F 000  INITIAL COMMENTS

Amended Statement of Deficiencies

On April 23-28, 2012, an annual recertification survey and complaint investigations #28892, #28876, and #27616, were completed.

The facility was cited with an Immediate Jeopardy at F278 and F323 with a scope and severity of "J" for failing to ensure an accurate assessment for safe smoking practices and failing to ensure one resident (#76) was provided supervision and assistive devices required for safe smoking. The facility's failure to ensure safe smoking practices was likely to cause serious injury, harm, impairment, or death to resident #76, and potentially for all residents who smoke.

An extended survey was completed on April 25-26, 2012.

The Administrator and the Director of Nursing (DON) were informed of the Immediate Jeopardy on April 25, 2012, at 1:30 p.m., in the conference room.

The Immediate Jeopardy was effective from April 24, 2012, through April 25, 2012. Substandard Quality of Care was cited under F323-J. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was accepted and corrective actions validated on-site by the survey team on April 25, 2012.

Non-compliance of the Immediate Jeopardy tags continues at a scope and severity of a "D" level for monitoring of corrective actions.

“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Willows at Winchester Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”
F225

How the corrective action will be accomplished for those issues identified by the deficient practice.

1. An event concerning resident #32 and resident #104 occurred on October 9, 2011 and the NHA reported the event to the state on October 21, 2011.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

2. On 4/26/12, the NHA reviewed the IRS.3.0 and of the four active reports found no other events reported that did not meet the 5 day time frame for reporting of unusual events.

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

3. The NHA was re-educated on April 25, 2012, by the Regional Vice President on the 5 day timeframe regulation for reporting of unusual events.
How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

4. The Unusual Reporting system of the state of Tennessee will be audited by the Regional Vice President for three future unusual events being reported by the NHA. The Performance Improvement Committee that meets monthly will review the audits and make recommendations. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.

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<td>F 225</td>
<td>Continued From page 2</td>
<td>F 225</td>
<td>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</td>
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The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, facility documentation review, and interview the facility failed to report an allegation of misappropriation of resident property (medication) to the State Department of Health within five working days for two residents (#32, #104) of forty residents reviewed.

- The findings included:

  - Resident #32 was admitted to the facility on September 23, 2011, with diagnoses including Hypertension, Mental Disorder, and Dysphagia.

  - Medical record review of the October 2011 Medication Administration Record revealed "...Morphine Sulfate 20 mg (milligram)/ 5 ml (milliliter) PRN (as needed) 0.5 mg po (per mouth) q (every) 4 hrs (hours) prn pain..."

  - Medical record review of the Controlled Drug Record date received September 29, 2011, revealed,"...10/9 (October 9, 2011) count off (reconciliation of medication to ensure each dose of the drug is accounted for revealed..."
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| F 225 | Continued From page 3 inconsistencies..."

Resident #104 was admitted to the facility on June 20, 2011, with diagnoses including Congestive Heart Failure, Hypertension, and Adult Failure to Thrive.

Medical record review of the October 2011 Medication Administration Record revealed "...Morphine Sulfate 20 mg/5 ml PRN 0.25 mg - 0.5 mg po or sl (sublingual) q 1 hr pm pain, air hunger (breathlessness)..."

Medical record review of a Controlled Drug Record date received September 29, 2011, revealed "...10/9...count off..."

Review of facility's documentation dated October 20, 2011, revealed a Licensed Practical Nurse (no longer employed) allegedly diverted medication (Morphine) belonging to two residents (#32 and #104), and self-administered the medication while on the job. Continued review revealed the incident occurred on October 9, 2011, and was not reported to the State until October 21, 2011, twelve days later.

Interview with the Nursing Home Administrator on April 24, 2012, at 2:30 p.m., in the Conference Room, confirmed the facility had not reported the incident within the five day timeframe for reporting unusual incidents.

C/O #28876

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How the corrective action will be accomplished for those issues identified by the deficient practice.

1. Resident #76 was re-assessed using the smoking evaluation by the licensed nurse while personally observing this resident smoking a cigarette on 4/24/12; based on the re-assessment resident #76 will continue to be a supervised smoker. Based on the fact that she dropped her cigarette during the 1:30 pm smoke break and the fact that the C.N.A. stated she was not "acting as usual" as well as the fact that the wind was blowing profusely and she had apparent ashes on her shirt that contained no embers, the CNA that was in charge of the smoking activity immediately reported the incident to the charge nurse. The charge nurse immediately reported the incident to the Director of Nursing Services who immediately reported the incident to the Administrator. Immediately following the incident the resident was re-assessed and as a result a smoking apron was implemented, care card and care plan updated.
**F 278** Continued From page 5

The facility's failure to accurately assess Resident #76 resulted in Immediate Jeopardy (likely to cause serious injury, harm, impairment, or death).

The findings included:

Resident #76 was admitted to the facility on May 16, 2011, with diagnoses Hemiplegia (weakness on one side of the body), Osteoarthritis, Diabetes, and Anxiety.

Medical record of the Minimum Data Set dated March 12, 2012, revealed the resident was cognitively intact, and had an impairment of the right upper extremity.

Medical record review of the Care Plan initiated September 24, 2011, revealed "...smokes cigarettes and is found to be safe with smoking...observe for burn holes in clothes...will continue to exhibit safe smoking habits...".

Medical record review of the Safe Smoking Evaluation dated February 14, 2012, revealed "...Can light, hold and extinguish smoking materials...personal belongings free from evidence of burn holes...history free from smoking related incidents..."

Observation on April 24, 2012, at 10:15 a.m., in the television room, revealed Resident #76 sitting in a wheelchair with cigarette ashes (black and white debris) on the resident's shirt, on the upper right arm.

Observation on April 24, 2012, at 10:50 a.m., in the designated smoking area outside, revealed resident #76 sitting in a wheelchair holding a lit smoking apron was implemented, care card and care plan updated.

This resident's care plan and C.N.A. care card was updated by licensed nurse to reflect the need for a smoking apron during smoke breaks on 4/24/12 and was implemented for the very next smoke break at 3:30pm on 4/24/12.

The family was notified by the Administrator on the morning of 4/25/12 that the resident would require a smoking apron during smoke breaks.

The family was educated by the Administrator on the morning of 4/25/12 regarding the location of smoking apron if they chose to supervise her smoking during visits. The MD was notified by the licensed nurse on 4/24/12 that the resident would require a smoking apron during smoke breaks.

Resident #76 had a skin assessment completed by the Director of Nursing Services on 4/24/12, with no skin break down, no new marks on skin, no change in condition and no apparent burns noted to skin.
A clothing audit was completed for this smoker on 4/24/12 by nursing management to identify clothing with possible holes. This smoker did have noted holes in a few items of her clothing. Staff could not determine if the holes noted were from ember burns, or normal wear and tear due to laundering and use and a list was developed listing the clothes with holes as part of the assessment process.

