, order change.

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 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 undermining, no odor, no exudate, no order change. Medical record review of a Pressure Ulcer Documentation Form dated February 1, 2013, revealed, Left Heel Stage U.Wound Measurements length 1.5 cm. width .5 cm, (no depth documentation) form dated February 5, 2013, revealed, Left Heel Stage U.Wound Measurements length 1.5 cm. width .5 cm, order change. Medica

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:4/7/2014 FORM APPROVED

				OMB NO. 0938-0391
DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTIO A. BUILDING B. WING	OIN.	(X3) DATE SURVEY COMPLETED 11/07/2013
	445319			
NAME OF PROVIDER OF SUPE	PLIER	ST	REET ADDRESS, CITY, STA	TE, 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

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

F 0314

WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER

(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 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 DTLno Wound Measurements, no tunneling, no odor, exudates mt 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, 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. 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 2013, revealed, new bed (with) air mattress which allows more from so (residents) feet don't touch foot board of (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) 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; earlie arthitics of thispitals (furction of larva lower less bone and ankle hore) in the progression of the potential of the progression of the potential progression. osteopEraGnoses Redached (initial minimation of the oble) in underlying carcinetous (fieter boile), tatar (alike boile) flead, flects, 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 would on anterior aspect of aince Joint, diceration over neer 3 x 3 cm with black necroic ussue 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 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 subcutaneous 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 scentist 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 priocian on Cotober 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 on October 3, 2

FORM CMS-2567(02-99) Event ID: YL1O11 Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391

CIT A TIPLY AT A TIPLY CO	(VI) PROVINCES (STEEL)	(VO) MITH TURN E 222727	ICTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRU A. BUILDING	CHON	COMPLETED
AND PLAN OF	IDENNTIFICATION	B. WING		11/07/2013
CORRECTION	NUMBER			
NAME OF PROVIDER OF	F SUPPLIER		STREET ADDRESS, CITY, ST	TATE ZIP
	ESTER CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE	····, —··
			WINCHESTER, TN 37398	
	sing home's plan to correct this deficient	-		DV EUL DECLUATORY
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR		CIENCY MUST BE PRECEDED I	SY FULL REGULATORY
F 0314	(continued from page 22) revealed .I can't remember exactl resident's attending physician on remembered the resident as being physician revealed the physician physician revealed the physician physician revealed the physician physician revealed the physician properly; make sure the boot was revealed if the boot was not appli physician revealed the physician specifically to care for the wound Practitioner first with problems a summary this fifty-eight year old neighbor; and transferred to a tra fracture which rendered the resid the left foot to help prevent footd and interview revealed the boot v November 26, 2012, but wound I resident developed two decubitus pressure ulcer on the back of the transferred to the hospital after the Stage III; and the left leg ulce also had osteo[DIAGNOSES RE so the resident underwent [RED/ 2. perform accurate assessments heel blister in a timely manner. 4 5. follow physician orders as evic to coccyx; application of skin pre on the heel ulcer for thirty-one d the right leg. 8. recognize a stage resident was admitted to the hosp	ly what the area looked like but November 7, 2013, at 12:38 p.; g quadriplegic and also remember did not recall writing an order expected nursing to check the stolean content of the cont	there was stuff on both legs. Intervent, in the conference room, reveale bered the multipodus boot. Continue for [REDACTED]. specifics. Furthskin under the boot every shift; ensis not worsening. Continued intervious blems including ulceration. Further sician on board but couldn't remem e physician revealed the facility ust varse Practitioner then they would on explosion occurred; two days later wered to [MEDICAL CONDITION] twas admitted to the facility with an a physician's order for use of the transparent of the transpa	d the physician ed interview with the erre the boot was applied ew with the physician interview with the ber exactly when, ally called the Nurse call the physician. In was found by a [] 15% of the body and a neck multipodus boot on multipodus boot to the left heel on id became a pressure ulcer and the ident developed a the resident was te right leg ulcer to IDITION] in the wounds and there was no way to save the foot e of the multipodus boot. the development of a t the resident's foot. ly; application of exuderm ment wound measurements ere discovered on t until the
	amputation.  Predicting Pressure Sore Risk co Resident #114 was admitted to the record review of the admission of area, black areas of the left and riscale). Medical record review of bilateral feet d/t (due to) black at physician orders dated Septembe four weeks). Pressure reducing maraden Scale - For Predicting Presever risk. Record review continintervals for the next three weeks 2013, revealed, Per patient's son tube placed 8-27-13 secondary to contractures. appears to have been (MDS) dated [DATE], revealed incontinent of urine, with one Standard September 2013 Treatment Adm (as needed). Review of the TAR month of September. Review of TAR in October 2013. Medical runder physical examination, asse record review of the Wound Carrevealed, Turn q (every) 2 hours Care Physician's orders dated Oc [MEDICATION NAME] dressin the October 2013 Treatment Adn October 1 or 9, 2013. Medical re 2013, fourteen days after the preskin Integrity Report revealed, Srecord review of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Conder of the Conder of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Conder of the Conder of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Conder of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Conder of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Conder of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change: Data of the Wound Carcleanser. Apply Santyl (a [MEDIE with: Sacral foam adhesive.change:	mpleted August 19, 2013, reveate facility from the hospital on tursing assessment dated [DATI gight heels, and scored the press the admission nursing note date as on each heel. Skin very thin r 14, 2013, revealed, Braden Slattress to bed.weekly skin checessure Sore Risk dated Septeml nued and revealed the Braden Stattress to bed.weekly skin checessure Sore Risk dated Septeml nued and revealed the Braden Stattress to bed.weekly skin checessure Sore Risk dated Septeml nued and revealed the Braden Statte and two Urinitation presents with B (bil ned bound for an extended per cognitive skills severely impairing 1 pressure ulcer and two Urinistration Record (TAR) revearevealed the treatment with Duthe October TAR revealed the I ecord review of the physician's soment, or plan related to the report on the proposition of the physician's orders dated Octol. Do not use gerichair - may (in tober 9, 2013, revealed, Sacral gwith: bordered gauze.change ninistration Record (TAR) or coord review revealed the tracking sure ulcer was first assessed by tage II, granulating, 2 cm (cent e Physician's orders dated Octol CATION NAME] agent) to the willy.Return to Center in 2 weekers of the October 2013 TAR revealed of the October 2013 TAR revealed of the Cord review of the October 2013 TAR revealed of the Cord review of the October 2013 TAR revenue of the October 2013 TAR revenue and several review of the October 2013 TAR revenue and several review of the October 2013 TAR revenue and several review of the October 2013 TAR revenue and several review of the October 2013 TAR revenue and several review of the October 2013 TAR revenue and several review of the October 2013 TAR revenue and several review of the October 2013 TAR revenue and several review revealed the review revenue and review reven	aled the resident had a score of 15, September 14, 2013, with [DIAGN E], revealed the resident had excoriure ulcer risk at 5 (indicating high red September 14, 2013, revealed, .F. and easy to tear. Medical record rein assessment on admission/readm k by licensed nurse. Medical record or 14, 2013, scored the resident an kin assessment was not completed initial Physical Therapy Evaluation ng, living in ALF (Assisted Living atteral) UE & LE (upper and lower did of time. Medical record review ed, required two person assistance that the stageable pressure ulcers. Medical led an entry for Duoderm to Right oderm began on admission and con Duoderm treatment to the right butt History & Physical dated October esident's skin integrity and/or pressiber 1, 2013, after the resident was screase) sacral wound. Medical recommend. Cleanse wound with wound in Daily. Return to Center in 2 weeks are plan did not include the Wound ng of the sacral/coccyx pressure ulce the wound bed. Cover wound with, and ber 15, 2013, revealed, Sacrum wow wound bed. Cover wound with: [M starea (refering to the pressure ulcer evened the daily wound care to the evened the sevened to the evened the daily wound care to the evened the daily wound care to the evened the sevened the daily wound care to the evened the daily wound care to	indicating mild risk.  OSES REDACTED]. Medical ation of the right buttock isk on the Norton deel protectors placed on view of the ission and weekly x4 (for a review revealed the which represented on the subsequent weekly a dated September 16, Facility).had feeding extremity) of the Minimum Data Set for bed mobility, always record review of the Buttock every 3 days and PRN tinued through the end of the ook was not continued on the 3, 2013, revealed no entry are ulcers. Medical een in the facility ord review of the Wound a cleanser. Fill wound with:  . Medical record review revealed Care Physician's Orders from the rebegan on October 15, wo of the tracking, on the 10.1 cm Depth. Medical ind. Cleanse wound with wound EDICATION NAME] dressing to 2.2.5 square
F 0315	Based on medical record review, for one resident (#113) of sixty-f on [DATE], with diagnosed inch [DATE], revealed the resident was alert; h psychoactive medications for any indwelling catheter and no bowel Use, dated October 1, 2005, reve CONDITION] to manage retentit 2010, revealed. Patients with an icatheter. Interview with the Directowel and bladder assessments we the DON on October 1, 2013, at	reservices to prevent urinary transport to review of facility policy, and in the residents reviewed. The final ding: [DIAGNOSES REDACT and no mood or behavior problet (iety; and had an indwelling cat and bladder assessment was coaled .Indwelling catheter may be on, persistent overflow. Review indwelling catheter will be assector of Nursing (DON) on Octowere to be completed within two 4:45 p.m., at the Nurse's Station		s urinary function admitted to the facility Nursing assessment dated and time; received led no diagnoses for the of facility policy, Catheter ollowing [MEDICAL agement, dated October 1, of an indwelling rse's Station revealed admission. Interview with for the Foley catheter
F 0315	Make sure that each resident w a catheter, and receive proper normal bladder function. **NOTE- TERMS IN BRACKE	ho enters the nursing home w services to prevent urinary tr IS HAVE BEEN EDITED TO	ithout a catheter is not given	*

FORM CMS-2567(02-99) Event ID: YL1O11 Facility ID: 445319 Previous Versions Obsolete DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 11/07/2013 445319 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 32 MEMORIAL DRIVE WINCHESTER, TN 37398 WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG 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], [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). 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 pm. 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. Update care plan with new interventions as appropriate. Communicate 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 intervention 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 for all F 0323 Make sure that the nursing home area is free from accident hazards and risks and provides 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 peuro checks were done, no root. 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 T 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 was seen in the energency room for a hematoma at the back of head the size of a baseban. No foot cause of 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 fall 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 bathrub, and hit head. Review revealed the resident was not seen in the resident stand, adjust crouning, furnishe into the bathruot, and intriead. 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 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 Augus 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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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE &				PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTA. BUILDING B. WING	ΓΙΟΝ	(X3) DATE SURVEY COMPLETED 11/07/2013
	445319			
NAME OF PROVIDER OF SUF	PPLIER		STREET ADDRESS, CITY, STA	ATE, ZIP
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER  32 MEMORIAL DRIVE WINCHESTER, TN 37398				
For information on the nursing h	nome's plan to correct this deficien	cy, please contact the nursing hor	ne or the state survey agency.	
	SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	Y FULL REGULATORY
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 as 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 dt (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			ress Note dated ical record review of cation due to a Urinary a score of 13, high risk , 2013. Review of ce room at 1:00 p.m., on resumed upon returned and develop new 2013, fall. ecord review of the e d/t (due to) ew of the Change of n safety mat.bed alarm re quarterly MDS dental Status) score of 2 staff for bed mobility, plinary Progress sosition.safety rented for the fall on ber 24, 2012, revealed .in

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 Cotober 9, 2013, at 11. 180 p.m., revealed activity tray in place 40f. (due to) decreased safety awareness low beds dated October 19, 2012, at 11.60 p.m., revealed activity tray in place 40f. (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 p. (pt apient) bying 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, tollet use, and personal hygeten. Medical accord review of the Interdisciplinary Progress (asserting the property of the plan of care revealed to review of the Interdisciplinary Progress (asserting the property of the plan of care revealed no new interventions documented for the fall on December 3, 2012. 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 24, 2012, revealed in dining from lying on left side. had removed lary 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 Interdisciplinary Progress Notes at 102 and pluddy interdisciplinary Progress Notes at 102 and pl

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 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

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. Op. 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,

