STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

445449

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______________
B. WING ______________

(X3) DATE SURVEY COMPLETED
10/16/2013

NAME OF PROVIDER OR SUPPLIER
WESTWOOD HEALTH CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
524 WEST MAIN STREET
DECATURVILLE, TN 38329

(X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 164 SS=F 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another health care institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined 4 of 4 (Nurses #1, 2, 3 and 4) nurses failed to ensure privacy of residents' was maintained during medication administration.

F 164 SS=F 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

Requirement:
The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

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RECEIVED
NOV. 9, 2013

Laboratory Directors or Provider/Supplier Representative's Signature
Melinda Wade
Administrator

DEFICIENCY IDENTIFICATION NUMBER AND DATE RECEIVED:
11/11/13

The above deficiencies were corrected and verified as of 11/11/13.

If continuation sheet Page 1 of 8

DRM CMS-2587(02-09) Previous versions obsolete
Event ID: HG111
Facility ID: TN2002

If continuation sheet Page 1 of 8

If continuation sheet Page 1 of 8
**F 164**

Continued From page 1

The findings included:

1. Review of the facility’s "Resident Rights" policy documented, "...Employees must treat all patients with... respect and dignity..."

2. Observations on 10/14/13 at 4:00 PM, Nurse #1 administered Resident #64's medications through the Percutaneous (PEG) tube with the door open to the hall with a visitor standing in view of the resident care.

3. Observations in Resident #71's room on 10/14/13 at 5:05 PM, Nurse #2 performed an accucheck on Resident #71. Nurse #2 did not pull the privacy curtain and did not close the door, leaving the resident in view of anyone that passed by.

Observations in Resident #24's room on 10/14/13 at 5:11 PM, Nurse #2 performed an accucheck on Resident #24. During the procedure three different staff members came into the room. Nurse #2 did not pull the privacy curtain or close the door.

4. Observations in Resident #37's room on 10/15/13 at 8:40 AM and 8:50 AM, Nurse #3 left the hall door open during administration of eye drops.

During an interview in the hall beside room 213 A on 10/15/13 at 8:55 AM, Nurse #3 was asked if the door to the resident's room should be closed during treatment or care. Nurse #3 stated, "Yes ma'am."

5. Observations in Resident #13's room on 10/15/13 at 4:00 PM, Nurse #4 left the hall door

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**Corrective Action:**

1. On 10/16/13 DON and Administrator conducted education and in-service with identified nurses 1, 2, 3, and 4 regarding providing privacy when administering medications.

2. On 10/16/13 the Administrator conducted a facility audit to ensure privacy of residents is maintained during medication administration.

3. On 10/16/13 DON and Administrator conducted in-service with nursing staff regarding privacy during medication administration.

4. The DON and Administrator will monitor for compliance through daily rounds and report findings to QA committee.

**Completion Date: 10/16/13**
F 164 Continued From page 2
open, the privacy curtain was not pulled around the foot of the bed and another resident propelled himself into the room, while Nurse #4 administered via a PEG tube to Resident #13.

6. During an interview in the Director of Nursing’s (DON) office on 10/16/13 at 9:05 AM, the DON was asked what her expectations are for patient privacy during medication pass. The DON stated, “...we have to provide privacy and treat them [residents] with dignity...”

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and, to the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

F 280 483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise CP

Requirement:
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

Corrective Action:
1. a. On 10/16/13, MDS Coordinator reviewed and revised Resident #30’s care plan to reflect fall intervention.
   b. On 10/16/13, MDS Coordinator reviewed and revised Resident #60’s care plan to include fall interventions.
2. On 10/16/13 the DON, ADON, and MDS Coordinator reviewed other fell resident’s charts for accuracy.
3. On 10/16/13 Administrator and DON inserviced the MDS Coordinator regarding accuracy and revision of care plans.
4. The DON or designee will monitor for compliance through random chart audits and report findings to QA committee.

Completion Date: 10/16/13
F 280  Continued From page 3

Based on policy review, medical record review, observation and interview, it was determined the facility failed to revise the care plan with interventions for falls for 2 of 12 (Residents #30 and 60) sampled residents reviewed of the 29 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "Care Plans" policy documented, "...The care plan process must begin upon admission into the facility and be fluid and changeable representing the patient's status until the patient is discharged from the facility or is deceased... The care plan... Must be reviewed every 90 days and as needed. "As needed" may mean... When there is a change in patient status... Reviews should reflect continuation of already identified problems, newly developed problems, new approaches, and newly developed goals. New problems should be added with the date of review reflected on the care plan..."

