<table>
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<tr>
<th><strong>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</strong></th>
<th><strong>ID PREFIX TAG</strong></th>
<th><strong>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECINCTED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</strong></th>
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<tr>
<td>(X) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: 445449</td>
<td><strong>F 279</strong> 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
<td>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(d)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure a plan of care was developed to address the decrease in urinary continence functioning for 1 of 26 (Resident #38) residents in the Stage 2 review. The findings included: Medical record review for Resident #38 documented an admission date of 2/21/08 with diagnoses of Hypokalemia, Hypertension, <strong>Corrective Action:</strong> 1. On 7/19/12 DON and MDS coordinator reviewed and revised resident #38’s care plan to reflect a decrease in urinary continence functioning. 2. On 7/19/12 DON, ADON, and MDS Coordinator reviewed other resident’s chart for accuracy. 3. On 7/19/12 Administrator and DON conducted interview with 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: 7/19/12</td>
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<td><strong>F 279</strong> 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
<td><strong>SS-D</strong></td>
<td>Requirement: A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(d)(4).</td>
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Attention: Directors or Providers/Suppliers of Care, Representative's signature (must be faxed to the Agency)
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| F 279 Continued From page 1
Seizure, Coronary Artery Disease, History of Cardiovascular Accident, Schizophrenia and Urinary Tract Infection, Review of the Minimum Data Set (MDS) dated 6/5/12 documented, "...H0300: Urinary Continence... 0... Always continent..." Review of the MDS dated 6/17/12 and 6/27/12 documented, "...H0300. Urinary Continence... 2... Frequently incontinent..." Review of the nurses' admission and readmission assessment dated 6/20/12 documented, "CONTINENCE: Bladder... Incontinent [checked]..." Review of the bladder assessment dated 6/20/12 documented, "...[checked] Admission... Continent of urine... [box checked] No... Frequency of incontinence: (in the last 7 days)... [box checked] Greater than 7 episodes of incontinence..." Review of the care plan dated 6/27/12 revealed no plan of care for the decrease in urinary continence functioning.

During an interview in the conference room on 7/19/12 at 3:14 PM, the Director of Nursing (DON) was asked if Resident #38's decrease in urinary continence functioning should be reflected on the care plan. The DON stated, "...Yes sir..."

During an interview in the conference room on 7/19/12 at 10:30 AM, the MDS Coordinator was asked if Resident #38's decrease in urinary continence functioning should be reflected on the care plan. The MDS Coordinator stated, "...It should be on the care plan..." The MDS Coordinator confirmed the care plan did not address Resident #38's decrease in urinary continence functioning. | F 279 | | | |
| F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO | F 280 | | | |

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**NAME OF PROVIDER OR SUPPLIER**

WESTWOOD HEALTH CARE

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

524 WEST MAIN STREET
DECATURVILLE, TN 38329

**DATE SURVEY COMPLETED**

07/20/2012

**SUMMARY STATEMENT OF DEFICIENCIES**

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- (X4) ID PREIX TAG

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**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:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure the care plan was revised for 2 of 26 (Residents #4 and 48) residents in the Stage 2 review.

The findings included:

1. Review of the facility’s “Fall Risk/Fall Prevention Guidelines” policy documented, “...Purpose: To provide a coordinated system to

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**(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

| F 280 | 483.20(c)(2)| 483.10(k)(2) |

**Right to Participate Planning Care-Revise CP**

**SS-D**

**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 7/19/12, MDS Coordinator reviewed and revised Resident #4’s care plan to remove intervention to encourage resident to eat 75-100% of diet.
   b. On 7/19/12, MDS Coordinator reviewed and revised Resident #48’s care plan to include all fall interventions.
2. On 7/19/12, DON, ADON, and MDS Coordinator reviewed other resident’s charts for accuracy.
3. On 7/19/12, Administrator and DON insured 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:** 7/19/12
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| identify patients at risk for falls and develop an individualized interdisciplinary care plan to minimize the incidence of falls and subsequent injury... B. Interventions... 1. A score of ten (10) or greater on the Fall Risk Assessment Form will be referred to the Falls Focus Team for review and possible placement on the Fall Prevention Program. a. Patients identified as appropriate for the Fall Prevention Program will have an identifier (gold star, falling leaf...) placed at their doorway. This Identifier communicates to facility staff that this patient is at risk for falls and therefore should be checked each time the staff passes the room... Care Plans... 1. A care plan will be developed by the interdisciplinary team specific to the patient assessment, interventions and goals..."