CENTERS FOR MEDICARE 8	e WEDIC/ND SERVICES		OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
DEFICIENCIES	CLIA	A. BUILDING	COMPLETED
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING	11/07/2013
	445319		
NAME OF PROVIDER OF SUI	PPLIER	STREET ADDRESS, CITY, STA	ATE, ZIP
WILLOWS AT WINCHESTE	R CARE & REHABILITATION		
Fi-ftiti		WINCHESTER, TN 37398	
	•	cy, please contact the nursing home or the state survey agency.	VEH L DECLII ATODV
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY MATION)	FULL REGULATORY
F 0323	crown, no bleeding noted assister review of facility Change of Conresident was trying to transfer sel and sounding. Resident was educ Administrator on October 29, 20 falls, including a fall on February report completed immediately af hospital; investigations were not resident was dismissed to home cacknowledged there were system.  Resident #100 was admitted to the fall report dated February 18, 201 call light usage. call light within rotated February 18, 201 call light usage. call light within rotated February 18, 2013, revealed leg/foot.encourage.to use handrai Condition Documentation dated I injury.re-educated to call light us Medical record review of the Carobjects near bed to prevent injury call for assistance.PT (Physical Tolutter. Medical record review of light.laying in floor next to bed.sleg anymore. Medical record review of thor next to bed.going to change facility's fall report dated Februar over and fell out of wheelchair. No ask for help.bed in lowest posi 2013, revealed. continues with the 2013, revealed. Continues with the 2013, revealed of continues with the review of the MDS revealed, the impairment). Medical record review of the MDS revealed, the impairment). Medical record review of the MDS revealed, the impairment) medical record review of the MDS revealed, the impairment of the MDS revealed for a strength training. Medical record review of the Chastiting upright on the bed at his berport dated April 20, 2013, revealed adjust level of card and showers per schedule.encour needs.encourage to use call light. Increased confusion.new order to Medical record review of the Chastiting upright on the bed at his berport dated April 20, 2013, revealed adjust level of card and showers per schedule.encour needs.provide verbal cues.reinfor Documentation dated April 20, 2013, revealed adjust level of cardinal showers per schedule.encour needs.provide verbal cues.reinfor Documentation dated April 20, 2	at found sitting on floor complained of bilateral hip pain.Golf-ball si d to wheelchair; Nurse Practioner (NP) notified x-ray of bilateral hi dition Documentation fall dated January 13, 2013, a facility report of from bed to chair and fell on floor, landed on bottom. No injuries ated on using call light to ask for assistance for transfers. Interview 13, at 3:30 p.m., in the conference room, with concurrent review of v. 10, 2013, and a fall on March 15, 2013, verified the following: The rethe resident's four falls; the resident did not have injuries requirity completed to address the root cause and contributing factors to the for May 5, 2013. Interview continued and the Administrator stated, I problems with falls.  The facility on [DATE] with [DIAGNOSES REDACTED]. Medical reach bed in lowest position. safety alarm placed. Medical record revel d. poor coordination due to recent aka (above knee amputation) of r. Is.have commonly used articles within easy reach. Medical record revel d. poor coordination due to recent aka (above knee amputation) of r. Is.have commonly used articles within easy reach. Medical record revel and call light placed within reach. bed in lowest position.safety alarm in be. when resident in bed place all necessary personal items within reach herapy) evaluation.place call light within easy reach.ensure environ the facility's fall report dated February 21, 2013, revealed and the facility's fall report dated February 21, 2013, revealed and the facility's fall report dated February 21, 2013, revealed are of the Care Plan revealed no new interventions documented for he Change of Condition Documentation dated February 23, 2013, revealed record review of the Interdisciplinary Note dated February 21, 2013, revealed record review of the Interdisciplinary Note and February 26, 2013, revealed record review of the facility's fall report dated April 5, 2013, revealed encourage to work the facility's fall report dated April 5, 2013, revealed encourage to be with the facility's fall report dated April 5, 2	p. Medical record lated 1/15/13.  observed. Alarm on with the the resident's four per facility had a neg transfer to the our falls; and the thas already been ecord review of the facility's night, and the thas already been ecord review of the Care Plan ight eview of the Change of the floor bedside bed.no alarm placed.  ed/chair.remove all ch.reinforce need to ment is free of ed to call not) have a right the fall on February 21, evealed .observed laying on eview of the chair alarm.bending realed teach resident es dated February 23, lation dated February 23, lation dated February 23, leant) was bending 25, 2013, revealed the al hygiene. Further 6 (no cognitive I alert with to ambulate. Medical hair mobility and ing on floor at verbalize .2013, revealed s/ per hour) times one. messed the resident f the facility's fall review of the Care dated April 23, ind undressing.baths and assist with grooming unge of Condition ety alarm in place. between bed and all for evaluation. Medical aunding.sitting on safety sispital for evaluation. medical ounding.sitting on safety sispital for evaluation. ranial abnormality.no or required extensive a nad was totally DS revealed, the g) on November 6, 2013, at the cause of d May 2, 2013.
	Medical record review of the Quamemory problems; required exterpersonal hygiene and bathing; rectoilet use; and was continent of bhad a fall on January 13, 2013, at Further review of the documentainterventions to prevent future fa 13, 2013, at 7:25 a.m., revealed, pillow between.knees. Pt has elec (neurological) checks in place. R laceration and was sent to the eminvestigation to determine the car	racinty on [DATE], and readmitted to the facility on [DATE], revaled the residnsive assistance with one person physical assist for transfers, walk in quired extensive assistance with two plus person physical assistance owel and bladder and had no falls. Review of facility's fall report resolved and bladder and had no falls. Review of facility's fall report resolved in revealed no investigation to determine the cause of the fall and lls. Medical record review of the Change of Condition Documentation bed alarm sounding and pt (patient) was lying on the floor beside the tric bed and the bed was in the highest position per pts (patient's) of eview of facility's fall report revealed the resident had a fall from the regency roiagnom on [DATE], at 3:30 p.m. Further review of the dase of the fall and failed to add interventions to prevent future falls. In Documentation form, dated January 13, 2013, at 15:30 (3:30) p.m.	ent had short and long term n corridor, dressing, for bed mobility and vealed the resident bed was elevated. failed to add on form, dated January he bed on back with ontrol.neuro bed with a bocumentation revealed no Medical record
F 0323	supervision to prevent avoidable **NOTE- TERMS IN BRACKET Based on review of facility policy fall reports, review of facility donew interventions to address falls #52, and #89) of twenty-two resinterventions to address falls planon-compliance has caused or like effective on November 26, 2012, and Director of Nursing were informed in the findings included: Review of the second s	the area is free from accident hazards and risks and provides the accidents.  TS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**  TO HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**  TO HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY*  TO HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY*  TO HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY*  TO HE Facility failed to investigate and de the theoretic state of the facility's failure to investigate and de the deed residents #35 and #73 in Immediate Jeopardy (a situation in whitely to cause serious injury, harm, impairment or death). The Immediand is ongoing. The Regional Vice President, Director of Clinical Sormed of the Immediated Jeopardy on November 6, 2013, at 2:30 p. If the facility policy entitled Falls Management, effective on Septeml, . If patient falls. Update care plan to reflect new interventions. Revi	review of the facility gate and develop 120, #26, #23, #113, velop new ch the provider's liate Jeopardy was Services, Administrator m. in the conference room. ber 15, 2001, and

DEPARTMENT OF HEALT CENTERS FOR MEDICARE	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 445319	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OF S WILLOWS AT WINCHEST	UPPLIER FER CARE & REHABILITATION	N CENTER	STREET ADDRESS, CITY, STA 32 MEMORIAL DRIVE	ATE, ZIP
			WINCHESTER, TN 37398	
(X4) ID PREFIX TAG	g home's plan to correct this deficience SUMMARY STATEMENT OF D			Y FULL REGULATORY
	OR LSC IDENTIFYING INFORM			
F 0323	(continued from page 26) policy entitled Falls Care Deliver. Complete.Resident Incident repole interventions to staff. Review of t revealed. If patient falls: Perform injury. Review of the facility poli Neurological assessensentological asses hours, then every four hours x 24 review revealed the resident was a Medical record review of the Mincognitive impairment. Medical re March 8, and June 8, 2013, reveal (PT) notes from admission throug of the PT notes dated June 3, 201. safety awareness and judgment. In ambulation with the rolling walke through September 2013) revealed to bathroom, unwith the rolling walke through September 2013) revealed to bathroom, unwith the rolling walke through September 2013) revealed to bathroom, unwith the rolling walke through for review, no neuro che developed; March 6, 2013 at 7:50 October 1, 2013, by the Director of headache, had a small skin tear of cause or contributing factors identified. Review revealed to the fall was not completed. Rev to the bathroom and slid out of the intervention developed; April 1, 2 was seen in the emergency room factors identified. Review revealed this was a witnessed fall assisted to the bathroom by a Cert the resident stand, adjust clothing the emergency room. No root ca 2013, at 7:25 a.m., facility fall rep blinking, and found the resident in subsequent facility documentation attributed to the fall of May 21, 21 done, no root cause or contributin facility fall report was not initiate floor and old skin tear re-opened. the Care Plan revealed, 7/19/13 fa floor beside the bed.noted abrasio telephone on October 3, 2013, at revealed when the resident fell an who were both drawing blood and (resident #35) way down at the er admission to the hospital on August 12, 2013, arevealed, price of the fall report for falls. Review of a fall report for falls. Review of a fall report for falls. Review of a fall report for the resident for a fall report was concurrent review of the fall on Januar the right hip requiried to be comp sustained by the resident fro	y Process, with revision date of Jutto implement new intervention: ete Condition of Change Docume e following: Update care plan with facility policy entitled Falls M to Neurological Assessment for all cy entitled Assessment for all cy entitled Assessment: Neurological Sessment will be performed: every hours. Resident #35 was admitter eadmitted [DATE], after an Openitumen Data Set (MDS) dated [DD four dreview of the Fall Risk Evalled the resident was high risk for the June 13, 2013, revealed the res. 3, revealed., good progress with gratient continues to require minin handicap will prevent gait independing walker and began a restorer. Medical record review of facilid the resident had a history of [RI tro (neurological) checks (to assestety alarm. was added to the residencks were done, no root cause or collam, the fall report was initiated of Nurses. Review revealed the reform the bed onto my bottom, no root causing and the bed onto my bottom, no root causified no new intervention device revealed, asked resident where the bed onto my bottom, no root causified Nurse Aide (CNA) who left, tumble into the bathrub, and hit use or contributing factors were it contrevealed a CNA heard the saft in the bathroom on the floor with the addressed a large bruise to the resident of the saft was tified Nurse Aide (CNA) who left, tumble into the bathrub, and hit use or contributing factors were it contrevealed a CNA heard the saft in the bathroom on the floor with the addressed a large bruise to the resident of the properties of the resident of the properties of the fall was tified Nurse Aide (CNA) who left, tumble into the bathrub, and hit use or contributing factors were it contrevealed a CNA heard the saft in the bathroom on the floor with the addressed a large bruise to the resident of the properties of the fall was tified Nurse Aide (CNA) who left, tumble into the bathrub, and hit use or contribution of the fall was tified Nurse Aide (CNA) who left, tumble into the bathrub, and hit use or contribution of the nurse of the lef	anne 1, 2013, revealed, response to s. Investigate fall circumstances. In the staff. Conduct interdisciplinary ith new interventions as appropriat lanagement, with revision date of unwitnessed falls and witnessed falls and intersed in the don [DATE], with [DIAGNOSES IN Reduction and Internal Fixation and Internal F	aplement immediate team meeting within 72 te. Communicate June 1, 2013, alls with head 1, 2012, revealed, or to the head and/or on every one hour x four is REDACTED]. Medical record of a Right Hip Fracture. The score of 14, indicating no did at quarterly reviews on the physical therapy is gait training. Review is to demonstrate poor ers secondary to the resident was able 2013, to continue in December 2012 4:20 a.m., fell on the way coot cause or no facility report new intervention is months later, on the foliation of a swere done, no root is all the fell of the way of the resident was sommate and witnessed it was not seen in was developed; May 25, regency call light Review of 1013, and the bruise was in Mass downwas developed; May 25, regency call light Review of 1013, and the bruise was . No neuro checks were at 8:20 a.m., was found on the dentified. Review of 1013, and the bruise was . No neuro checks were at 8:20 a.m., was found on the dentified. Review of 1013, and the bruise was evaled in was developed; May 25, regency call light Review of 1013, and the bruise was in the province of 1013, and the bruise was exported by 19, 2013; dent sitting in Interview by of August 12, 2013, wo nurses on duty, ed and revealed I heard orry and Physical on of where a call light had sement and Plan: fall on the detail on the deciment of the fall with fracture ust 12, 2013, fall and completed arch 6, 2013, fall and complete the falls were not eight falls were not eight falls. The fall with fracture ust 12, 2013, fall and complete the fall with fracture ust 12, 2013, fall and complete the fall with fracture ust 12, 2013, fall and complete the fall with fracture ust 12, 2013, fall and complete the fall with fracture ust 12, 2013, fall and complete the fall with fracture ust 12, 2013, fall and complete the fall with fracture ust 12, 2013, fall and complete the fall with fracture ust 12, 2013, fall and complete the fall with fracture ust 2013, fall and complete the fall with fracture ust 2013, fall and complete the fall with fra