This resident was discharged from the center to the hospital for an unrelated illness on 4/25/12. The resident returned from the hospital on 4/28/12 and was re-admitted to the facility. The resident had a smoking evaluation completed by the licensed nurse upon re-admission. The results of the evaluation is that the resident requires supervised smoking with use of smoking apron.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

2. Six of the seven total smokers were re-assessed using the smoking evaluation by a licensed nurse while personally observing these residents smoking a cigarette on 4/24/12. The
**continued from page 7**

On April 24, 2012, at 6:45 p.m., in the nurse's station, confirmed LPN #1 had supervised smoking, and was aware resident #76 had dropped cigarettes while smoking. Continued interview at this time revealed Central Supply Specialist had informed LPN #1 resident #76 dropped a lit cigarette on April 24, 2012.

Interview with LPN #2 on April 24, 2012, at 6:35 p.m., confirmed LPN #2 completed the Safe Smoking Evaluation for resident #76, on April 24, 2012. The evaluation revealed "...can light, hold, and extinguish smoking materials...personal belongings free from burn holes...history free from smoking related incidents...", and confirmed the assessment was not accurate due to the resident dropped cigarettes, and the resident had a known history of dropping cigarettes. Further interview at this time revealed LPN #1 had informed LPN #2, resident #76 dropped a lit cigarette on April 24, 2012.

Observation and interview with the Director of Nursing (DON) on April 24, 2012, at 5:55 p.m., of resident #76 seated in the TV room, confirmed three burn holes on the upper right area of resident #76's brown pants.

Interview and observation with the DON on April 25, 2012, at 7:45 a.m., in resident #76's room, confirmed five of fifteen pairs of pants belonging to resident #76 had burn holes, and one of the five pairs were blue nylon pants with several burn holes (an open area in the fabric with brown crusty areas).

The Immediate Jeopardy was effective from April 24, 2012, through April 25, 2012, and was re-assessed using the smoking evaluation by a licensed nurse while personally observing this resident smoking a cigarette on 4/25/12 during the first smoke break she attended.

A chart audit of all other smokers who did not attend another smoke break on 4/24/12 was conducted by the Director of Nursing Services and MDS Nurses on 4/24/12 to ensure all smoking care plans and C.N.A. care cards were updated to reflect any changes identified in the newly completed re-assessments.

Staff members responsible for taking residents out for supervised smoking were interviewed by the administrator and through the investigation there has been no staff member that has physically witnessed any resident that smokes burn a hole in clothing or obtain burns on the skin or any other body part.

A clothing audit was completed for all other smokers by nursing management to identify any other clothing with possible holes on 4/25/12. One other smoker did have noted holes in her clothing. Staff could not determine if the holes noted were from ember burns, or normal wear and tear due to
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<th>COMPLETION DATE</th>
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<tr>
<td>F 278</td>
<td>Continued From page 8 removed on April 26, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on April 26, 2012, through review of facility documents, staff interviews, and observations. The survey team verified the allegation of compliance by:</td>
<td>F 278</td>
<td>laundering and use. At this evaluation, the resident was deemed to need still be supervised while smoking and a smoking apron was implemented.</td>
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<td>1.) Verifying resident #76 had been reassessed, and the Safe Smoking Evaluation revised to accurately reflect the resident's unsafe smoking habits; and verifying the other residents who smoke at the facility had accurate Safe Smoking Evaluations. Accuracy of the Safe Smoking assessments were confirmed by the survey team through observation during smoking sessions and supervised inspection of the resident's wardrobe for burn holes in clothing.</td>
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<td>A list of smoking residents including any devices deemed necessary continues to be provided in the box that contains the smoking materials and has been updated to reflect any changes related to the reassessment of smoking residents.</td>
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<td>2.) Verifying the revision of the facility's policy, titled, Smoking, with an effective date of April 26, 2012, the Smoking Contract for Independent Smokers, and the facility's addendum to the Smoking policy, individualized to the center's specific practices to ensure the safe smoking environment for all smokers.</td>
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<td>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</td>
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<td>3.) Verification by the survey team on April 26, 2012, ensured by interviews with multidisciplinary staff, and review of in-service logs confirmed the staff received information regarding the facility's Smoking policy revision including the location of smoking materials, interventions for smokers deemed unsafe, designated smoking areas, designated smoking times, and how to monitor for safety during smoke breaks including but not limited to, 1) observation of holes in the resident's</td>
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<td>3. The Administrator revised the center smoking policy on 4/25/12 to reflect current facility practice and upon further review with state surveyors and the request for clarification the policy was once again revised to clarify assessments and information as it relates to supervised and independent smokers on 4/26/12. All staff responsible for supervising smoke breaks were re-educated on the revised smoking policy by the Director of Nursing Services, licensed nurses and Administrator on 4/24/12 and 4/25/12. The smoking policy was once again</td>
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clothing; 2) new marks on skin or change in skin condition; 3) embers on clothing; 4) difficulty in handling lit cigarettes; 5) changes in smoking behavior; and 6) any other observation that causes concern or is perceived by staff to be an unsafe practice. Staff interviews confirmed sound knowledge of the facility's expectations regarding supervised smoke breaks for the residents, observation during the smoke breaks, accountability for the smoking materials, and whom to report unsafe smoking practices.

4.) Verifying the smoking residents' care plans and Certified Nurse Assistants care cards had been updated to reflect the safety needs for resident's who smoke, including the use of smoking aprons on resident #78 as indicated by the Safe Smoking Evaluation assessments.

Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a Plan of Correction.

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.

revised to better clarify assessments and information as it relates to supervised and independent smokers. Supervised smokers, independent smokers and facility staff were re-educated on 4/26/12 by nursing management on the current smoking policy revisions and smoking contract for independent smokers. Staff education on the current smoking policy was completed by nursing management on 4/29/12.

The Director of Nursing Services, Staff Development Coordinator and RN Supervisor were re-educated on 4/24/12 by the Regional Director of Clinical Operations regarding smoking evaluations upon admission, quarterly and significant change. They were also re-educated on proper completion and use of the smoking evaluation.