2. Medical record review for Resident #4 documented an admission date of 10/29/99 with diagnosis of Chronic Kidney Disease Stage 3, Gastrostomy Tube Placement, Multiple Sclerosis, Seizures, Manic Depression, Dysphagia, Arthritis, Depression, Quadriplegia, Colostomy, Fistula, Obesity, Dysmenorhea, Abdominal Wall Cellulitis, Neurogenic Bladder, Pleural Effusion, Urinary Tract Infection and Hypertension. Review of a physician's order dated 6/29/12 documented, "...Increase TwoCal by 50cc/hr [cubic centimeter per hour] until reach 55cc/hr..." Review of the care plan dated 6/2/12 and revised 7/12/12 documented, "Interventions... encourage resident to eat 75- [to] 100% [percent] of diet..."

Observations in Resident #4's room on 7/18/12 at 7:47 AM, revealed TwoCal enteral feeding infusing at 45 cc/hr per pump.
During an interview in the conference room, on 7/19/12 at 10:30 AM, the MDS Coordinator was asked why the care plan for pressure ulcers documented that staff should encourage her to eat 75-100% of her meal. The MDS Coordinator looked at the care plan and stated, "...that's one of those that should have been crossed off..."

3. Medical record review for Resident #46 documented a readmission date of 3/22/12 with diagnoses of General Weakness, Frequent Falls, Osteoporosis, Confusion, Urinary Tract Infection and Hypertension. A nurses event note dated 7/7/12 documented "fall-CNA [certified nursing assistant] found resident on floor on buttocks, no apparent injury, resident did not have on socks or shoes—steps to prevent recurrence—inservice—Pt [patient] is to wear socks while out of bed & [and] staff is to assist to bathroom q [every] 2hrs. A nurses event note dated 6/3/12- documented, "fall-right knee fracture- sent to hospital, returned same day. Inservice / enc [encourage] pt. [patient]... not to wear flip flops and ask for assistance when she has dropped something on floor, assess room for clutter and make sure pathway is cleared." The care plan updated 7/7/12 documented "ensure proper lighting, have non-skid soles..."

During an interview in the conference room on 6/18/12 at 9:10 AM, the MDS Coordinator was asked about revising the care plan to include all interventions. The MDS Coordinator stated, "I don't really have a good answer why it's not on there. When you do annual, admission and significant change. Try to follow up with previous..."
F 280 Continued From page 5 care plan."

During an interview in the conference room on 7/18/12 at 9:45 AM, the Director of Nursing (DON) stated, "We know our patients, and confirmed the June 3rd fall was not placed on the current care plan and that past interventions were not placed on current care plan."

F 371 483.35(i) FOOD PROCURE, STORE/prepare/serve - Sanitary

The facility must —
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to store dishes and utensils under sanitary conditions in the kitchen on 2 of 4 (7/16/12 and 7/17/12) days observed during the survey.

The findings included:

Observations in the kitchen on 7/16/12 at 9:55 AM and on 7/17/12 at 4:40 PM, revealed a large fan with dirt and dust on the fan blades and cover blowing on dishes stored on two wheeled carts.
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<td>During an interview in the kitchen on 7/19/12 at 8:30 AM, the Dietary Supervisor was asked about the cleaning schedule for the fan. The Dietary Supervisor stated, &quot;...it [fan] is usually cleaned once a month by the maintenance man... it was not cleaned this month because he has been out...&quot;</td>
<td>F 371</td>
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