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 445319 Previous Versions Obsolete

	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 11/07/2013
	445319			
NAME OF PROVIDER OF WILLOWS AT WINCHES	SUPPLIER STER CARE & REHABILITATION	N CENTER	STREET ADDRESS, CITY, S' 32 MEMORIAL DRIVE WINCHESTER, TN 37398	ΓΑΤΕ, ZIP
For information on the nursi	ng home's plan to correct this deficien	cy, please contact the nursing ho		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		IENCY MUST BE PRECEDED	BY FULL REGULATORY
F 0323	(continued from page 27) Pain Evaluation dated January 12 (moderate pain). Medical record 12, 2013. Medical record review bed.c/o (complains of) pain to rt revealed the resident had pain in plan of care revealed no new inte Interdisciplinary Progress Notes: Medical record review of the Inter purple and blue/green bruising to Interdisciplinary Progres Notes a hospital. Review of the hospital I hospital with [REDACTED]. Re June 1, 2013, revealed .patients e care plan to reflect new intervent Director of Nursing) on October the facility's policy to investigate the falls on December 8, 2012, D clavicle. Resident #17 was admit revealed the resident in the bed n facility documentation revealed t the wheel chair (w/c) an investiga contributing factor determined ar October 30, 2013, with LPN #1 a in the Nurse's Notes, could be for developed after the fall. April 8, checks were done. No investigate help. May 5, 2013, at 2:00 p.m initiated, but no root cause or cor developed. May 12, 2013, at 3:00 cause or contributing factors dete a.m Slipped out of the w/c onto 23, 2013, at 8:45 a.m An invest #1 at 10:30 a.m., in the conferenc the June 23, 2013, fall, the reside on [DATE], with [DIAGNOSES to return home on October 4, 2013. falls had investigations initiated fell in the bathroom, swelling in 1 fracture noted. A new interventio been mopped and remained wet. new interventions to address falls the way to the bathroom. Resider conference room, on October 30, individualized interventions were [DATE], with [DIAGNOSES RE May 25, 2013, revealed the resident was n mobility, transfers, and locomotic record review of facility docume follows: January 29, 2013, at 8:5 floor and hit head on the doorfrar contributing factors were lying on back. Record review rev identified. March 12, 2013, at 2:1 revealed an investigation was not 6:00 p.m Found lying on floor w/c. Record review revealed at July 25, 2013, at 1:2:20 pm - Stoo not completed and no root cause the conference room, with LPN # pressure alarm sounding, resider	2, 2013, revealed the resident had review of the plan of care reveal of the Change of Condition Doc (right) shoulder. Medical record the the right shoulder at an inten reventions documented regarding at 1:05 a.m., January 14, 2013, redisciplinary Progress Notes at 0. R (right) posterior shoulder. gua t 8:00 a.m., January 14, 2013, redisciplinary Progress Notes at 0. R (right) posterior shoulder. gua t 8:00 a.m., January 14, 2013, redisciplinary Progress Notes at 0. R (right) posterior shoulder. gua t 8:00 a.m., January 14, 2013, redisciplinary Progress Notes at 0. Scale and 1. Scale	ed no new interventions documer umentation dated, January 13, 20 review of the Pain Evaluation dat sity of 1-2 (mild pain). Medical review of the Pain Evaluation dat sity of 1-2 (mild pain). Medical review of 1-2 (mild pain). Medical review of (o complains of) R (rig 5:00 a.m., January 14, 2013, reverding area. Medical record review evaeled. c/o R shoulder pain.large ry 18, 2013, revealed Resident #7 (1.7.0 Falls Management dated Sep porporiate care investigation of this so of interventions. Interview with ssions office, confirmed the faciliand had failed to implement new ind 3 and January 13, 2013 which SES REDACTED]. Observation at bedside on October 30, 2013. If as follows: March 3, 2013, at 3 distributed the work of the work	tied for the fall on January 13, revealed rolled out of ed January 13 2013, ecord review of the this shoulder pain. It should be pain amount bruising, send to 3 was admitted to the tember 15, 2001 and revised e cause. 64 update in the ADON (Assistant ty had failed to follow interventions after resulted in a fractured right at 10:00 a.m., and 4:00 p.m., Medical record review of 3:15 pm - fell out of but no root cause or 23, 2013 - Interview on all, other than what was plan interventions ead, no neuro e-e-ducate to call for An investigation was the fall were ted, but no root ed. June 8, 2013, at 8:30 lress the fall. June ctober 30, 2013, with LPN stigated the falls after ident #24 was admitted ollowed by Hospice and was able in reported and none of the 013, at 11:45 a.m acility with no bathroom, the floor had tinterventions working and no e electric wheelchair on aw with LPN #1, in the falls was done and no new of to the facility on Sets (MDS) dated [DATE], and assistance with bed and toilet use. Medical rough August 2013 as mething off of the dn no root cause or by staff due to completed and no root n dining room floor, intributing factors were. Record review ed. April 9, 2013, at seven falls from January developed to address the, with admitting ion fall dated January 5, 2013, sized bruise noted on the factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard the pull away g factors were identified. A heard t
	call light usage.call light within r dated February 18, 2013, revealed			

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED:4/7/2014 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER / SUPPLIER (X3) DATE SURVEY STATEMENT OF (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA IDENNTIFICATION A. BUILDING 11/07/2013 NUMBER 445319 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. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (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 Care Plan 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 fal F 0323 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 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 and accuse intracranial abnormality no 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 acute factar 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. 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 hed

mg bed,
[MEDICATION NAME] ([MEDICAL CONDITION] medication) 10 mg 2 x (times) day, Trazadone (Anti-depressant medication)
25 mg prn
[MEDICATION NAME] (Anti-anxiety medication) 0.5 mg prn. Alprazolom used nightly for anxiety (and)

2.5 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-

recommendations F/U (follow-up) recommendations January 17, 2013, DC Trazadone, Decrease [MEDICATION NAME] report.non-use

azadone.Recommendation-1) DC Trazadone non-use >30 days, 2) DC [MEDICATION NAME] 10 mg po 2 x day.3)

[MEDICATION NAME] 5

Induction Walking) are go 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

[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].

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 pm (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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1O11

Facility ID: 445319

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PRINTED:4/7/2014

CENTERS FOR MEDICAR	RE & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OF	445319		CENTER ADDRESS CHEW OF	DATE ZID
NAME OF PROVIDER OF WILLOWS AT WINCHES	SUPPLIER STER CARE & REHABILITATION	N CENTER	STREET ADDRESS, CITY, S' 32 MEMORIAL DRIVE WINCHESTER, TN 37398	TATE, ZIP
For information on the nursi	ing home's plan to correct this deficien	cy, please contact the nursing ho	me or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF I OR LSC IDENTIFYING INFOR		ENCY MUST BE PRECEDED I	BY FULL REGULATORY
F 0329	February 4, 2013, revealed .Curro NAME] 7.5 mg 8P, [MEDICATION NAME] 10 previous recommendations F/U (follow-up report.non-use Trazadone.Recommendation-1) I [MEDICATION NAME] 5 mg po 2 x day. Medical record re .Reason for Visit: Psych (psychia CONDITION] Medications: [ME bed, [MEDICATION NAME] 10 mg 2 x day.Trazadon days.2) DC [MEDICATION NAME] po 10 r Reduction)	mg bid (2 times daily), Trazador o) recommendations January 17, DC Trazadone non-use >30 days, eview of the Comprehensive Non atric).F/U.Recommendations fror EDICATION NAME] (Donepezi the 25 mg prn, [MEDICATION N mg 2 x day.3) [MEDICATION N	Medications: Donepezil 5 mg 8P (at 25 mg prn, [MEDICATION N. 2013, DC Trazadone, Decrease [1, 2) DC [MEDICATION NAME] -Psychiatric Progress Note dated in February 4, 2013, not done as of [1) 5 mg [MEDICATION NAME] AME] 0.5 mg prn.Recommendation [2] 5 mg pro 2 x day.Informed	AME] 0.5 mg pm.not completed- MEDICATION NAME] 10 mg po 2 x day.3) March 4, 2013, revealed f now.Current [MEDICAL ([MEDICATION NAME]) 7.5 m on-1) DC Trazadone non-use >30 consent for GDR (Gradual Dose
	to [MEDICATION NAME], DC orders [REDACTED]. Interview there was no documentation the p January 2013 or February 2013. I recommendation, and the residen months until an order for [REDA	with Licensed Practical Nurse # physician was notified of the [MI Further interview confirmed the part continued to receive the medical	1 on October 3, 2013, at 9:40 a.m EDICAL CONDITION] medicationly significant was not notified until at	, in the TV lounge confirmed on recommendations initiated fter the March 4, 2013
F 0364	Prepare food that is nutritional, right temperature.	, appetizing, tasty, attractive, w	vell-cooked, and at the	
	Based on observation of the residialed to serve hot food at or above meal observations. The findings it ray-line in the dining room rever. F. Ground hamburger 112 degree Interview with the dietary cook of confirmed the .food should be at resident's room on the B wing reg. Sometimes in evening have to we 2013, revealed an overhead page of the A Hall cart revealed it confrom the A Hall cart at 5:49 p.m. dining room revealed resident #4 observation revealed resident #4 observation revealed resident #9; the pinto beans could have been department, on October 1, 2013, Cubed potatoes 171 degrees F. T potatoes 201 degrees F. Pureed p degrees F. Observation on Octobe 5:39 p.m., for the B wing, the las observation revealed the Certificativay: Pinto beans 138 degrees F., a loss of 40 degre F., a loss of 45 degrees; Pureed the an increase of 5 degrees. Intervie temperatures had fallen significant.	we 135 degrees Fahrenheit (F.) ari included: Observation on Septernal deld the dietary cook obtained for the SF. Pureed hamburger 104 degrobtaining the food temperatures of least 140 degrees F. Interview we garding facility food temperature at a long time to get meal. Obser at 5:22 p.m., for the A Hall resictatined thirteen resident trays. Fut, a 27 minute timeframe. Observ. 7 received food and stated the pit 7 received food much later than to warmer. Observation of the resid at 5:25 p.m., revealed the follow urnip greens 176 degrees F. (a no into beans 194 degrees F. Puree er 1, 2013, revealed seven reside tresident tray was delivered and do Dietary Manager (CDM) obtain a loss of 28 degrees Cubed potates Mashed potatoes 119 degrees greens 129 degrees F., a los with the CDM on October 1, 2 loss of 28 with the CDM on October 1, 2 loss of 28 with the CDM on October 1, 2 loss of 28 loss of	ad cold food at or less than 41 deg aber 30, 2013, at 12:23 p.m., of the od temperatures as follows: Hamlees F. Tater tots 108 degrees F. Non September 30, 2013, at 12:23 p ith resident #28 on October 1, 20 revealed .not always, usually at sevation of the resident evening melent trays were ready to be passed ther observation revealed the last ation of dinner on October 1, 201 nto beans could have been a lot whe other residents at the table and ent's evening tray-line service in ing temperatures in degrees F.: Piew pan was placed on the tray-lin turnip greens were 163 degrees F nt trays and one test tray left the all residents were eating at 5:45 p need the following temperatures at oes 107 degrees F., a loss of 64 degrees; Pureed I so of 34 degrees; Pureed I so of 34 degrees; and Milk, in a gl 2013, at 5:45 p.m., on the B wing	rees F. for two of two e resident mid-day burger patties 120 degrees lashed potatoes 112 degrees Fm., in the dining room 13, at 7:55 a.m., in the upper food cold. al service on October I, . Continued observation tray was removed 3, at 5:30 p.m., in the armer. Continued dinner the resident stated in the dietary nto beans 166 degrees F. e at 5:36 p.m.) Mashed . Milk, in a glass, 48 lietary department at .m. Further 5:45 p.m., on the test egrees Turnip greens into beans 149 degrees ass, 53 degrees F., confirmed the test tray
F 0364	Prepare food that is nutritional, right temperature.  Based on observation of the resid failed to serve hot food at or above meal observations. The findings it tray-line in the dining room rever F. Ground hamburger 112 degree Interview with the dietary cook of confirmed the food should be at resident's room on the B wing resometimes in evening have to we 2013, revealed an overhead page of the A Hall cart revealed it confrom the A Hall cart at 5:49 p.m. dining room revealed resident #4 observation revealed resident #9	lent tray-line service, food tempe we 135 degrees Fahrenheit (F.) ar included: Observation on Septem aled the dietary cook obtained for es F. Pureed hamburger 104 degree obtaining the food temperatures of least 140 degrees F. Interview w garding facility food temperature ait a long time to get meal. Obser at 5:22 p.m., for the A Hall resic tained thirteen resident trays. Fur , a 27 minute timeframe. Observe 7 received food and stated the pi	ratures, tray distribution, and inted cold food at or less than 41 degiber 30, 2013, at 12:23 p.m., of the od temperatures as follows: Hamlees F. Tater tots 108 degrees F. We n September 30, 2013, at 12:23 p ith resident #28 on October 1, 20 revealed .not always, usually at systion of the resident evening melent trays were ready to be passed ther observation revealed the last ation of dinner on October 1, 201 nto beans could have been a lot w	grees F. for two of two e resident mid-day burger patties 120 degrees lashed potatoes 112 degrees Fm., in the dining room 13, at 7:55 a.m., in the unper food cold. al service on October 1, . Continued observation tray was removed 3, at 5:30 p.m., in the armer. 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 