Licensed Nursing Staff were re-educated on 4/24/12-4/26/12, and completed on 4/29/12, regarding smoking assessments upon admission, quarterly and significant change. They were also re-educated on proper completion and use of the smoking evaluation.
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<td>Continued From page 9 clothing; 2) new marks on skin or change in skin condition; 3) embers on clothing; 4) difficulty in handling lit cigarettes; 5) changes in smoking behavior; and 6) any other observation that causes concern or is perceived by staff to be an unsafe practice. Staff interviews confirmed staff knowledge of the facility’s expectations regarding supervised smoke breaks for the residents, observation during the smoke breaks, accountability for the smoking materials, and whom to report unsafe smoking practices.</td>
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<td>4. Verifying the smoking residents' care plans and Certified Nurse Assistant care cards had been updated to reflect the safety needs for the residents who smoke, including the use of smoking aprons on resident #75 as indicated by the Safe Smoking Evaluation assessments. Non-Compliance continues at a &quot;D&quot; level for monitoring corrective actions. The facility is required to submit a Plan of Correction.</td>
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<td>F 280</td>
<td>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.</td>
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<td>SS=ES</td>
<td>All resident smokers were re-educated on the revised smoking policy by the Director of Nursing Services on 4/25/12 and upon further review with state surveyors and the request for clarification the policy was once again revised to better clarify assessments and information as it relates to supervised and independent smokers and was presented to the residents that smoke on 4/26/12. All staff responsible for supervising smoke breaks were re-educated by Director of Nursing, licensed nurse and Nursing Home Administrator on 4/24/12 and 4/25/12 and completed on 4/29/12, on how to monitor for safety of residents during smoke breaks including but not limited to observations of holes in clothes, new marks on skin or change in skin condition, embers on clothing, difficulty in handling lit cigarettes, changes in smoking behavior, or any other observation that causes concern or deemed by staff to be an unsafe practice. Any of these observations will be immediately reported to the charge nurse. The Charge Nurse will report the concern to the Director of Nursing Services/Nursing Home.</td>
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1. clothing; 2) new marks on skin or change in skin condition; 3) embers on clothing; 4) difficulty in handling lit cigarettes; 5) changes in smoking behavior; and 6) any other observation that causes concern or is perceived by staff to be an unsafe practice. Staff interviews confirmed sound knowledge of the facility's expectations regarding supervised smoke breaks for the residents, observation during the smoke breaks, accountability for the smoking materials, and whom to report unsafe smoking practices.

4.) Verifying the smoking residents’ care plans and Certified Nurse Assistants care plans had been updated to reflect the safety needs for resident’s who smoke, including the use of smoking aprons on resident #75 as indicated by the Safe Smoking Evaluation assessments.

Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a Plan of Correction.

F 280 SS=E

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.

Administrator for further review and action if deemed necessary.

Staff absent from the facility during education/re-education will be educated/re-educated upon their return to the facility. New staff will be educated during new hire orientation.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

4. On 4/25/12, The Director of Nursing Services, or designee, began auditing each new admission of residents who smoke to ensure smoking evaluation has been completed. The audit will continue for three months.

The Director of Nursing Services, or designee, will audit the smoking evaluation tool used by the staff member that supervises smoke breaks weekly for one month and monthly for two months to ensure the audits are completed.
Continued from page 9:
clothing; 2) new marks on skin or change in skin condition; 3) embers on clothing; 4) difficulty in handling lit cigarettes; 5) changes in smoking behavior; and 6) any other observation that causes concern or is perceived by staff to be an unsafe practice. Staff interviews confirmed sound knowledge of the facility's expectations regarding supervised smoke breaks for the residents, observation during the smoke breaks, accountability for the smoking materials, and whom to report unsafe smoking practices.

4.) Verifying the smoking residents' care plans and Certified Nurse Assistants' care cards had been updated to reflect the safety needs for resident's who smoke, including the use of smoking aprons on resident #75 as indicated by the Safe Smoking Evaluation assessments.

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,

The Administrator or designee will monitor resident smoke breaks for safety and supervision one smoke break per day times five days per week for two weeks, three times per week for two weeks and weekly for two months, beginning 4/25/12.

The Administrator and Director of Nursing Services will report findings of audits and observations in the monthly Performance Improvement meeting for three months for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.

5/8/12
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER

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

32 MEMORIAL DRIVE

WINCHESTER, TN 37398

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**F280**

How the corrective action will be accomplished for those issues identified by the deficient practice.

1. On April 24, 2012 the licensed nurse completed a smoking evaluation for Resident # 76 and updated the care plan and care card to reflect the need for a smoking apron during smoke breaks.

On April 25, 2012, the Social Services Director updated the post form with resident # 51’s spouse to reflect the change in code status to match the physician order. On
Continued From page 10

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 medical record review, facility investigation, observation, and interview, the facility failed to evaluate and revise the care plan to reflect the resident's current status for five (#76, #51, #30, #39, #28) of forty residents reviewed.

The findings included:

Resident #76 was admitted to the facility on May 16, 2011, with diagnoses including Hemiplegia (weakness on one side), Osteoarthritis, Diabetes, and Anxiety.

Medical record review of the Minimum Data Set (MDS) dated March 12, 2012, revealed the resident was cognitively intact, and was unable to use the right upper extremity.

Medical record review of the Care Plan Initiated September 24, 2011, revealed "...smokes cigarettes and is found to be safe with smoking...observe for burn holes in clothes..."

Observation on April 24, 2012, at 10:50 a.m., in the designated smoking area outside, revealed resident #76 sitting in a wheelchair holding a lit
Continued From page 11
cigarette in the left hand. Continued observation
revealed resident #76 dropped the cigarette,
hitting the upper right thigh, and landed on the
ground.

Interview with the Central Supply Specialist,
supervising the residents, on April 24, 2012, at
10:55 a.m., outside in the designated smoking
area, confirmed the following: 1) the resident
dropped cigarettes frequently; and 2) the staff
were aware the resident dropped cigarettes.

Interview with the Care Plan Coordinator on April
25, 2012, at 2:30 p.m., in the nurse's station,
confirmed the Interdisciplinary Care Plan initiated
September 24, 2011, had not been updated or
revised to reflect interventions for the resident
dropping cigarettes or burn holes in the resident's
clothing.

Resident #51 was readmitted to the facility on
April 10, 2012, with diagnoses including
Pneumonitis, Diabetes Mellitus, Dementia, and
Dysphagia.

Medical record review of the Interdisciplinary
Care Plan revised March 2, 2012, revealed
"...resident desires CPR (cardiopulmonary
resuscitation)..."

Medical record review of Physician Orders dated
April 10, 2012, revealed "...DNR (Do Not
Resuscitate)"

Interview with Licensed Practical Nurse on April
25, 2012, at 9:32 a.m., in the nurse's station,
confirmed the resident's spouse verified the DNR
status on readmission and the Post Form had not
new approaches and interventions.
The previous skin tear was
addressed on the care plan and care
card.

How the facility will identify other
residents having the potential to be
affected by the same deficient
practice.

