**STANDARD OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLINIC IDENTIFICATION NUMBER: 445342</th>
</tr>
</thead>
</table>

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1550 NEW HIGHWAY 62
WESTMORELAND, TN 37186

**DATE SURVEY COMPLETED**
05/11/2011

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**NAME OF PROVIDER OR SUPPLIER**
WESTMORELAND CARE & REHAB CTR

**STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>(X4) 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-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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</table>
| F 309 SS=O         | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to follow physician orders for floating heels for 2 of 17 (Residents #1 and 12) sampled residents.

The findings included:
1. Medical record review for Resident #1 documented an admission date of 2/23/85 with a readmission date of 4/8/11 with diagnoses of Senile Dementia, Diabetes Mellitus, Macular Degeneration and Hemorrhages. Review of a physician's order dated 4/19/11 documented, "FLOAT HEELS WHILE IN BED - CHECK Q [every] SHIFT QD [daily]."

Observations in Resident #1's room on 5/9/11 at 11:25 AM, 2:30 PM and 5:00 PM and on 5/10/11 at 7:40 AM and 10:40 AM, revealed Resident #1 lying in bed with her heels not floating as ordered.

During an interview in Resident #1's room on 5/10/11 at 10:45 AM, Nurse #3 confirmed that Resident #1's heels were not floating.

Laboratory Director or Provider/Suppliers' Representative Signature:

**DATE**
05/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See instructions.) Except for nursing homes, the findings stated above are discernible 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discernible 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:
445342

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
05/11/2011

NAME OF PROVIDER OR SUPPLIER
WESTMORELAND CARE & REHAB CTR

STREET ADDRESS, CITY, STATE, ZIP CODE
1559 NEW HIGHWAY 52
WESTMORELAND, TN 37186

(X4) ID PREFIX TAG

(X5) COMPLETION DATE

F 309
Continued From page 1
2. Medical record review for Resident #12 documented an admission date of 2/23/03 with diagnoses of Anemia, Depressive Disorder, Esophageal Reflux, Pylonephritis, Acute Kidney Failure, Peripheral Vascular Disease, Dementia and Diabetes Mellitus. Review of the current physician's orders documented, "FLOAT HEELS ON BED WITH PILLOWS...QD Q SHIFT."

Observations in Resident #12's room on 5/9/11 at 4:30 PM and on 5/10/11 at 8:00 AM and 9:05 AM, revealed Resident #12's in bed with feet lying on a pillow, but not floating as ordered.

During an interview in Resident #12's room on 5/10/11 at 9:05 AM, Certified Nursing Assistants (CNAs) #4 and #5 confirmed Resident 12's heels were not floating.

F 309
Identification of the residents with potential to be affected:
A review of all current residents that require their heels to be floated will be performed by the DON and ADON by 5-26-11. All residents that require her heels to be floated will have their current plan of care updated to reflect the current needs of the resident. The Nursing Staff will be made aware of the current residents that require their heels to be floated by the Staff Development Coordinator by 5-27-11.

Measures to prevent recurrences:
An In-service was completed for the alleged deficient practice by the Staff Development Coordinator on 5-11-11. A follow-up in-service on how to correctly float resident's heels will be conducted by 5-31-11 by the Staff Development Coordinator to prevent future occurrences.

Monitoring:
The DON and the Nursing Management team will monitor for compliance weekly times 4 weeks and reported to QA for 3 months for recommendations and further follow-up as needed.

F 371
483.35) 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 policy review, observation and interview, it was determined the facility failed to maintain the temperature of hot foods on the steam table at or above 135 degrees Fahrenheit

F 371
Food Procedure,
Store/Prepare,
Serve-Sanitary

Immediate Interventions:
No residents were identified in this citation. Immediately upon identification of low food temperature, food was reheated to acceptable standards.
F 371  Continued From page 2
(F) which had the potential to affect 13 residents who received pureed diets and all residents who received alternate foods from the kitchen.

The findings included:

Review of the facility's "Food Temperatures" policy documented, "...Foods will be maintained at proper temperature to insure food safety..."

Observations in the kitchen on 5/10/11 beginning at 11:55 AM, revealed the following:
- a. Pureed chicken - 120.7 degrees F.
- b. Pureed baked beans - 122 degrees F.
- c. Beef fritter - 122.5 F.

During an interview in the kitchen on 5/10/11 at 12:10 PM, the Assistant Dietary Manager stated, "...We need to put them [hot foods] back in the steamer to bring them back to temperature..."

F 441  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.

(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.
F 441  Continued From page 4

documented, "Guideline: Before and after caring for each resident and/or their units. This includes handling anything the resident has touched. Before handling a resident’s food or food tray... Procedure: ...7. Using towel, turn off faucet. Don’t touch the faucet with bare hands..."

2. Observations on the 300 hall on 5/9/11 at 5:38 PM, Nurse #1 entered Random Resident (RR) #1’s room and assisted Nurse #2 to position RR #1 in bed. Nurse #1 washed her hands and turned the water off with her bare hands.

3. Observations on the 300 hall on 5/9/11 at 5:38 PM, Nurse #2 entered RR #1’s room positioned RR #1 in bed, prepared RR #1’s food, touched the bed covers, moved the overbed table and wash basin, then patted Resident #10 on the shoulder. Nurse #2 did not wash her hands between direct contact with the residents or between handling inanimate objects.

4. Observations in Resident #11’s room on 5/9/11 at 5:50 PM, CNA #1 pulled Resident #11 up in the bed, raised the head of the bed, then set the food tray up and opened a sandwich and cookie with her bare hands. CNA #1 did not wash her hands after handling environmental contaminates or prior to setting up the meal tray.

5. Observations in the dining room on 5/10/11 at 12:55 PM, CNA #2 touched a resident with her bare hands, moved the chair and repositioned the table and then touched the plate and cups without washing her hands. CNA #2 proceeded to the next resident and touched their plate and cups with her bare hands without washing her hands. CNA #2 repeated this four more times with other
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<tr>
<td>F441</td>
<td></td>
<td>Continued from page 5 residents before she washed her hands with alcohol gel.</td>
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<td>6. Observations in room 207 on 5/10/11 at 12:10 PM, Nurse #4 positioned a resident in the bed and proceeded to set up the resident's meal tray without washing her hands.</td>
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<td>During an interview in 100 hall on 5/10/11 at 5:40 PM, Nurse #4 stated, &quot;I didn't use the alcohol, I guess I should have.&quot;</td>
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<td>7. Observations in room 215 on 5/10/11 at 12:35 PM, CNA #3 placed the meal tray on the overbed table, moved the overbed table in front of the resident, removed the plate cover, picked up the roll on the resident's plate with her bare hands and applied butter to the roll. CNA #3 did not perform hand hygiene prior to touching the resident's roll.</td>
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