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1O11

Facility ID: 445319

If continuation sheet Page 30 of 39

PRINTED:4/7/2014 FORM APPROVED

				OMB NO. 0938-0391		
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY		
DEFICIENCIES	/ CLIA	A. BUILDING		COMPLETED		
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING		11/07/2013		
CORRECTION						
NAME OF PROMPER OF GIV	445319		CERTEE ADDRESS CHEV CE	ATE ZID		
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, STA	ATE, ZIP		
WILLOWS AT WINCHESTE	ER CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE WINCHESTER, TN 37398			
For information on the nursing	home's plan to correct this deficien	cv. please contact the nursing ho				
(X4) ID PREFIX TAG			ENCY MUST BE PRECEDED BY	Y FULL REGULATORY		
(NI) ID TREE IN THO	OR LSC IDENTIFYING INFOR		ELICI MOST BETREEEBED B	TOLL REGULTION I		
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):					
F 0369	Red Ware Silverware; Red Ware Certified Nurse Aide (CNA #12), none available to use. Interview v 2013, at 8:00 a.m., confirmed the	Cup; Red Ware Plate. Interview, confirmed the Red Ware had nowith the Director of Nurses in the re was Red Ware stocked in the	on October 1, 2013, at 6:00 p.m., i ot been provided for the resident and e office adjacent to the nursing stati kitchen, ready for use. C/O #	n the dining room with d the CNA stated there was		
F 0309	Based on medical record review, visual impairment of one resident on [DATE], with [DIAGNOSES of the	IS HAVE BEEN EDITED TO P observation, and interview, the fat t (#35) of sixty-five residents rev REDACTED]. Medical record r	ROTECT CONFIDENTIALITY** facility failed to provide eating equi- riewed. The findings included: Resi- eview of the [DIAGNOSES REDA	pment to address the dent #35 was admitted CTED]. Medical record review		
	initial Care Plan dated December identified. Review of the initial C equipment with meals as recomm Nutrition Services revealed the R divided plate, spoon, fork, and cu unable to see, recognize foods on location. Review revealed the pla resident eating lunch on Septemb regular dishes, not on the Red W: dining room revealed the resident resident's tray on the evening of C Red Ware Silverware; Red Ware Certified Nurse Aide (CNA #12).	care Plan revealed the interventic lended. Adjust PRN (as needed), egistered Dietician (RD) had dep, secondary to visual deficits. R plate, Staff should tell pt (patien in was co-signed by a licensed pier 30, 2013, at 1:00 p.m., in the are. Observation of the resident of the had not been served with the Roctober 1, 2013, revealed the ins Cup; Red Ware Plate. Interview, confirmed the Red Ware had not with the Director of Nurses in the	mber 6, 2013, revealed the problem on for the impaired vision was to Pr Record review of the Interdiscipling veloped a plan to provide the reside ed Ware divided plate to continue at the water of the water of the place them in actical nurse (LPN) on August 9, 2 dining room revealed the resident wating supper on October 1, 2013, a ded Ware. Review of the supper meatructions included Adapt. (adaptive on October 1, 2013, at 6:00 p.m., i of been provided for the resident and office adjacent to the nursing statikitchen, ready for use. C/O #	ovide adaptive ary Communication to nt with .Red Ware us pt (patient) is a specific 013. Observation of the vas served lunch on the t 6:00 p.m., in the ll ticket placed on the c) equip (equipment): n the dining room with d the CNA stated there was		
F 0371	Store, cook, and serve food in a	safe and clean way.				
	preparation equipment; ensure pothe food thermometer between for prior to use; maintain a sanitary on September 30, 2013, at 9:55 a dispenser, and soap dispenser we hand sink, faucet and handles, an revealed the two foil lined range foil. Interview with dietary emple during the observations confirme interview confirmed the two spill foil. Observation on September 3 for processing soiled pots, pans a sauce pan, stainless steel bowl, at were submerged into the sanitizir #3, and the Certified Dietary Mat the items in the sanitizer sink were sanitizer test strips could not be for sanitizer in the three comparting mid-day meal service in the dining revealed dietary employee #1 use hamburger, pureed hamburger, taining room tray line at 12:26 p. thermometer was rinsed under rusanitizing the thermometer betwee steam table at 12:49 p.m. Further and onion slices with the same gl steam table was concluded at 1:2 for meal service to residents eatir serving utensils to a sink, ran wat a plate, and took the plate of uten utensils were stored on contained the utensils stored on the plate, at cloth to wash the utensils, rinsed contact with 100 percent sanitizer revealed the CDM removed the u in the sanitizer sink. Interview on confirmed the same cloth was us aware alcohol wipes were to be u dietary department with dietary e utensils. Further interview confirm p.m., in the dietary department we reheated. Further interview confirmed the utensils utensils in the sanitizer solution f sanitizer level could not be tested million. Further interview confirm lettuce leaves on the dining room with the CDM present during the build-up of blackened debris by t in the vicinity of the food prepara	otis, pans and utensils were appro- od items; serve food in a sanitar lish room; and maintain a sanitar .m., in the dietary department re- re on the soiled side of the dish r d the towel and soap dispensers; top spill pans had a heavy accur ovee #1 and the facility Adminis d the hand sink, faucet, handles, pans for the range top had an ac 0, 2013, at 11:45 a.m., revealed nd utensils. Further observation nd a cutting board. Further obsery august of the solution per the manufa nager (CDM), on September 30, the not submerged into the sanitiz ound. Further interview confirm ent sink. Observation on Septen ager mor revealed dietary employ de the same cloth to wipe the the tiger tots, and mashed potatoes. Further, and taken to the dietary depart ming water in the sink and the te- ene cach food item. Further observation at 12:51 p.m., reve- eve oved hand at the dining room ste 0 p.m., and all food and utensils ing in their rooms. Further observation at 12:51 p.m., reve- ever over the utensils, used a clean sils to the dietary department ste ground meat, mashed potatoes, the dietary department ste ground meat, mashed potatoes, the dietary department ste and the stemsils in running water, act r solution, then returned the utensils from the steam table and to experiment so, 2013, at 12:23 p ad to wipe the thermometer betweed to sanitize the thermometer med the utensils were stored on; ith the CDM confirmed the ther med the utensils were stored on; ith the CDM confirmed the ther med the verify the appropriate level p med the CDM used the same glo tray line. Observation on Octob observation confirmed the wall he base board. Further observa- tition area and dietary department	na clean hand sink area; maintain sipriately sanitized in the three compy manner; appropriately wash and sy dietary department. The findings vealed the only dietary department inachine. Further observation reveal had an accumulation of food debris inulation of food and blackened debratter, on September 30, 2013, at 9: and the towel and soap dispensers reumulation of food and blackened dietary employee #3 working at the revealed the sanitizer sink containe vation revealed none of the items in currer's recommendation. Interview 2013, at 11:45 a.m., at the three corer water solution. Further interview ed the facility could not ensure the inber 30, 2013, beginning at 12:23 pee #1 obtained food temperatures. I mometer between each food item: arther observation revealed the food temperature was taken for the reheat vation revealed the food temperature was taken for the reheat vation revealed dietary employee #2 ding cloth to wipe the utensils, store am table. Further observation revealed dietary departion revealed dietary employee #2 ding cloth to wipe the utensils, store am table. Further observation revealed dietary employee #2 ding cloth to wipe the utensils, store am table. Further observation revealed dietary employee #2 ding cloth to wipe the utensils, store am table. Further observation revealed dietary steam table. Further interview on September 30, 2013, byte had not washed, rinsed, or sanitized or the rinterview on Sep	artment sink; sanitize anitize serving utensils included: Observation hand sink, towel ed the interior of the . Further observation is on and under the 55 a.m., present were soiled. Further debris on and under the three compartment sink d ta third size pan, in the sanitizer sink with dietary employee mpartment sink confirmed revealed the appropriate levelm., of the resident "urther observation hamburger patties, ground It was removed from the in revealed the ed food without ded to the dining room artment steam table took the soiled d the utensils on ded the plate the revealed the CDM took used a cleaning the utensils in the sanitizer solution employee #1 ed dietary employee #1 was at 1:20 p.m., in the itized the serving ber 30, 2013, at 1:20 each food item being appropriately. Further I had not submerged the erview confirmed the ion of 200 parts per o, onion slices, and room and interview chine table had a ing tiles and tile grid of debris and rust.		
			were stored under the steam table a of the eleven pans had a heavy acc			
F 0371	Store, cook, and serve food in a Based on observation and intervio	•	n a clean hand sink area; maintain s	anitary food		