2. On April 26, 2012, the Clinical Case
Manager, the MDS nurse, and
nursing management audited all
other current resident medical
records for accuracy with residents
having a fracture diagnosis,
smoking safety, Plavix and Aspirin
therapy, and skin conditions related
care plans and care cards. No
other issues were found.

The Social Services Director audited
all resident medical records for
correct code status. The two
medical records with code status
concerns had family contacted by
the SSD on 4/26/12 and were
corrected on May 7, 2012.

What measure will be put in place or
systemic changes made to ensure that
the deficient practice will not recur.

3. On April 26, 2012, the Clinical Case
Manager and the MDS Coordinator
Continued From page 12

Interview with the Director of Nursing on April 24, 2012, at 9:30 a.m., in the nurse's station confirmed the Interdisciplinary Care Plan had not been updated or revised to reflect the change in the code status.

Resident #30 was readmitted to the facility on December 21, 2011, with diagnoses including Paranoid Schizophrenia, Stage Four Decubitus, Diabetes, Cerebral Palsy, and Osteoporosis.

Medical record review of the Minimum Data Set (MDS) dated February 19, 2012, revealed the resident required total assistance with all Activities of Daily Living (ADL) except eating, was non-ambulatory, and had no fractures.

Review of a facility investigation revealed on April 10, 2012, the Certified Nurse Assistant (CNA)'s found a grapefruit sized knot on the resident's right upper thigh. Continued review revealed the physician was notified and x-rays were ordered and completed. Medical record review of an x-ray report dated April 10, 2012, revealed "...displaced healing fracture of the distal right femur (thigh bone) with osteoporosis...". Continued review of the facility investigation revealed the Nurse Practitioner (NP) was notified by Licensed Practical Nurse #1, and a new order for an immobilizer to be applied to the right leg for six weeks.

Medical record review of the resident's current Care plan last revised on April 23, 2012, revealed no problems or approaches to provide care for the fractured thigh bone and care for the were re-educated by the Nursing Home Administrator and the other licensed nurses were re-educated by nursing management regarding timely updating, care plans, and care cards to correctly indicate resident care.

Staff absent from the facility during education/re-education will be educated/re-educated upon their return to the facility. New staff will be educated during new hire orientation.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

4. Audits of 10 care plans and care cards will be completed by nursing management weekly for 2 weeks, and monthly for two months. The Director of Nursing Services will report findings of audits and observations in the monthly Performance Improvement meeting for three months for further recommendation and/or suggestions and follow-up as needed. The Performance Improvement committee consists of the Administrator, Director of Nursing.
<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LCS Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 13 immobilizer to prevent further injury.</td>
<td>F 280</td>
<td>Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.</td>
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<td></td>
<td>Interview on April 26, 2012, at 9:56 a.m., in the MDS office with the Clinical Care Coordinator-Skilled confirmed the resident had fractured the thigh bone and the care needs for the fracture and care for the immobilizer were not addressed on the resident's Care Plan.</td>
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<td></td>
<td>Resident #39 was admitted to the facility with diagnoses including Cerebral Vascular Accident (stroke), Seizure Disorder, and Hemiplegia (one side of the body weak from the stroke)</td>
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<td>Medical record review of the April 2012, Medication Administration Record (MAR) revealed the resident received Aspirin EC (Enteric Coating dissolves in the intestine versus the stomach) (Aspirin and Plavix keeps blood from clotting) 81 mg (milligram) and Plavix (Clopidogrel) 75 mg daily for the month of April 2012.</td>
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<td>Medical record review of the Consultation Report (pharmacy) dated April 16, 2012, revealed &quot;...receives aspirin and Clopidogrel (Plavix) concomitantly (continuously together)...(patients have a higher risk of moderate-to-severe bleeding events...&quot; In the reply area, the Physician chose to continue the medications as ordered.</td>
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<td>Observation and interview on April 24, 2012, at 9:00 a.m., with the resident in the dining room, revealed a quarter size bruise on the left hand.</td>
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<td>Interview with the resident at that time revealed the resident was not sure how the bruise happened and frequently bumps the hands and</td>
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F 280 | Continued From page 14
bruises easily.

Medical record review of the resident’s current Care Plan revised on October 26, 2011, revealed no problems or approaches to address bruising and other symptoms of bleeding with the aspirin and Plavix combination.

Interview with the Clinical Care Coordinator-Skilled on April 25, 2012, at 11:30 a.m., at the nurse’s desk confirmed the resident received aspirin and Plavix per physician’s orders, and the Coordinator was unaware of the Pharmacist’s Recommendations. Continued interview revealed the system to alert the Coordinator of any changes in the residents is provided in the morning clinical meeting. Continued interview revealed this would include the Pharmacist’s Recommendations. Continued interview confirmed the resident’s Care Plan did not have approaches to address the risk of bleeding/bruising.

Resident #28 was admitted to the facility on August 7, 2010, with diagnoses including Alzheimer’s Dementia, Diabetes, Anemia, and Chronic Kidney Disease.

Medical record review of the Change of Condition Documentation dated April 16, 2012, 6:30 a.m., revealed "...resident combative while CNAs (Certified Nurse Assistant) were cleaning BM (Bowel Movement) off (resident) and changing...gown-grabbing out at CNA and hit arm on side rails causing skin tear approx. 1" (inch) long on LFA-(left forearm) cleansed with wound cleanser and steri-strips 4 applied..."
<table>
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<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 15</td>
<td>Medical record review of Physician's Order dated April 16, 2012, revealed &quot;...steri strips to left forearm skin tear. Monitor wound q (every) shift for signs and sx (symptoms) of infection...&quot; Medical record review of the resident's current Care Plan revised on April 13, 2012, revealed &quot;...attempts to hit at staff during care, medications and finger sticks...skin tear to right hand...&quot; Medical record review of a nursing assessment dated April 23, 2012, revealed the resident had a skin tear on the left forearm. Observation of the resident on April 23, 2012, at 1:30 p.m., in the resident's room, revealed a healing skin tear approximately 1 inch long on the resident's left forearm. Interview and record review with the Clinical Care Coordinator-Skilled on April 25, 2012, at 11:30 a.m., at the nurse's desk revealed the Clinical Care Coordinator-Skilled was unaware of the Change of Condition Documentation on April 16, 2012, and that the resident had a skin tear on the left forearm...&quot; Continued interview confirmed the resident's Care Plan addressed the old skin tear on the right hand but had no problem or approaches to address the skin tear on the left forearm.</td>
<td>F 323</td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, observation, and interview, the facility failed to supervise, and failed to provide clothing protection/assistive devices for one resident known to drop lit cigarettes (#76); and failed to follow the facility’s smoking policy for one resident (#120) of seven residents identified as smokers.