2. Medical record review for Resident #30 documented an admission date of 5/6/2011 with diagnoses of Aftercare of Traumatic Fractured Hip, Altered Mental Status, Hypertension, Diabetes Mellitus, Anxiety, Fractured Neck of Femur, Chronic Kidney Disease, Esophageal Reflux, Acidosis, Weight Loss, Hyperpotassiumia, Hyperlipidemia, Conjunctivitis, Hemolytic Anemia, Urge Incontinence, Osteoporosis, Depression, Dementia with Behavior Disturbance, Intestinal Malabsorption, Convulsions and Urinary Tract Infection. Review of the nurses' event note dated 9/26/13 documented, "...Patient observed laying in hallway on back with legs out in front of her and arms to side... No apparent injury..." Review of the current care plan updated 8/27/13 did not
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<td>F 280</td>
<td>Continued From page 4 document an intervention for the 9/26/13 fall.</td>
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<td>Observations in the Resident #30's room on 10/14/13 at 10:14 AM, 12:05 PM and on 10/16/13 at 7:55 AM, revealed Resident #30 lying in bed, with fall mats to each side of bed.</td>
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|               | During an interview in the Minimum Data Set (MDS) office on 10/16/13 at 5:30 PM, the MDS Coordinator was asked about an intervention for the 9/26/13 fall on the care plan for Resident #30. The MDS Coordinator stated, "...I don't see one [intervention]."
|               | 3. Medical record review for Resident #30 documented an admission date of 9/10/13 with diagnoses of Dementia with Behavioral Disturbances, Secondary Parkinsonism, Status Post Coronary Artery Bypass Graft, Peripheral Vascular Disease, Cardiac Pacemaker, Depressive Disorder, Anxiety, Hyperlipidemia, Hypertension, Chronic Respiratory Failure, Constipation, Abnormal Loss of Weight, Esophageal Reflux, Dysphagia and Symbolic Dysfunction. Review of the nurses' event note dated 9/29/13 documented, "...observed patient sitting on safety mat beside bed with both knees bent and left arm bent outwards..." Review of the current care plan dated 9/10/13 did not document an intervention for the 9/29/13 fall. |
|               | During an interview in the MDS office on 10/15/13 at 3:20 PM, the MDS Coordinator was asked what was put in place on 9/29/13 to help prevent a future fall. The MDS Coordinator stated, "There is no intervention on the fall thing [care plan]."
| F 441         | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS |
| SS=0D         | F 441 |
**F 441** Continued From page 5

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

**F 441**

F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

**Requirement:**
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

**Corrective Action:**
1. On 10/16/13 DON inserviced identified nurse #2 regarding the proper cleaning procedure of the glucometer.
2. On 10/16/13 DON and ADON conducted random audits of licensed nursing staff to ensure proper cleaning procedures regarding glucometer.
3. On 10/16/13 DON and Administrator inserviced licensed nursing staff on proper procedure for regarding cleaning of the glucometer.
4. The DON or designee will monitor for compliance through random daily rounds and report findings to QA committee.

Completion Date: 10/16/13
F 441 Continued From page 6

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained when 1 of 4 (Nurse #2) nurses failed to clean the glucometer with bleach wipes.

The findings included:

1. Review of the facility's "PROCEDURE FOR OBTAINING AN ACCU-CHECK" policy documented, "...Obtain clean glucometer, 2 sani-cloth bleach wipes... Clean front and back of glucometer with sani-cloth bleach wipes..."

2. Observations in Resident #71's room on 10/14/13 at 4:47 PM, Nurse #2 performed an accuchek on Resident #71, exited the room, and cleaned the glucometer with an alcohol swab.

3. Observations in Resident #24's room on 10/14/13 at 4:54 PM, Nurse #2 performed an accuchek on Resident #24, exited the room, and cleaned the glucometer with an alcohol swab.

4. During an interview in Resident #24's room on 10/14/13 at 5:20 PM, Nurse #2 was asked what he cleaned the glucometer with. Nurse #2 stated, "...I cleaned them with alcohol..." Nurse #2 was then asked if that was the policy. Nurse #2 stated, "Yes."

5. During an interview in the conference room on 10/15/13 at 2:30 PM, the Director of Nursing (DON) was asked what the facility policy is for cleaning the glucometers. The DON stated, "...we have the sani wipes that I prefer they use..."
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**NAME OF PROVIDER OR SUPPLIER**

WESTWOOD HEALTH CARE AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

524 WEST MAIN STREET
DECATURVILLE, TN 38329

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| F 441              | Continued From page 7
DON was asked if it is acceptable for them to be cleaned with alcohol. The DON stated, "I prefer them to use the sani wipes..." as she shook her head no. | F 441         |                                                                                                           |                 |

During an interview in the conference room on 10/15/13 at 3:35 PM, when asked about the policy for cleansing glucometers, the DON stated, "We follow CMS [Center for Medicare and Medicaid Services] guidelines... we use sani wipes..."

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