STATEMENT OF	(X1) PROVIDER / SUPPLIER			(X3) DATE SURVEY COMPLETED	
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	B. WING		11/07/2013	
CORRECTION	NUMBER 445319				
NAME OF PROVIDER OF SUI			STREET ADDRESS, CITY, STA	TE, ZIP	
WILLOWS AT WINCHESTE	R CARE & REHABILITATION	CENTER	32 MEMORIAL DRIVE WINCHESTER, TN 37398		
	nome's plan to correct this deficience				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				
F 0371	(continued from page 31) preparation equipment; ensure po the food thermometer between for profice to use; maintain a sanitary d on September 30, 2013, at 9:55 a. dispenser, and soap dispenser wei hand sink, faucet and handles, an revealed the two foil lined range t foil. Interview with dietary emplo during the observations confirmed interview confirmed the two spill foil. Observation on September 30 for processing soiled pots, pans as auce pan, stainless steel bowl, an were submerged into the sanitizin #3, and the Certified Dietary Man he items in the sanitizer sink wer sanitizer test strips could not be fo of sanitizer in the three compartm ind-day meal service in the dinin revealed dietary employee #1 use hamburger, pureed hamburger, ta dining room tray line at 12:26 p. nthermometer was rinsed under ru sanitizing the thermometer betwe steam table at 12:49 p.m. Further and onion slices with the same gle steam table was concluded at 1:26 for meal service to residents eatin serving utensils to a sink, ran wate a plate, and took the plate of uten- utensils were stored on contained the utensils stored on the plate, at cloth to wash the utensils, rinsed to contact with 100 percent sanitizer revealed the CDM removed the u in the sanitizer sink. Interview on confirmed the same cloth was use aware alcohol wipes were to be us dietary department with dietary e utensils. Further interview confir p.m., in the dietary department wi reheated. Further interview confir p.m., in the dietary department wi reheated. Further interview confir nettuce leaves on the dining room with the CDM present during the uids-up of blackened debris by ti the vicinity of the food prepara Observation, confirmed eleven in Further observation and interview debris.	intinued from page 31) eparation equipment; ensure pots, pans and utensils were appropriately sanitized in the three compartment sink; sanitize food thermometer between food items; serve food in a sanitary manner; appropriately wash and sanitize serving utensils for to use; maintain a sanitary dish room; and maintain a sanitary detary department. The findings included: Observation September 30, 2013, at 95.5 a.m., in the detary department revealed the only dietary department hand sink, towel spenser, and soap dispenser were on the soiled side of the dish machine. Further observation revealed the interior of the nd sink, faucet and handles, and the towel and soap dispensers had an accumulation of food debris. Purther observation wealed the two foil lined range top spill pans had a heavy accumulation of food and blackneed debris on and under the il. Interview with dietary employee #1 and the facility Administrator, on September 30, 2013, at 95.5 a.m., present ring the observations confirmed the hand sink, faucet, handles, and the towel and soap dispensers were soiled. Further eview confirmed the two spill pans for the range top had an accumulation of food and blackneed debris on and under the il. Observation on September 30, 2013, at 11.45 a.m., revealed dietary employee #3 working at the three compartment sink processing soiled pots, pans and utensils. Further observation revealed more of the items in the sanitizer sink revealed into the sanitizing water solution per the manufacturer's recommendation. Interview with eters were submerged into the sanitizer was an accumulation, and accumulation of the sanitizer sink contained a third size pan, use pansitizer sink were not submerged into the sanitizer was the commendation of the sanitizer sink revealed the certified Dietary Manager (CDM), on September 30, 2013, at 11.45 a.m., at the three compartment sink confirms eitens in the sanitizer sink were solved and at the sanitizer sink representation of the sanitizer sink representation of the sanitizer sink represent			
F 0425	Safely provide drugs and other s in emergencies, by a licensed ph **NOTE- TERMS IN BRACKET Based on medical record review, anxiety for one resident (#33), of findings included: Resident #33 w of	narmacist. S HAVE BEEN EDITED TO PR and interview, the facility failed to sixty-five residents reviewed. Thi was admitted to the facility on [DA	OTECT CONFIDENTIALITY** o provide pharmaceutical services is failure resulted in harm to reside ATE], with [DIAGNOSES REDAG	to relieve pain and ent #33 The CTED]. Medical record review	
	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				
F 0425	resident's complaint of pain and a Safely provide drugs and other s in emergencies, by a licensed ph **NOTE- TERMS IN BRACKET Based on medical record review, anxiety for one resident (#33), of findings included: Resident #33 w of the Nurse's Admission Note datec review of the Admission Physicia tablet) I tab every 6 hours as neec ADMINISTRATION RECORD I resident's room, revealed the resident had a not get pain medications until the finally got my medicine about 6:0 in the conference room, revealed the facility failed to provide the re resident's complaint of pain and a	similar products available, whice armacist.  S HAVE BEEN EDITED TO PR and interview, the facility failed to sixty-five residents reviewed. This was admitted to the facility on [DA] I May 3, 2013, at 8:10 p.m., revea in order [REDACTED]325 mg (led. Medical record review of the DETAILS REDACTED] Interview short stay in the hospital and when eaxt morning. Continued interview 10 a.m. Interview with the Directothe resident complained of pain are sident's pain and anxiety medicat	OTECT CONFIDENTIALITY** o provide pharmaceutical services is failure resulted in harm to reside ATE], with [DIAGNOSES REDAC ided C/O (complained of) pain/anx is mg of Hydrocodone and 325 mg Medication Administration Recor with the resident on September is the the resident returned in May 20; we revealed the resident stated, I w or of Nursing (DON) on September and anxiety on admission. Continue	to relieve pain and ent #33 The CTED]. Medical record review siety. Medical record of Acetaminophen per each d [MEDICATION 25, 2013, at 8:00 a.m., in the 13, the resident could ras miserable; I r 26, 2013, at 10:35 a.m., at interview confirmed	
F 0431	Maintain drug records and prop to accepted professional standar		r similar products according		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:4/7/2014

CENTERS FOR MEDICARI	E & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 445319	(X2) MULTIPLE CONSTRUC A. BUILDING B. WING	FION	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OF S WILLOWS AT WINCHES		N CENTER	STREET ADDRESS, CITY, ST 32 MEMORIAL DRIVE WINCHESTER, TN 37398	TATE, ZIP
For information on the nursin (X4) ID PREFIX TAG	g home's plan to correct this deficien SUMMARY STATEMENT OF I	DEFICIENCIES (EACH DEFICI	me or the state survey agency.	3Y FULL REGULATORY
For information on the nursin	g home's plan to correct this deficien  SUMMARY STATEMENT OF IOR LSC IDENTIFYING INFOR!  (continued from page 32)  Based on review of facility docur manage controlled drugs for thirt approach for receipt and destruct substances properly for one (#16, The findings included: Review of Licensed Practical Nurse (LPN) & Controlled Drug Records records at the Controlled Drug Records at the Controlled Drug Records records as the Controlled Drug Records records as the Controlled Drug Records records as the Controlled Drug Records records records as the Controlled Drug Records records as the Controlled Drug Records recor	cy, please contact the nursing hor DEFICIENCIES (EACH DEFICE MATION)  mentation, review of facility police of of forty-three residents receivation of firty-one residents; and failed the facility Allegations Report of 4th to the Office of Investigations une through August, 2013, identification of the Office of Investigations une through August, 2013, identification of the Office of Investigations and the Occurrent placement of control to document placement of control to document placement of Control to document placement of Control of Ocurrent of Ocurrent of Control of Ocurrent of O	me or the state survey agency.  ENCY MUST BE PRECEDED E  The state survey agency.  ENCY MUST BE PRECEDED E  The state survey agency.  ENCY MUST BE PRECEDED E  The state survey agency.  ENCY MUST BE PRECEDED E  The state survey agency.  The state survey agency.  ENCY MUST BE PRECEDED E  The state survey agency.  The state survey and failed to follow eceiving narcotics; and failed to follow active survey.  The state survey agency agency and failed to follow active survey.  The state survey agency agency agency and failed to follow active survey.  The state survey agency a	e facility failed to y a systematic ose of controlled one of three carts. he facility reported eview of the facility Director of Nursing (DON) ce officer on August 27, on June 2013, through (012, revealed, Storage: ction: Two licensed the 'controlled cking of all controlled drugs are required to immediately og the required cumentation and sign the DON or designee and the date drug removed, by wed drug entry line on the the area. Signatures of two Nurse (LPN) #4 signing as needed (prn) facility investigated tims of the ton diversion and no the Consultant Pharmacist methods in order to the provide of the pain retired from the pharmacy; than insterning the pain retired. Continued diversion to the one, revealed the notected. Interview with def the facility had not throlled substances from onled Substance Card cotics enabled LPN #4 teptember 23, 2013, at esident was bathing. If the facility failed to 2013, at 95.55 a.m., on on) stored on top of the ated May 16, 2011, patients. Interview irmed the B-12 was not n the Nurse's Station,  al Nurse (LPN #2) on the of tablets along with fication was not labeled verted. The controlled verted to the facility on systematic ose of controlled on or of three carts. The facility reported eview of the facility on of three carts. The facility reported eview of the facility on of three carts. The facility reported eview of the facility on of three carts. The facility reported eview of the facility on of three carts. The facility reported eview of the facility on of three carts. The facility reported eview of the facility on of three carts. The facility reported eview of the facility on of three carts. The facility reported eview of the facility on of three carts. The facility reported eview of the facility one of three carts. The facility reported eview of the facility one of three carts. The facility reported eview of the facility one of three carts. The facility reported eview of the facility one of three carts. The facility reported eview of the facility one of three carts. The fa
	professionals are required to dest Substances Book' a bound books on each medication cart. Storage a log the received medication into a information for each entry and sig- entry. To store drugs awaiting des licensed nursing staff. Signatures whom and highlight 'off' the Inde Index Page. Document the disposi licensed nursing staff are required reported on August 27, 2013, LPI medications as administered to re- all residents who received narcoti	roy and document destruction of system from which the pages car and Maintenance of Controlled Dathe Controlled Substances Book. In the entry. The second licensed struction. Perform count of drugs to of two licensed nursing staff are ax Page. Two licensed nursing staff ition to storage in the bound destruction. Review of the facility investige N #4 had been taking the resident stidents, but keeping the medicatives of the facility investiges.	f controlled drugs. Centers will us unot be removed, for ongoing trac trugs. Two licensed nursing staff at One licensed nursing staff will le nursing staff will witness the doc to be stored. Count to be done by required. document on Index Page if must sign the highlighted removuction book located in the storagation revealed Licensed Practical is discontinued medications and sons. Further review revealed the	the the 'controlled cking of all controlled drugs ure required to immediately by the required cumentation and sign the DON or designee and e date drug removed, by the drug entry line on the e area. Signatures of two Nurse (LPN) #4 signing as needed (prn) facility investigated

FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 33 of 39 Event ID: YL1O11 Facility ID: 445319