The facility’s failure placed resident #76, in Immediate Jeopardy (situation in which a provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death).

The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified of the Immediate Jeopardy on April 25, 2012, at 1:30 p.m., in the Conference Room.

The findings included:
Resident # 76 was admitted to the facility on May 16, 2011, with diagnoses Hemiplegia (weakness on one side of the body), Osteoarthritis, Diabetes, and Anxiety.

Medical record review of the Minimum Data Set dated March 12, 2012, revealed the resident was cognitively intact, and had an impairment of the right upper extremity.

re-assessment resident #76 will continue to be a supervised smoker. Based on the fact that she dropped her cigarette during the 1:30 pm smoke break and the fact that the C.N.A. stated she was not ”acting as usual” as well as the fact that the wind was blowing profusely and she had apparent ashes on her shirt that contained no embers, the CNA that was in charge of the smoking activity immediately reported the incident to the charge nurse. The charge nurse immediately reported the incident to the Director of Nursing Services who immediately reported the incident to the Administrator. Immediately following the incident the resident was re-assessed and as a result a smoking apron was implemented, care plan and care plan updated.

This resident’s care plan and C.N.A. care card was updated by licensed nurse to reflect the need for a smoking apron during smoke breaks on 4/24/12 and was implemented for the very next smoke break at 3:30pm on 4/24/12.

The family was notified by the Administrator on the morning of 4/25/12 that the resident would
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<tr>
<th>(X4) ID PREFIX TAG</th>
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| F 323               | Continued From page 17  
|                     | Medical record review of the Care Plan initiated September 24, 2011, revealed "...smokes cigarettes and is found to be safe with smoking...observe for burn holes in clothes...will continue to exhibit safe smoking habits."  
|                     | Medical record review of the Safe Smoking Evaluation dated February 14, 2012, revealed "...can light, hold and extinguish smoking materials...personal belongings free from evidence of burn holes...history free from smoking related incidents..."  
|                     | Review of the facility's Smoking Policy (undated) revealed "...residents are permitted to smoke, supervised."  
|                     | Observation on April 24, 2012, at 10:15 a.m., in the television room, revealed Resident #76 sitting in a wheelchair with cigarette ashes (black and white debris) on the resident's shirt, on the upper right arm.  
|                     | Observation on April 24, 2012, at 10:50 a.m., in the designated smoking area outside, revealed resident #76 sitting in a wheelchair holding a lit cigarette in the left hand. Continued observation revealed resident #76 dropped the cigarette, the lit cigarette hit the upper right thigh, and landed on the ground. Further observation at this time revealed resident #102 picked up the cigarette and handed it to resident #76.  
|                     | Interview with the Central Supply Specialist, supervising the residents, on April 24, 2012, at 10:55 a.m., outside in the designated smoke area, confirmed the following: 1) the resident dropped cigarettes frequently; 2) the staff were require a smoking apron during smoke breaks.  

The family was educated by the Administrator on the morning of 4/25/12 regarding the location of smoking apron if they chose to supervise her smoking during visits. The MD was notified by the licensed nurse on 4/24/12 that the resident would require a smoking apron during smoke breaks. Resident #76 had a skin assessment completed by the Director of Nursing Services on 4/24/12, with no skin break down, no new marks on skin, no change in condition and no apparent burns noted to skin. A clothing audit was completed for this smoker on 4/24/12 by nursing management to identify clothing with possible holes. This smoker did have noted holes in a few items of her clothing. Staff could not determine if the holes noted were from ember burns, or normal wear and tear due to laundering and use and a list was developed listing the clothes with holes as part of the assessment process. This resident was discharged from the center to the hospital for an unrelated illness on 4/25/12. The resident returned from the hospital.
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<tr>
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<tr>
<td>F 323</td>
<td>Continued From page 18 aware the resident dropped cigarettes; 3) the residents were to be supervised during smoke breaks; and 4) the Central Supply Specialist did not witness resident #76 dropping the cigarette due to assisting another resident.</td>
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Interview with the Central Supply Specialist on April 24, 2012, at 5:35 p.m., in the Nurse's Station, confirmed the resident dropped cigarettes and had witnessed the resident dropping cigarettes at least two times each smoke break. Continued interview at this time confirmed smoke aprons were available and were not used for resident #76 and the nursing staff had been informed the resident dropped cigarettes frequently.

Interview with Certified Nurse Aide (CNA) #1 on April 24, 2012, at 5:38 p.m., in the 300 hallway, confirmed the resident had dropped cigarettes and had witnessed the resident dropping cigarettes when CNA #1 was assigned to supervise smokers and the nursing staff had been informed.

Interview with Licensed Practical Nurse (LPN) #1 on April 24, 2012, at 5:45 p.m., in the nurse's station, confirmed LPN #1 had supervised smoking, and was aware resident #76 had dropped cigarettes while smoking.

Interview with LPN #2 on April 24, 2012, at 5:35 p.m., confirmed LPN #2 completed the Safe Smoking Evaluation for resident #76, on April 24, 2012. The evaluation revealed "...can light, hold, and extinguish smoking materials...personal belongings free from burn holes...history free from smoking related incidents...", and confirmed on 4/28/12 and was re-admitted to the facility. The resident had a smoking evaluation completed by the licensed nurse upon re-admission. The results of the evaluation is that the resident requires supervised smoking with use of smoking apron.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

2. Six of the seven total smokers were re-assessed using the smoking evaluation by a licensed nurse while personally observing these residents smoking a cigarette on 4/24/12. The seventh smoker who did not attend another smoke break on 4/24/12 was re-assessed using the smoking evaluation by a licensed nurse while personally observing this resident smoking a cigarette on 4/25/12 during the first smoke break she attended.

A chart audit of all other smokers was conducted by the Director of Nursing Services and MDS Nurses on 4/24/12 to ensure all smoking care plans and C.N.A. care cards were updated to reflect any changes identified in the newly completed re-assessments.
Staff members responsible for taking residents out for supervised smoking were interviewed by the administrator and through the investigation there has been no staff member that has physically witnessed any resident that smokes burn a hole in clothing or obtain burns on the skin or any other body part.

A clothing audit was completed for all other smokers by nursing management to identify any other clothing with possible holes on 4/25/12. One other smoker did have noted holes in her clothing. Staff could not determine if the holes noted were from ember burns, or normal wear and tear due to laundering and use. At this evaluation, the resident was deemed to need supervised smoking and smoking apron.

A list of smoking residents including any devices deemed necessary continues to be provided in the box that contains the smoking materials and has been updated to reflect any changes related to the re-assessment of smoking residents.
F 323 Continued From page 20
Station...scheduled times 8:30 a.m., 10:30 a.m., 1:30 p.m., 3:30 p.m., 6:30 p.m., 8:30 p.m..."

Observation on April 24, 2012, at 10:50 a.m., in the designated smoke area, revealed resident #120 with a pack of cigarettes in the resident's back pocket of the pants.

Observation on April 25, 2012, at 9:30 a.m., in the designated smoke area outside, revealed the resident smoking a cigarette unsupervised.

Interview with resident #120 on April 24, 2012, at 10:50 a.m., confirmed the staff allowed the resident to keep cigarettes; the resident smoked without supervision; and the staff provided a lighter during unsupervised smoking.

Interview with the Nursing Home Administrator (NHA) on April 25, 2012, at 11:09 a.m., in the Conference Room, confirmed the facility had not implemented any interventions to prevent resident #76 from burning clothing/self, and resident #120 had been allowed to keep cigarettes and smoke unsupervised.

Interview with the NHA on April 25, 2012, at 1:30 p.m., in the Conference Room, confirmed the facility failed to follow the facility policy on smoking.

The Immediate Jeopardy was effective from April 24, 2012, through April 25, 2012, and was removed on April 25, 2012. An acceptable Allegation of Compliance, which removed the immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on April 26, 2012, through review of

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

3. The Administrator revised the center smoking policy on 4/25/12 to reflect current facility practice and upon further review with state surveyors and the request for clarification the policy was once again revised to clarify assessments and information as it relates to supervised and independent smokers on 4/26/12. All staff responsible for supervising smoke breaks were re-educated on the revised smoking policy by the Director of Nursing Services, licensed nurses and Administrator on 4/24/12 and 4/25/12. The smoking policy was once again revised to better clarify assessments and information as it relates to supervised and independent smokers. Supervised smokers, independent smokers, and facility staff was re-educated on 4/26/12 by nursing management on the current smoking policy revisions and smoking contract for independent smokers. Staff education on the current smoking policy was completed by nursing management on 4/29/12.
<table>
<thead>
<tr>
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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 21 facility documents, staff interviews, and observations. The survey team verified the</td>
<td>F 323</td>
<td>The Director of Nursing Services, Staff Development Coordinator and RN Supervisor were re-educated on</td>
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<td>allegation of compliance by:</td>
<td></td>
<td>4/24/12 by the Regional Director of Clinical Operations regarding smoking evaluations upon admission,</td>
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<td></td>
<td>1.) Verifying resident #76 had been reassessed, and the Safe Smoking Evaluation revised to accurately reflect</td>
<td></td>
<td>quarterly and significant change. They were also re-educated on proper completion and use of the smoking</td>
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<td>the resident's unsafe smoking habits; and verifying the other residents who smoke at the facility had accurate</td>
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<td>evaluation.</td>
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<td>Safe Smoking Evaluations. Accuracy of the Safe Smoking assessments were confirmed by the survey team through</td>
<td></td>
<td>Licensed Nursing Staff were re-educated on 4/24/12-4/26/12, and completed on 4/29/12, regarding smoking</td>
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<td>observation during smoking sessions and supervised inspection of the resident's wardrobe for burn holes in</td>
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<td>assessments upon admission, quarterly and significant change. They were also re-educated on proper</td>
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<td>clothing.</td>
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<td>completion and use of the company smoking evaluation.</td>
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<td>2.) Verifying resident #120 had been educated on the facility's revised policy including the storage of all</td>
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<td>All resident smokers were re-educated on the revised smoking policy by the Director of Nursing Services on</td>
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<td>smoking materials to be kept at the nurse's station. The survey team verified the information with resident</td>
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<td>4/25/12 and upon further review with state surveyors and the request for clarification the policy was</td>
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|              | #120 through observation and interview on April 26, 2012.                                                      |              | once again revised to better clarify assessments and information as it relates to supervised and independent 
|              |                                                                                                               |              | smokers and was presented to the residents that smoke on 4/26/12.                                        |
|              | 3.) Verifying the revision of the facility's policy, titled, Smoking, with an effective date of April 26, 2012,   |              | All staff responsible for supervising smoke breaks were re-educated by                                       |
|              | the Smoking Contract for Independent Smokers, and the facility's addendum to the Smoking policy, individualized  |              |                                                                                                              |
|              | to the center's specific practices to ensure the safe smoking environment for all smokers.                      |              |                                                                                                              |
|              | 4.) Verification by the survey team on April 26, 2012, ensured by interviews with multidisciplinary staff, and   |              |                                                                                                              |
**F 323**  Continued From page 22

Deemed unsafe, designated smoking areas, designated smoking times, and how to monitor for safety during smoke breaks including but not limited to: 1) observation of holes in the resident's clothing; 2) new marks on skin or change in skin condition; 3) embers on clothing; 4) difficulty in handling lit cigarettes; 5) changes in smoking behavior; and 6) any other observation that causes concern or is perceived by staff to be an unsafe practice. Staff interviews confirmed sound knowledge of the facility's expectations regarding supervised smoke breaks for the residents, observation during the smoke breaks, accountability for smoking materials, and whom to report unsafe smoking practices.

5. Verifying the smoking residents' care plans and certified Nurse Assistants care cards had been updated to reflect the safety needs for resident's who smoke, including the use of smoking aprons on resident #76 as indicated by the Safe Smoking Evaluation assessments.

Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a *Plan of Correction*.

483.35(f) *FOOD PROCUREMENT, 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

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**F 323**

Director of Nursing, licensed nurse and Nursing Home Administrator on 4/24/12 and 4/25/12 and completed on 4/29/12, on how to monitor for safety of residents during smoke breaks including but not limited to observations of holes in clothes, new marks on skin or change in skin condition, embers on clothing, difficulty in handling lit cigarettes, changes in smoking behavior, or any other observation that causes concern or deemed by staff to be an unsafe practice. Any of these observations will be immediately reported to the charge nurse. The Charge Nurse will report the concern to the Director of Nursing Services/Nursing Home Administrator for further review and action if deemed necessary.

Staff absent from the facility during education/re-education will be educated/re-educated upon their return to the facility. New staff will be educated during new hire orientation.

*How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.*
4. On 4/25/12, The Director of Nursing Services, or designee, began auditing each new admission of residents who smoke to ensure smoking evaluation has been completed. The audit will continue for three months.

The Director of Nursing Services, or designee, will audit all smoking evaluations weekly for one month and monthly for two months to ensure the audits are completed.

The Administrator or designee will monitor resident smoke breaks for safety and supervision one smoke break per day times five days per week for two weeks, three times per week for two weeks and weekly for two months, beginning 4/25/12.