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	1	1	OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING	
CORRECTION	NUMBER	B. WING	11/07/2013
	445319		
NAME OF PROVIDER OF SUI	PPLIER	STREET ADDRESS, CITY	, STATE, ZIP
WILLOWS AT WINCHESTE	R CARE & REHABILITATIO		0
Fi-ftiti	h	WINCHESTER, TN 3739	
		icy, please contact the nursing home or the state survey agency	
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE MATION)	ED BY FULL REGULATORY
F 0431	residents had been found to have dated September 9, 2013, reveale avoid detection. The nurse was decourier; taking the balance of the and had also documented giving medications. The pharmacist receive years are seen out a sheet from shift chang facility will begin using hard boy 24, 2013, at 10:38 p.m., in the Clarge amount of controlled drug resident interview confirmed the facility facility. Interview with the Consideration of the DON on September 24, 2013 followed the policy dated October the courier, destroy the empty nate Count Sheet. The facility's failure to divert narcotics for personal unitodivert narcotics for personal unitodive	tions. Further review revealed the facility investigated the med experienced uncontrolled pain. Review of a facility e-mail fro da nurse was diverting controlled substances by several differ iverting by taking the entire card and declining the inventory s card and inventory sheet on medications when a new sheet ha PRN pain medications to several residents (11) and not actuall mmendations were two nurses must sign for delivery from co e reports; two nurses must count and verify discontinued meds and books for declining inventory sheets. Interview with the Actual books for declining inventory sheets. Interview with the Actual books for declining inventory sheets. Interview with the Actual books for declining inventory sheets. Interview with the Actual books for declining inventory sheets. Interview with the Actual books for declining inventory sheets. Interview of the facility was unces had been diverted from the facility for personal use. Concoords from thirteen residents with a known amount of the drught and not identified a diversion before LPN #4 had reported the cultant Pharmacist on September 23, 2013, at 12:20 p.m., by telehecked for narcotic diversion on a regular basis and none had from 2:11 p.m., until 3:00 p.m., in the Conference Room, rever 1, 2012, and had only required one licensed nurse to sign for recotic cards, and remove the narcotic count sheets from the Cord to follow policy and procedure for receipt and destruction of se from residents living in the facility. Interview with LPN #2 revealed resident #16's Fentanyl (pain) Patch came off while the Y#2 disposed of the pain patch in the sharps container. Reviews and the pain patch in the conference room, confidence of the pain patch in the conference room, confidence of the pain patch in the conference room, confidence of the pain patch in the conference room, confidence of the pain patch in the conference room, confidence of the pain patch in the conference room, confidence of the pain patch in the conference room, confidence of the pain patch in	m the Consultant Pharmacist ent methods in order to heet upon delivery by the d arrived from the pharmacy; y administering the pain urier; two nurses must sign to to be destroyed; and, dministrator on September informed by an employee a tinued interview revealed gs diverted. Continued larug diversion to the ephone, revealed the been detected. Interview with ealed the facility had not controlled substances from ontrolled Substance Card narcotics enabled LPN #4 on September 23, 2013, at the resident was bathing. Wo of the facility policy ic instructions for removal and and Interview with the rimed the facility failed to 30, 2013, at 9:55 a.m., on ection) stored on top of the on dated May 16, 2011, ors/patients. Interview wonfirmed the B-12 was not
F 0441	confirmed all medications should Observation of the A wing medical A-wing, revealed a basket in the prefilled saline syringes, scissors for any particular resident. Intervallets of Doxcycline Hydrate we Have a program that investigat	ne Director of Nursing (DON) on October 2, 2013, at 10:14 a.r. I be stored in the locked medication carts.  ation cart on October 1, 2013, at 9:10 a.m., with Licensed Praright top drawer containing three Doxycycline Hydrate (antibi, and other medical items. Continued observation revealed the iew with LPN #2, in the A-wing, on October 1, 2013, at 9:10 are not stored properly and were not labeled for a resident. C/C es, controls and keeps infection from spreading.  TS HAVE BEEN EDITED TO PROTECT CONFIDENTIALI	ctical Nurse (LPN #2 ) on the otic) tablets along with medication was not labeled .n.m., confirmed the three 0 # , #
	Based on observations, interview	, and review of the facility policy, the facility failed to separate	e clean and dirty items
F 0441	employee health records; and fai Observation on September 23, 20 bag lying on the shelf with the sca.m., on the A-Wing, confirmed with soiled items. Observation o unused wipes stored on the soile 10:10 a.m., on the A-Wing, conf with the Director of Nursing (DC not to be stored with soiled items with two bags of dirty linen, on dirty linen bags was raised with confirmed the dirty linen bags with confirmed the dirty linen bag with policy [DIAGNOSES REDACT (millimeter) induration), repeat the revealed no second [MEDICATT] p.m., in the conference room, revon second TB test was performents shower room, revealed a sharps of acility policy Sharps Injury Predisease.safety razors.must be pla September 24, 2013, at 12:12 p.1 replaced.	three wings; failed to complete [DIAGNOSES REDACTED] eled to contain dirty razors for one of three shower rooms. The 1913, at 10:05 a.m., on the A-wing, revealed a soiled linen cart villed bags. Interview with Certified Nurse Aide (CNA) #4 on Sthe black and white bag contained clean items used for resident a September 23, 2013, at 10:10 a.m., on the A-Wing, revealed Ilinen cart. Interview with Licensed Practical Nurse (LPN) #4 tirmed clean items used for resident care had been stored on the NN) on October 2, 2013, at 10:14 a.m., at the Nurse's Station, c s. Observation on October 1, 2013, at 15:30 p.m., revealed four A-Wing during meal tray pass. Further observation revealed the litry linen exposed. Interview with CNA #11 on October 1, 20 ere not normally left on the hallway during meal service. Furth h the raised lid was overfilled and should have been emptied. I bell [TB) Screening dated March 21, 2013, revealed, .if result est in one to three weeks after first test was read. Review of fiv ON NAME] Skin Test. Interview with Registered Nurse (RN) realed RN #1 was responsible for employee health screening. Container on the counter with safety razors spilling over onto the trention dated March 1, 2012, revealed Purpose to prevent.trans ced in sharps disposal containers.replaced routinely when? ful. n., in the A-Wing shower room, confirmed the sharps containers, controls and keeps infection from spreading.	findings included: with a black and white print leptember 23, 2013, at 10:08 t personal care and was stored a box of gloves and clean, on September 23, 2013, at soiled linen cart. Interview onfirmed clean items were dirty linen carts, each e lid of one of the eight 13, at 5:35 p.m., on A-Wing, ter interview with CNA #11 Review of the facility is negative, (less than) 10 mm the personnel files #1 on September 23, 2013, at 2:40 Continued interview confirmed at 12:10 p.m., in the A-Wing the counter. Review of the mission of infectious I. Interview with RN #1 on
1. 04+1	**NOTĒ-TĒRMS IN BRACKE Based on observations, interview and contain dirty linen on one of employee health records; and fai Observation on September 23, 22 bag lying on the shelf with the sc a.m., on the A-Wing, confirmed with soiled items. Observation o unused wipes stored on the soile 10:10 a.m., on the A-Wing, conf with the Director of Nursing (DC not to be stored with soiled items with two bags of dirty linen, on a dirty linen bags was raised with confirmed the dirty linen carts w confirmed the dirty linen bag with policy (DIAGNOSES REDACT (millimeter) induration), repeat t revealed no second [MEDICATI p.m., in the conference room, rev no second TB test was performed shower room, revealed a sharps of facility policy Sharps Injury Predisease.safety razors.must be pla	es, controls and keeps infection from spreading. TS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY, and review of the facility policy, the facility failed to separate three wings; failed to complete [DIAGNOSES REDACTED] and to contain dirty razors for one of three shower rooms. The solided bags. Interview with Certified Nurse Aide (CNA) #4 on Sthe black and white bag contained clean items used for residen a September 23, 2013, at 10:10 a.m., on the A-Wing, revealed I linen cart. Interview with Licensed Practical Nurse (LPN) #4 in String delian items used for resident care had been stored on the in Short of the solid policy and the strength of the solid policy and the solid po	e clean and dirty items (TB) screenings for five of five findings included: with a black and white print eptember 23, 2013, at 10:08 t personal care and was stored a box of gloves and clean, on September 23, 2013, at soiled linen cart. Interview onfirmed clean items were dirty linen carts, each e lid of one of the eight 13, at 5:35 p.m., on A-Wing, her interview with CNA #11 Review of the facility is negative, (less than) 10 mm re personnel files #1 on September 23, 2013, at 2:40 Continued interview confirmed at 12:10 p.m., in the A-Wing the counter Review of the mission of infectious I. Interview with RN #1 on

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				OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER		JCTION	(X3) DATE SURVEY
DEFICIENCIES	/ CLIA	A. BUILDING		COMPLETED
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING		11/07/2013
	445319			
NAME OF PROVIDER OF			STREET ADDRESS, CITY, S	TATE, ZIP
WILLOWS AT WINCHES	STER CARE & REHABILITATIO	N CENTER	32 MEMORIAL DRIVE	
			WINCHESTER, TN 37398	
For information on the nurs	ing home's plan to correct this deficie	ncy, please contact the nursing	home or the state survey agency.	
(X4) ID PREFIX TAG			CIENCY MUST BE PRECEDED	BY FULL REGULATORY
	OR LSC IDENTIFYING INFOR	RMATION)		
F 0441	(continued from page 34) replaced			
	replaced.			
F 0490	Be administered in an acceptal			ale ale
			PROTECT CONFIDENTIALITY ation, interview and facility documents	
	administration failed to ensure s	taff provided the necessary care	to prevent pressure ulcers and pre	vent pressure ulcers
	surgery on the resident's right le	g to remove necrotic (dead) tiss	resident #95's left leg and resulted sue. The facility's failure to ensure s	in the need for systems and
	processes were in place and con	sistently followed by staff for th	ne provision of necessary care and	services to prevent
	#73 and potentially any resident	at risk for pressure ulcers in Im	ntified pressure ulcers placed Residented in the placed Residented Residente	hich the provider's
	noncompliance has caused or is	likely to cause serious injury, h	arm, impairment, or death). The fa-	cility administration
	devising new interventions to pr	ate in the facility by not investi-	gating accidents; not determining clusting the new interventions. The fa	auses of falls; not
	provide a system for manageme	nt of falls and failed to follow the	he facility's fall policy, resulting in	22 residents
	experiencing 93 falls in 2013. T	his failure placed Resident #35	in Immediate Jeopardy who, after in sustained a [MEDICAL CONDIT	nultiple falls, no ION1. This failure placed
	Resident #73 in Immediate Jeop	ardy who, after several falls with	th no investigation of the cause of t	he falls, and no new
			placed all residents at risk for falls s caused or is likely to cause seriou	
	impairment, or death). The facil	ity Administrator failed to ensu	re a systematic approach was follow	wed by nursing staff for
	receipt and destruction of medic	ations which provided an environment who was receiving parcetics	onment to allow Licensed Practical The Administrator's failure to imp	Nurse #4 to potentially
	prevent diversion of narcotics co	onstitutes Substandard Quality of	of Care. The Regional Vice Preside	nt, Director of Clinical
	Services, Administrator, and Dir	rector of Nursing were informed	d of the Immediate Jeopardy on No November 26, 2012. Substandard	vember 6, 2013, at 2:30 p.m.,
	F224-F, F314-K and F323-K. T	he facility provided an acceptab	ole Allegation of Compliance on No	ovember 22, 2013, and a revisit
			ented on November 25, 2013, remondings included: Interview with the	
			care plans were not updated to refle	
			ulcers or falls; falls were not investi	
	in the Administrator's office, con	nfirmed the facility had not ider	wwith the Administrator on Octobe ntified issues with receipt and destr	uction of medications
	or possible drug diversion until	Licensed Practical Nurse #4 sel	f-reported to the facility a history of	f drug diversion.
			p.m., in the Administrator's office, reened in the facility. Continued int	
	residents (#35, #73) had falls wi	th significant injury, and the fac	cility had not followed the facility's	policy for falls.
			nistrator stated did not feel there wa the Credible Allegation of Complian	
	on-site November 26, 2013, by	medical record review, review of	of facility documents, observation a	nd interview with nursing
			policy and procedures related to Fa vidence the new policies were revie	
	facility administration and the n	ew medical director. The facilit	y provided evidence the survey find	dings were reviewed and
			service training records including s provided, including abuse. Review	
	revealed, the leadership group w	as involved in daily review of f	facility operations, and implementa	tion of corrective
			e facility on November 26, 2013, re 52, #62). Medical record review of	
	the resident was discharged from	n the facility on October 29, 20	13. Medical record review of reside	ent #73 revealed the fall
			and updated with individualized in lity on May 6, 2013. Medical recor	
	of residents #73 and #114 (in-ho	ouse residents with pressure ulco	ers) confirmed the facility had conc	lucted comprehensive skin
			erventions were in place, and preve e new facility Administrator (interi	
	2013, and new Administrator as	of November 21, 2013) on Nov	vember 26, 2013, at the facility, rev	ealed the facility
			9, 2013), and the new Medical Dire flow up audit measures to assure co	
	actions during a Quality Assessi	nent and Assurance meeting. The	he facility will remain out of comp	liance at a Scope and
	that is not Immediate Jeopardy,		o actual harm with potential for mo	ore than minimal harm,
F 0490	Be administered in an acceptal			
1 01,50	**NOTE- TERMS IN BRACKE	TS HÅVE BEEN EDITED TO	PROTECT CONFIDENTIALITY	
			ation, interview and facility docume to prevent pressure ulcers and pre	
	from worsening. The facility's fa	ailure resulted in amputation of	resident #95's left leg and resulted	in the need for
			sue. The facility's failure to ensure some provision of necessary care and	
	development of avoidable press	ure ulcers and worsening of idea	ntified pressure ulcers placed Resid	lent #95, #114, #35, and
			nmediate Jeopardy (a situation in w arm, impairment, or death). The fa-	
	failed to ensure residents were s	afe in the facility by not investi-	gating accidents; not determining c	auses of falls; not
			nating the new interventions. The father facility's fall policy, resulting in	
			in Immediate Jeopardy who, after i	
			, sustained a [MEDICAL CONDIT th no investigation of the cause of t	
	interventions, sustained a clavic	le fracture. The facility's failure	placed all residents at risk for falls	in Immediate
	Jeopardy (a situation in which the	ne provider's noncompliance has	s caused or is likely to cause seriou	s injury, harm,
			re a systematic approach was follow onment to allow Licensed Practical	
	divert narcotics from any reside	nt who was receiving narcotics.	The Administrator's failure to imp	lement a system to
			of Care. The Regional Vice Preside d of the Immediate Jeopardy on No	
	in the conference room. The Im-	mediate Jeopardy was effective	November 26, 2012. Substandard	Quality of Care was cited under
			ole Allegation of Compliance on No ented on November 25, 2013, remo	
	Noncompliance for F-490 contin	nues at a E level citation. The fi	ndings included: Interview with the	Administrator on October
			care plans were not updated to refluicers or falls; falls were not investi	
	interventions not implemented to	o prevent further falls. Interview	w with the Administrator on October	er 3, 2013, at 4:10 p.m.,
			ntified issues with receipt and destr	
I	or possible drug diversion until	LICCHSCU FTACUCAI INUISE #4 SEI	f-reported to the facility a history of	i urug urversioii.