The Administrator and Director of Nursing Services will report findings of audits and observations in the monthly Performance Improvement meeting for three months for further recommendation and/or suggestions and follow-up as needed. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director,
F 323 | Continued From page 22
| deemed unsafe, designated smoking areas, designated smoking times, and how to monitor for safety during smoke breaks including but not limited to; 1) observation of holes in the resident's clothing; 2) new marks on skin or change in skin condition; 3) embers on clothing; 4) difficulty in handling lit cigarettes; 5) changes in smoking behavior; and 6) any other observation that causes concern or is perceived by staff to be an unsafe practice. Staff interviews confirmed sound knowledge of the facility's expectations regarding supervised smoke breaks for the residents, observation during the smoke breaks, accountability for the smoking materials, and whom to report unsafe smoking practices.
5.) Verifying the smoking residents' care plans and Certified Nurse Assistants care cards had been updated to reflect the safety needs for resident's who smoke, including the use of smoking aprons on resident #76 as indicated by the Safe Smoking Evaluation assessments.
Non-Compliance continues at a "D" level for monitoring corrective actions. The facility is required to submit a Plan of Correction.

F 371 | 483.36(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

F 371 | How the corrective action will be accomplished for those issues identified by the deficient practice.

1. The ground meat was removed from the sink to the cooler by the nutrition aide on 4/24/12. The cornbread was removed from the area by the nutrition Services Manager on 4/24/12 and discarded.
This REQUIREMENT is not met as evidenced by:

Based on observation and interview, the facility failed to maintain proper sanitary preparation and storage of foods in the Dietary Department.

The findings included:

Observation on April 24, 2012, at 11:45 a.m., in the Dietary Department, revealed three 10 pound packages of frozen hambuger meat, wrapped in plastic, in a metal pan, in the handwash sink, and the water running over the hamburger meat.

Observation on April 24, 2012, at 11:57 a.m., in the Dietary Department, revealed a round metal pan with cornbread, partially covered with foil, and stored next to the handwash sink.

Observation on April 24, 2012, at 11:57 a.m., in the Dietary Department, revealed Dietary Aides #1 placed the hamburger meat in the cooler, washed the hands in the sink, and cleaned the sink with bleach.

Observation on April 24, 2012, at 12:02 p.m., in the Dietary Department, revealed the Dietary Manager washed the hands, and shook the water off the hands, with the partially covered cornbread present.

Interview with the Dietary Manager on April 24, 2012, at 12:05 p.m., in the Dietary Department, confirmed the hamburger meat had been thawing in the handwash sink, the cornbread was stored next to the handwash sink, and the food was not

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<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Provider's Plan of Correction</th>
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<td>F371</td>
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How the facility will identify other residents having the potential to be affected by the same deficient practice.

2. On April 24, 2012, the Nutritional Services Manager designated the sink as a food preparation sink. The Nutrition Service Manager/Maintenance Director removed all hand washing supplies from the immediate area: i.e. soap, towels, and hand washing instruction sheet and installed a sign designating the sink as food preparation.

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

3. On April 24, 2012 the Regional Dietician re-educated the Nutritional Services Manager on appropriate hand washing techniques and use of food preparation sink. On April 24, 2012 and April 25, 2012, cooks and dietary aides were re-educated by the Nutrition Services Manager and Registered Dietitian on appropriate hand washing techniques and that the sink is designated for food preparation. Two other available sinks within the department will be utilized by the dietary staff for hand washing.
Staff absent from the facility during education/re-education will be educated/re-educated upon their return to the facility. New staff will be educated during new hire orientation.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

4. Audits of the food prep sink and hand washing sinks will be completed by the Nutrition Services Manager or the Registered Dietitian three times per week for two weeks, weekly for 2 weeks, and monthly for two months. The Nutrition Services Manager will report findings of audits and observations in the monthly Performance Improvement meeting for three months for further recommendation and/or suggestions and follow-up as needed. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities...
<table>
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<th>Prefix Tag</th>
<th>Description</th>
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<td>F 371</td>
<td>Continued From page 24 prepared or stored in a sanitary manner.</td>
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<tr>
<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS. 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.</td>
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- (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 371     Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.

5/8/11

F 441

How the corrective action will be accomplished for those issues identified by the deficient practice.

1. On April 23, 2012, resident #15 was assessed by the licensed nurse and there was no negative outcome. LPN #3 was immediately re-educated on April 23, 2012 regarding the use of gloves while administrating injections by the Director of Nursing Services.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

2. On April 23, 2012 and April 24, 2012, Nursing management observed administration of insulin...
This REQUIREMENT is not met as evidenced by:
Based on observation, facility policy review, and interview, the facility failed to apply gloves prior to administering insulin injections for one resident (#15) of forty residents reviewed.

The findings included:
Observation on April 23, 2012, at 4:00 p.m., revealed Licensed Practical Nurse (LPN) #3 administered an insulin injection to resident #15 with ungloved hands.

Review of the facility's policy, Universal Precautions, revised February 2011 revealed "...Gloves - should be worn when contact with blood...is anticipated..."

Interview on April 23, 2012, at 4:00 p.m., with LPN #3, at the time of the observation, revealed gloves are to be worn when there is potential contact with blood or body fluids, and confirmed gloves were not worn when the insulin injection was administered to the resident.

Interview on April 25, 2012, at 11:23 a.m., with the Regional Director of Clinical Operations, in the conference room, confirmed gloves should be worn with all injections.

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of laboratory work ordered by licensed practitioners.

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

3. Re-education of licensed nurses was completed on 4/29/12 by the Director of Nursing Service and nursing management regarding the use of gloves during administering of injections.

Staff absent from the facility during education/re-education will be educated/re-educated upon their return to the facility. New staff will be educated during new hire orientation.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

4. Audits of medication being administered by injection will be completed by nursing management by observing 5 injections three times per week for two weeks, weekly for 2 weeks, and monthly thereafter.
This REQUIREMENT is not met as evidenced by:

Based on observation, facility policy review, and interview, the facility failed to apply gloves prior to administering insulin injections for one resident (#15) of forty residents reviewed.

The findings included:

Observation on April 23, 2012, at 4:00 p.m., revealed Licensed Practical Nurse (LPN) #3 administered an insulin injection to resident #15 with ungloved hands.

Review of the facility’s policy, Universal Precautions, revised February 2011 revealed "...Gloves - should be worn when contact with blood...is anticipated..."

Interview on April 23, 2012, at 4:00 p.m., with LPN #3, at the time of the observation, revealed gloves are to be worn when there is potential contact with blood or body fluids, and confirmed gloves were not worn when the insulin injection was administered to the resident.

Interview on April 25, 2012, at 11:23 a.m., with the Regional Director of Clinical Operations, in the conference room, confirmed gloves should be worn with all injections.