STATEMENT OF	(V1) PROVIDED / CURRITER	(V2) MIII TIDI E CONSTRUI	CTION	(X3) DATE SURVEY
DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRU- A. BUILDING	CHON	COMPLETED
AND PLAN OF	IDENNTIFICATION	B. WING		11/07/2013
CORRECTION	NUMBER			
NAME OF PROVIDER OF S	445319 SUPPLIER		STREET ADDRESS, CITY, ST	ATE, ZIP
	TER CARE & REHABILITATION	N CENTER	32 MEMORIAL DRIVE	,
			WINCHESTER, TN 37398	
	ng home's plan to correct this deficien			
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR		CIENCY MUST BE PRECEDED B	Y FULL REGULATORY
F 0490	residents (#95, #35, #114) develc residents (#95, #35, #114) had falls wit Continued interview with the Ad pressure ulcers. Refer to F224, F. on-site November 26, 2013, by n and administrative staff. The faci Ulcers, and Quality Assessment a facility administration and the ne shared with the facility leadership staff members related to the new revealed, the leadership group w measures to prevent falls and pre interventions were in place for re the resident was discharged from risk assessment was completed, a review revealed resident #95 had of residents #73 and #114 (in-hot assessments by the new Wound C current on certified nursing assist 2013, and new Administrator as a leadership group, the new Direct 2013), reviewed the findings of tactions during a Quality Assessm	pped pressure ulcers which worsh significant injury, and the faci ministrator revealed the Admini 280, F314, F323 Validation of t nedical record review, review of dility provided evidence of new pand Assurance activities and eview medical director. The facility p group and staff members. In-spolicies and procedures were pass involved in daily review of fassure ulcers. Observation at the sisdents (#17, #23, #26, #42, #52) the facility on October 29, 201 and the care plan was reviewed at been discharged from the faciliuse residents with pressure ulcer Care Nurse, treatments and intertant kardexs. Interview with the of November 21, 2013) on Novor of Nursing (as of October 29, he survey and implemented follnent and Assurance meeting. The cient practice that constitutes no	p.m., in the Administrator's office, sened in the facility. Continued inteility had not followed the facility's pistrator stated did not feel there was he Credible Allegation of Compliar f facility documents, observation an policy and procedures related to Fall idence the new policies were review provided evidence the survey findiervice training records including significant to the provided, including abuse. Review of acility operations, and implementatif facility on November 26, 2013, rev. 4, #62). Medical record review of residen and updated with individualized in ty on May 6, 2013. Medical record residen some confirmed the facility had conductentions were in place, and prevent new facility Administrator (interimember 26, 2013, at the facility, reve, 2013), and the new Medical Direction actual harm with potential for more lacility will reuran of correction.	rview confirmed two policy for falls. a problem with falls or nee was accomplished d interview with nursing l Prevention, Pressure red and approved by the ngs were reviewed and gn in sheets for all f facility documents on of corrective realed, all fall related sisting the facility according to the fall erventions. Medical record review and observations teted comprehensive skin tative interventions were a as of November 8, aled the facility tor (as of November 20, pupliance with corrective ance at a Scope and
F 0501	Choose a doctor to serve as the coordinate medical care in the **NOTE- TERMS IN BRACKE' Based on medical record review, Medical Director failed to ensure medical care provided to resident pressure ulcers and prevent press and resulting in the need for surg director's failure to ensure systen necessary care and services to proplaced Resident #95, #114, #35, situation in which the provider's situation in which the provider's residents experiencing 93 falls. To investigation of the cause of the facility of the Resident #73 in Immediate Jeopa interventions, sustained a clavicle Jeopardy (a situation in which the impairment, or death). The Regic were informed of the Immediate was effective November 26, 2015 findings included: Telephone into falls occur at night due to short si review patient and family concer at 1:30 p.m., in the conference ro	medical director to create resisfacility.  TS HAVE BEEN EDITED TO a facility policy review, review of the facility policy review, review of the facility policy review, review of the facility sfall policy and prosts. The medical director's failure sure ulcers from worsening ultim the properties of the facility in the properties of the facility in the properties of the facility in the fact to ensure the facility implement in failure placed Resident #35 falls, and no new interventions, and who, after several falls with the fracture. The facility's failure the fracture. The facility's failure placed president, Director of Jeopardy on November 6, 2013 2, and is ongoing. Substandard cerview with the Medical Director than the facility in the failure with the Medical Director in the Medical Director of the Medical Director's office we administrator stated reviewed a faministrator stated reviewed in the facility of the Medical Director's office we administrator stated reviewed in the facility of the Medical Director's office we administrator stated reviewed in the facility of the Medical Director's office we administrator stated reviewed in the facility of the Medical Director's office we administrator stated reviewed in the facility of the facility o		nd interview, the ed to coordinate the sary care to prevent sident #95's left leg facility medical or the provision of dentified pressure ulcers nmediate Jeopardy (a ,, impairment, or ing in 22 nultiple falls, no ON]. This failure placed e falls, and no new n Immediate injury, harm, ad Director of Nursing om. The Immediate Jeopardy 4-K and F323-K. The m. revealed .most of the Assurance) meeting they tor on November 6, 2013, Meetings the rector to review.
F 0501	Based on medical record review, Medical Director failed to ensure medical care provided to resident pressure ulcers and prevent press and resulting in the need for surg director's failure to ensure systen necessary care and services to proplaced Resident #95, #114, #35, situation in which the provider's death). The medical director faile residents experiencing 93 falls. To investigation of the cause of the Resident #73 in Immediate Jeopa interventions, sustained a clavicle Jeopardy (a situation in which the impairment, or death). The Regic were informed of the Immediate was effective November 26, 2015 findings included: Telephone inte falls occur at night due to short streview patient and family concer at 1:30 p.m., in the conference ro Administrator would walk over to	facility.  IS HAVE BEEN EDITED TO I facility policy review, review of the facility's fall policy and protes. The medical director's failure are ulcers from worsening ultimery on the resident's right leg to as and processes were in place a event development of avoidable and #73 and potentially any resinoncompliance has caused or is ed to ensure the facility implement in failure placed Resident #35 falls, and no new interventions, ardy who, after several falls with the fracture. The facility's failure e provider's noncompliance has onal Vice President, Director of Jeopardy on November 6, 2013 2, and is ongoing. Substandard cerview with the Medical Director diffing. Continued interview revns; review pressure ulcers and foom, revealed if the Medical Director of the Medical Director's office we administrator stated reviewed.	PROTECT CONFIDENTIALITY* of facility fall reports, observation as occurres were implemented and fail et on ensure staff provided the necesses nately resulting in amputation of restriction of restrictio	nd interview, the ed to coordinate the arry care to prevent sident #95's left leg facility medical or the provision of dentified pressure ulcers nmediate Jeopardy (a 1, impairment, or ing in 22 nultiple falls, no ON]. This failure placed e falls, and no new n Immediate injury, harm, ad Director of Nursing om. The Immediate Jeopardy 14-K and F323-K. The m. revealed .most of the Assurance) meeting they tor on November 6, 2013, Meetings the rector to review.
F 0514	Based on medical record review,	TS HAVE BEEN EDITED TO interview, and review of facility	ch resident that meet  PROTECT CONFIDENTIALITY* y policy, the facility failed to maint sixty-five residents reviewed. The	ain accurate and

				OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER		CTION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		
CORRECTION	NUMBER	B. WING		11/07/2013
	445319			
NAME OF PROVIDER OF SUI	PPLIER		STREET ADDRESS, CITY, ST	ATE, ZIP
WILLOWS AT WINCHESTE	R CARE & REHABILITATIO	N CENTER	32 MEMORIAL DRIVE WINCHESTER, TN 37398	
For information on the nursing l	nome's plan to correct this deficien	ncy, please contact the nursing ho		
(X4) ID PREFIX TAG	•		IENCY MUST BE PRECEDED B	Y FULL REGULATORY
	OR LSC IDENTIFYING INFOR	RMATION)		
F 0514	review of the facility's Skin Inte, was identified on the side of the dated June 27, 2013, revealed a: toe and also on the side of the le 2, 2013, revealed, .DTI (deep tis treatment orders dated July 8, 2C the facility's Medical Nutrition T (left) toe tx (treatment) noted. M. DTI to left lateral foot and side record review of the physician's Medical record review of the physician's Medical record review of the yespember 2, 4, 6, and 11, 2013. 2013, .Stage II to side of left foo Care Nurse on October 29, 2013 on the right foot. Interview with a.m., in the dining room, confirm for Resident #73 was inaccurate. Resident #13 was admitted to the Management atted June 1, 2013, revealed, .conotification of family/physician. September 30, 2013, at 3:37 p. mout of the wheelchair since the a October 1, 2013, at 8:30 a.m., at a fall since the resident's admissine Nurse's Station, revealed the resident. Further interview confit to complete documentation of this Situation, Background, Assessm 2013, revealed, .CNA (Certified Interview with the DON on Octo September 27, 2013, confirmed the SBAR as completed on September 26, 201 Charting and Documentation rever for a minimum of 72 hours. Intermedical record was incomplete a September 26, 2013. Resident #revealed the resident had a fall fiheadache on January 20, 2013, at 10:50 p.m., floor on butt in front of w/c (whe bathroom to urinate. (resident) st to refuse to use call light for assi w/c.goes to bathroom approx. (a water, very weak., Review of the 2013. Interview on October 3, 20 facility failed to maintain a complanuary 20, 2013, fall.	grity Report dated June 27, 2013 left great toe. Medical record revisue suspected deep tissue injury pressue injury) to right lateral aspect 1013, revealed, skin prep left later Pherapy assessment dated [DATE ledical record revisue injury) to right lateral aspect 1013, revealed, skin prep left later Cherapy assessment dated [DATE ledical record review of the Inter of left great toe. and on August 8 treatment orders dated August 1 revealed. Medical record review of the Inter of the Inter of left great toe. and on August 8 treatment orders dated August 1 revealed. Medical record review of the Int. and on October 29, 2013, . Stag 3, at 10:20 a.m., revealed revealed the DON (Director of Nursing) and the documentation in the men. The facility on [DATE], with [DIADE] with [DIADE] might be resident's room, revealed dimission to the facility. Interview the Nurse's Station, confirmed the Nurse's Station, confirmed the Nurse's Station, confirmed the new left and the resident had a fall on She fall until October 1, 2013 (whe hent/Appearance and Request (SE Nurse Aide) walked resident roober 28, 2013, at 2:45 p.m., in the the DON had instructed the RN the mober 27, 2013. Medical record 13, until October 2, 2013. Review vised on January 1, 2013, revealer view with the DON on October and failed to contain the first thre 62 was admitted to the facility or row the bed with no injury and wthe 10:00 p.m. Medical record revirevealed, Resident attempting to eel chair). CNAs (Certified Nurse ates, has bad head ache, house she istance and refuses to wait till assupproximately) every 30 to 40 min. Neurological Evaluation form rol13, at 12:55 p.m., with the Med plete medical record regarding the plete medical record regarding	itted on [DATE], with [DIAGNOS], revealed a suspected deep tissue i riew of the facility's Wound Managsure ulcer was identified on the sid riew of the Interdisciplinary Progres of foot. Medical record review of all foot and left great toe. Medical reJ, revealed the resident had no pre disciplinary Progress Notes revealed, 2013, side of left lateral foot rest, 2013, side of left lateral foot rest, 2013, revealed, skin prep outer jrd open areas on the right inner and terdisciplinary Progress Notes revealed, 2013, revealed, skin prep outer jrd open areas on the right inner and terdisciplinary Progress Notes revealed. Interview II to left outer foot area. Interview II to left outer foot area. Interview II to left outer foot area. Interview and the Wound Care Nurse on Octobical record regarding the locations. AGNOSES REDACTED]. Review a nupdate care plan to reflect new into the facility had notified the family with the ASSISTANT Director of Nunere was no documentation in the riview with the ADON on October I rise (RN) #2 regarding a fall since a eptember 27, 2013, at 8:15 a.m., are are quested by the surveyor). Med BAR) form (to assess change of command found resident sitting on fit of conference room, after reviewing to date the SBAR as a late entry, by review revealed no nursing documental of the facility policy entitled Policy of the facility policy entitled Policy (New Admissions/Re-admission 28, 2013, at 2:45 p.m., in the conference work of the Change of Condition Door of the C	njury pressure ulcer gement Tracking Tool e of the left great ss Notes dated July the physician's ecord review of ssure ulcers and (L) dd on August 2, 2013, blved. Medical part of right foot. left outer feet on aled on October 22, w with the Wound ne left foot and no wound ober 30, 2013, at 10:15 of the pressure ulcers  of facility policy Falls terventions. document family member on y the resident fell rsing (ADON) on nedical record regarding, 2, 2013, at 2:35 p.m., in idmission for the did the facility failed ical record review of the didtion) dated September 27, or next to B bed. the SBAR form dated it the RN inaccurately dated entation from the resident's cy Clinical Record: S Chart on all three shifts rence room, confirmed the after the admission on w of facility fall report to complaints of a cumentation form, dated ng and then slid in in in w/c and go to ing, resident continues its out of bed in drinks large amount of er the fall on January 20, ence room, confirmed the
F 0514	Based on medical record review complete medical records for thr Resident #73 was admitted to the review of the facility's Skin Integrate was identified on the side of the dated June 27, 2013, revealed a toe and also on the side of the le 2, 2013, revealed, DTI (deep tis treatment orders dated July 8, 20 the facility's Medical Nutrition T (left) toe tx (treatment) noted. M DTI to left lateral foot and side record review of the physician's Medical record review of the wesptember 2, 4, 6, and 11, 2013. 2013, Stage II to side of left foo Care Nurse on October 29, 2013 on the right foot. Interview with a.m., in the dining room, confirm for Resident #73 was inaccurate.  Resident #113 was admitted to the Management dated June 1, 2013, at 3:37 p.m out of the wheelchair since the a October 1, 2013, at 8:30 a.m., at a fall since the resident's admission the Nurse's Station, revealed the resident. Further interview confit to complete documentation of the Station, Background, Assessm 2013, revealed, .CNA (Certified Interview with the DON on Octo September 27, 2013, confirmed the SBAR as completed on Septe admission on September 26, 201	Trs HAVE BEEN EDITED TO I  a, interview, and review of facility ree residents (#73, #113, #62) of e facility on [DATE], and readm grity Report dated June 27, 2013 left great toe. Medical record rev suspected deep tissue injury pres ff lateral foot. Medical record rev suspected deep tissue injury pres ff lateral foot. Medical record rev sus injury) to right lateral aspect 1013, revealed, skin prep left later Therapy assessment dated [DATT Idedical record review of the Inter of left great toe. and on August 8 treatment orders dated August 1 teekly bath and skin report reveale . Medical record review of the In to, and on October 29, 2013, .Stag 3, at 10:20 a.m., revealed revealed the DON (Director of Nursing) a med the documentation in the me	ch resident that meet  PROTECT CONFIDENTIALITY* policy, the facility failed to maint sixty-five residents reviewed. The itted on [DATE], with [DIAGNOS, revealed a suspected deep tissue i riew of the facility's Wound Manas sure ulcer was identified on the sid riew of the Interdisciplinary Progre of foot. Medical record review of al foot and left great toe. Medical re], revealed the resident had no pre disciplinary Progress Notes reveale state of left lateral foot rest 1, 2013, side of left lateral foot rest 1, 2013, revealed, skin prep outer p d open areas on the right inner and terdisciplinary Progress Notes reve ge If to left outer foot area. Intervie the resident had two wounds on it and the Wound Care Nurse on Oct dical record regarding the locations  AGNOSES REDACTED]. Review a pupdate care plan to reflect new in s of interventions. Interview with a the facility had notified the family with the Assistant Director of Nu nere was no documentation in the r view with the ADON on October 1 rse (RN) #2 regarding a fall since a petember 27, 2013, at 8:15 a.m., ar an requested by the surveyor). Med SAR) form (to assess change of cor om and found resident sitting on fice conference room, after reviewing of date the SBAR as a late entry, b review revealed no nursing docume of the facility policy entitled Polic d, New Admissions/Re-admission	ain accurate and findings included: ES REDACTED]. Medical record njury pressure ulcer rement Tracking Tool e of the left great ss Notes dated July the physician's record review of ssure ulcers and .(L) do n August 2, 2013, olved. Medical bart of right foot. left outer feet on aled on October 22, w with the Wound leel foot and no wound ober 30, 2013, at 10:15 of the pressure ulcers of facility policy Falls reviewed the pressure ulcers of the distinguished the facility failed ical record review of the dittion) dated September 27, for next to B bed. the SBAR form dated the the RN inaccurately dated entation from the resident's by Clinical Record:

CENTERS FOR MEDICARE C	e WEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCT	TION	(X3) DATE SURVEY
DEFICIENCIES AND DI AN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		COMPLETED
AND PLAN OF CORRECTION	NUMBER	B. WING		11/07/2013
	445319			
NAME OF PROVIDER OF SUI	PPLIER	•	STREET ADDRESS, CITY, STA	TE, ZIP
WILLOWS AT WINCHESTE	R CARE & REHABILITATION		32 MEMORIAL DRIVE	
For information on the nursing 1	nome's plan to correct this deficien		WINCHESTER, TN 37398	
(X4) ID PREFIX TAG	•		ENCY MUST BE PRECEDED BY	FILL REGULATORY
(A4) ID TREFIX TAG	OR LSC IDENTIFYING INFOR		AVET WEST BETREEEDED BT	TOLL REGULATION I
F 0514	(continued from page 37)			
	medical record was incomplete as September 26, 2013. Resident #6 revealed the resident had a fall for headache on January 20, 2013, at January 20, 2013, at 10:50 p.m., 1 floor on butt in front of w/c (whe bathroom to urinate.(resident) stato refuse to use call light for assis w/c.goes to bathroom approx. (ap water, very weak, Review of the 2013. Interview on October 3, 20	nd failed to contain the first three 2 was admitted to the facility on [10m the bed with no injury and was 10:00 p.m. Medical record review revealed, Resident attempting to gel chair). CNAs (Certified Nurse A tes. has bad head ache. house shoes tance and refuses to wait till assis pproximately) every 30 to 40 minu Neurological Evaluation form revisits, at 12:55 p.m., with the Medica	3, 2013, at 2:45 p.m., in the confert days (72 hours) of nursing notes at DATE], and readmitted to Review s sent to the emergency room due to the Change of Condition Doct get out of bed when alarm soundinates) assisted (resident) to get up as were on, floor dry, alarm soundinance arrives before (resident) gets tes, then comes back to bed and drealed no neurological checks after al Records Director, in the confere lack of neurological checks documents.	fter the admission on of facility fall report to complaints of a amentation form, dated g and then slid in in w/c and go to gg, resident continues out of bed in rinks large amount of the fall on January 20, nce room, confirmed the
F 0520		ment and assurance group to re	eview quality deficiencies	
	Based on review of medical reconfacility Quality Assurance (QA) of procedure for receipt and destructailure to prevent pressure ulcers as a problem; failed to identify the action plans to address the issues prevent pressure ulcers and preversulting in the need for surgery of afulure to ensure systems and procare and services to prevent deve Resident #95, #114, #35, and #73 situation in which the provider's ideath). The facility's QA Commit failure to follow the facility's fall Resident #35 in Immediate Jeopa interventions, sustained a [MEDI falls with no investigation of the facility's failure placed all resider ensure a systematic approach was an environment to allow Licensec arrootics. The facility's failure to of Care. The Regional Vice Presi of the Immediate Jeopardy on No November 26, 2012, and is ongoi provided an acceptable Allegatio corrective actions implemented on an Elevel citation The findings in Administrator, on October 3, 201 falls, grievances, and put plans in revealed the committee had not ic revisions. Further interview with identifying pressure ulcers, or any confirmed the facility had not ide until Licensed Practical Nurse #4 Administrator on October 3, 201: reflect changing needs of residen investigated completely; and inte administrator/Director of QA on Director of Nursing had not brou, interview revealed the fall QA with medical record review, review of facility provided evidence of new and Assurance activities and evid new Medical Director (as of Novadministration was in-serviced by Nursing (as of October 29, 2013) pressure ulcers in addition to dep monitoring the implementation of all staff members related to the new measures contained in the All the facility Audit Tools revealed actions as specified in the Allega 2013, at the facility, confirmed the nursing staff were aware of the residents revealed the specific or ompliance at a Scope and Seyonential for more than minimal for more than minimal facing the proper sevential for more than minimal facing the proper sevential for more than	IS HAVE BEEN EDITED TO PR of review, facility policy review, rad review, failure to include a facility was not following the facility was not following the facility was not following the facility QA Committee's fail ent pressure ulcers from worsening on the resident's right leg to removesses were in place and consisten lopment of avoidable pressure ulce and potentially any resident at rist moncompliance has caused or is littee failed to ensure a system for no policy, resulting in 22 residents early who, after multiple falls, no in CAL CONDITION]. This failure cause of the falls, and no new intents at risk for falls in Immediate Jes followed by nursing staff was fold d Practical Nurse #4 to potentially implement a system to prevent dident, Director of Clinical Services ovember 6, 2013, at 2:30 p.m., in time. Substandard Quality of Care on of Compliance on November 25, at 4:10 p.m., in the Administrator place when issues were identified any problems with trackithe Administrator revealed the coopy problems with the measurement intified issues with receipt and des self-reported to the facility a history and procedures review ember 6, 2013 at approximate sympassion of the Credible Allegation of Cfacility documents, observation at policy and procedures treated to prev November 6, 2013, interview with the measurement and the info (information) to the as not in depth as it needed to be a led the meetings did not necessarion of the Credible Allegation of Cfacility documents, observation at policy and procedures were pleadion of Compliance. Interview with the new policies and procedures were pleadion of Compliance were in ple the facility was involved in ongoin the facility was involved in ongoin the facility leadership team had met rocedures to reduce falls and present and Assurance Meeting was:  1 the Director of Clinical Services committee monthly to provide the new interventi	coTECT CONFIDENTIALITY** eview of fall reports, observation a cility staff failure to follow facility ersion of narcotics; failed to identi- treatment to prevent pressure ulcer cility's fall policy; and failed to im ure to ensure staff provided the ne treatment to prevent pressure ulcer cresulting in amputation of resider re necrotic (dead) tissue. The facili- dity followed by staff for the provise res and worsening of identified pre- sk for pressure ulcers in Immediate kely to cause serious injury, harm, annagement of falls and failed to ix experiencing 93 falls in 2013. This rvestigation of the cause of the fall placed Resident #73 in Immediate rventions, sustained a clavicle frac- topardy. The facility QA Committe fllowed for receipt and destruction- divert narcotics from any resident version of narcotics constitutes Su- s, Administrator, and Director of N- sh e conference room. The Immedia- version of narcotics constitutes Su- s, Administrator, and Director of N- sh e conference room. The Immedia- version of narcotics constitutes Su- s, Administrator, and Director of N- sh e conference room. The Immedia- version of narcotics constitutes su- cited under F224-F, F314-K at, 2013, and a revisit on November the Immediate Jeopardy. Noncompli- or of Quality Assurance, who was or's office, revealed the committee de. Continued interview with the A- ng falls, missing incident reports, mmittee had not identified any pro- of wounds. Further interview with struction of medications or possible ory of drug diversion. Interview with struction of medications or possible ory of drug diversion. Interview with struction of medications or possible ory of drug diversion. Interview with struction of medications or possible ory of drug diversion interview with struction of medications or possible ory of drug diversion. Interview with struction of medications or possible ory of drug diversion interview with struction of medications or possible ory of drug diversion interview with drug diversion interview with the prevention, Pressu	y policy and fy the facility's so from worsening plement any cessary care to the #95's left leg and ty QA committee's sion of necessary seasure ulcers placed be Jeopardy (a impairment, or leentify the facility's failure placed s, and no new Jeopardy who, after several sture. The se's failure to of medications provided who was receiving betandard Quality fursing were informed to Jeopardy was effective and F323-K. The facility 26, 2013, revealed the iance for F-520 continues at also the looked at incidents, Administrator and/or care plan blems with tracking or the Administrator et drug diversion with the were not updated to s; falls were not e mount of the mount of the facility staff. The ad Quality Assessment definition and the vealed the facility new Director of the fall risks and ties relevant to ing sign in sheets for ion of corrective on November 20, 2013, of the Medical at 2:30 p.m. at the r was to meet with the r was to meet with the nof the facility's CONDITION] medication inistrator (as of November 21, llegation of Compliance staff members revealed and observation of y will remain out harm with plan of correction
F 0520	quarterly, and develop correcti		view quality deficiencies	
i l	HOLE- LEMNIS IN DRACKE	O HAVE DEEN EDITED IUPK	OTECT CONTIDENTIALITY**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:4/7/2014 FORM APPROVED

WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER			32 MEMORIAL DRIVE WINCHESTER, TN 37398	
NAME OF PROVIDER OF SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP
	445319			
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING		11/07/2013
STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUCT A. BUILDING	TION	(X3) DATE SURVEY COMPLETED
- CENTERS FOR MEDICINE C	MEDICAID SERVICES			OMB NO. 0938-0391

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency

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

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 provide treatment to prevent pressure ulcers from worsening as a problem; failed to identify the facility was not following the facility's fail 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 fail 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 layed fracture. The facility's failure placed al 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 revisions. Further interview with the Administrator revealed the committee had not identified any problems with tracking 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 please in the facility, the role of the Medical. 2013, at the facility, committed the facility featership team had net with the new Medical Director of 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 November 24, 2014 (Compliance and facility test) five the facility of the November 24 (Compliance Compliance). 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

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 445319 If continuation sheet Previous Versions Obsolete Page 39 of 39