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness for two months. The Director of Nursing Services will report findings of audits and observations in the monthly Performance Improvement meeting for three months for further recommendation and/or suggestions and follow-up as needed. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility policy review, and interview, the facility failed to apply gloves prior to administering insulin injections for one resident (#15) of forty residents reviewed.

The findings included:

Observation on April 23, 2012, at 4:00 p.m., revealed Licensed Practical Nurse (LPN) #3 administered an insulin injection to resident #15 with ungloved hands.

Review of the facility's policy, Universal Precautions, revised February 2011 revealed "...Gloves - should be worn when contact with blood...is anticipated..."

Interview on April 23, 2012, at 4:00 p.m., with LPN #3, at the time of the observation, revealed gloves are to be worn when there is potential contact with blood or body fluids, and confirmed gloves were not worn when the insulin injection was administered to the resident.

Interview on April 25, 2012, at 11:23 a.m., with the Regional Director of Clinical Operations, in the conference room, confirmed gloves should be worn with all injections.

F 502. How the corrective action will be accomplished for those issues identified by the deficient practice.

1. The licensed nurse notified the physician of Resident # 97's lab work on April 25, 2012. The physician gave no new orders.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

F 502. An audit of all lab orders and transcription to the electronic medical record was completed on April 26, 2012 by nursing management on the current active
Continued From page 25
the services.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, the facility failed to obtain lab work timely for one resident (#97) of forty residents reviewed.

The findings included:

Resident #97 was readmitted to the facility on March 12, 2011, with diagnoses including Orthostatic Hypotension, Hypertension, and Hypothyroidism.

Medical record review of lab work included a blood test for T4 and TSH (lab for the thyroid) dated December 30, 2011, revealed a physician order "...repeat lab work in 6 weeks..."

Medical record review revealed no T4 and TSH was obtained until April 18, 2012.

Interview with the Director of Nursing (DON) on April 25, 2012, at 11:00 a.m., in the DON office, confirmed the facility failed to obtain the lab timely.

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

F 502

resident medical records and found no additional lab and transcription issues noted from 1/1/12 to 4/26/12.

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

3. Re-education for the licensed nurses was completed by the Director of Nursing Service and Nursing Management on April 29, 2012 for transcribing physicians’ orders to the electronic medical record to assure completion of the orders.

Staff absent from the facility during education/re-education will be educated/re-educated upon their return to the facility. New staff will be educated during new hire orientation.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

4. Audits of all physician lab transcriptions will be completed by nursing management five times per week for two weeks, weekly for 2 weeks, and monthly for two months. The Director of Nursing Services
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER: 445319

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED: 04/26/2012

NAME OF PROVIDER OR SUPPLIER

WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
32 MEMORIAL DRIVE
WINCHESTER, TN 37398

(X4) ID TAG
PREFIX

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

ID TAG
PREFIX

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 502
Continued From page 26
of the services.

This REQUIREMENT is not met as evidenced
by:

Based on medical record review and interview,
the facility failed to obtain lab work timely for one
resident (#97) of forty residents reviewed.

The findings included:

Resident #97 was readmitted to the facility on
March 12, 2011, with diagnoses including
Orthostatic Hypotension, Hypertension, and
Hypothyroidism.

Medical record review of lab work included a
blood test for T4 and TSH (lab for the thyroid)
dated December 30, 2011, revealed a physician
order "...repeat lab work in 6 weeks..."

Medical record review revealed no T4 and TSH
was obtained until April 18, 2012.

Interview with the Director of Nursing (DON) on
April 25, 2012, at 11:00 a.m., in the DON office,
confirmed the facility failed to obtain the lab
timely.

F 514
463.75(1)(1) RES
SS=D

RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each
resident in accordance with accepted professional
standards and practices that are complete;
accurately documented; readily accessible; and
systematically organized.

F 514
How the corrective action will be
accomplished for those issues
identified by the deficient practice.

1. On April 25, 2012, the Social
Services Director reviewed the post
form with the Resident #51 and his
Continued From page 27

The clinical record must contain sufficient information to identify the resident; a record of the resident’s assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, the facility failed to ensure the medical record was accurate for one resident (#51) of forty residents reviewed.

The findings included:

Resident #51 was readmitted to the facility on April 10, 2012, with diagnoses including Pneumonitis, Diabetes Mellitus, Dementia, and Dysphagia.

Medical record review of the Post Form dated March 2, 2012, revealed the resident was a full code.

Medical record review of the Interdisciplinary Care Plan revised March 2, 2012, revealed "...resident desires CPR (cardiopulmonary resuscitation)...

Medical record review of the Physician Orders dated April 10, 2012, revealed "...DNR (Do Not Resuscitate)..."

Interview with Licensed Practical Nurse #1 on April 25, 2012, at 9:32 a.m., in the nurse’s station revealed the resident’s spouse verified the DNR spouse. The Resident’s spouse signed the post form verifying the Resident # 51 is a “Do Not Resuscitate”. The care plan was updated on April 25, 2012 by the Social Services Director.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

On May 2, 2012, the Social Services Director completed an audit and found two medical records without an updated post form. On May 7, 2012, both post forms and care plans were updated by the Social Services Director.

All other post forms, physician orders and care plans were correct.

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

2. On April 26, 2012, the Social Services Director was re-educated by the Nursing Home Administrator and the licensed nurses were re-educated by nursing management regarding timely updating of post forms, physicians’ orders, care
plans, and care cards to correctly indicate resident choice.

Staff absent from the facility during education/re-education will be educated/re-educated upon their return to the facility. New staff will be educated during new hire orientation.

How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.

3. Audits of post forms, physician orders, care plans and care cards will be completed by the Social Services Director for all new admissions and re-admissions during the admission process five times per week for two weeks, weekly for 2 weeks, and monthly for two months. The Director of Nursing Services will report findings of audits and observations in the monthly Performance Improvement meeting for three months for further recommendation and/or suggestions and follow-up as needed. The Performance Improvement committee consists of the Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 28 status on readmission on April 10, 2012, and the Post Form had not been updated. Interview with the Social Service Director (SSD) on April 24, 2012, at 9:33 a.m., in the nurse's station, confirmed the SSD was unaware of the DNR status. Interview with the Social Service Director on April 24, 2012, at 10:00 a.m., in the nurse's station, confirmed the facility failed to update the Post Form on April 10, 2012, to reflect a change in the code status.</td>
<td>F 514 Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Admissions/Marketing Director, Environmental Services Director, Staff Development Coordinator, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator.</td>
<td>5/8/12</td>
<td></td>
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</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER

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

32 MEMORIAL DRIVE

WINCHESTER, TN 37398

**DATE SURVEY COMPLETED**

04/26/2012