

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Elk River Health & Nursing Center of Winchester		STREET ADDRESS, CITY, STATE, ZIP CODE 32 Memorial Drive Winchester, TN 37398	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480</p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to implement a comprehensive person-centered care plan related to falls for 1 resident (Resident #19) and adaptive eating utensils for 1 resident (Resident #46) of 15 residents reviewed for comprehensive care plans.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, showed . A comprehensive, person-centered care plan that includes measurable objectives and time tables to meet the resident's .needs is .implemented for each resident .The comprehensive person-centered care plan will . describe the services that are to be furnished to attain or maintain the resident's highest practicable . well-being .</p> <p>Review of the facility policy titled, Assistance with Meals, revised 7/2017, showed .Assistive Devices . Adaptive devices (special eating equipment and utensils) will be provided for residents who need to request them. These may include devices such as silverware with enlarged/padded handles .</p> <p>Resident #19 was admitted to the facility on [DATE] with diagnoses including Parkinsonism and Repeated Falls.</p> <p>Review of a Fall Scene Investigation Report dated 1/11/2024, showed .Resident lost their balance . Ambulating .at time of fall .Alone and unattended .cause of the fall .unsteady Gait .interventions to prevent future falls .floor mats to bedside .</p> <p>Review of a nursing note dated 1/11/2024, showed .resident .was laying on the floor .going to the bathroom when he fell .no .report of injuries .Immediate .Action .Floor mats at right and left side of bed .</p> <p>Review of Resident #19's comprehensive care plan dated 1/26/2024, showed .Potential for falls .related to falls .Intervention .1/11/24 [1/11/2024]Mats to bedside bilaterally .Intervention .2/12/24 [2/12/2024] Add [non-slip product used to prevent sliding] to w/c [wheelchair] seat .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Fall Scene Investigation Report dated 2/12/2024, showed .Resident slipped .Lost strength .What was resident doing .prior to fall .Reaching for something .Slide out .fall from wheelchair .assistance .at time of fall .Alone and unattended .</p> <p>Review of a facility investigation report dated 2/12/2024, showed .recommendations .taken .add [non-slip product used to prevent sliding] to w/c .</p> <p>During an observation on 4/1/2024 at 9:18 AM, Resident #19 was observed lying in bed, the w/c was at bedside, and the w/c did not contain a no non-slip product in the seat. Further observation showed a fall mat was placed on the floor at the resident's left side and there was no fall mat placed on the floor at the resident's right side.</p> <p>During an observation on 4/1/2024 at 4:19 PM, Resident #19 was observed lying in bed, the w/c was at bedside, and the w/c did not contain a no non-slip product in the seat. Further observation showed a fall mat was placed on the floor at the resident's left side and there was no fall mat placed on the floor at the resident's right side.</p> <p>During an interview on 4/2/2024 at 8:30 AM, Certified Nursing Assistant (CNA) #1 stated she was familiar with Resident #19 and cared for him routinely. CNA #1 stated .I have worked this hall for a year . I have never known him [Resident #19] to have [non-slip product] to his [Resident #19] wheelchair or for him to have fall mats on both sides [both sides of the bed] .</p> <p>During an interview on 4/2/2024 at 8:36 AM, the Director of Therapy (DOT) stated .I put the [non-slip product] in his wheelchair seat yesterday evening [4/1/2024] .</p> <p>During an interview on 4/3/2024 at 4:22 PM, the Director of Nursing (DON) confirmed Resident #19's comprehensive care plan was not implemented to include bilateral fall mats to both sides of the bed and a non-slip product to the seat of the wheelchair.</p> <p>50407</p> <p>Resident #46 was admitted to the facility on [DATE] with diagnoses including Need for Assistance with Personal Care, Osteoarthritis, Dementia with Agitation, and Lack of Coordination.</p> <p>Review of Resident #46's comprehensive care plan dated 3/22/2024, showed .built up utensils on tray with meals .[non-slip product used to prevent sliding] .under food .bowls with every meal to maximize independence with self feeding .</p> <p>Review of a physician's order dated 3/22/2024, showed .Built-up utensils .[nonslip product used to prevent sliding] under food .bowls .w [with] every meal to maximize independence w .self-feeding .</p> <p>Review of Resident #46's weights showed the resident's weights were stable and had a 1.67 % gain in 3/2024.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 4/1/2024 at 1:11 PM, of Resident #46 in his room, during lunch, showed the resident was eating independently. The resident was served food in bowls and used regular eating utensils to consume his food. Further observation showed the resident did not have built-up eating utensils, and the resident did not have a non-slip product under his food bowls to prevent the bowls from sliding.</p> <p>Observation on 4/2/2024 at 8:12 AM, of Resident #46 in his room, during breakfast, showed the resident was eating independently. The resident was served food in bowls and used regular eating utensils to consume his food. Further observation showed the resident did not have built-up eating utensils, and the resident did not have a non-slip product under his food bowls to prevent the bowls from sliding.</p> <p>During an observation and interview on 4/2/2024 at 8:25 AM, in Resident #46's room with DOT showed Resident #46 was eating independently. The resident was served food in bowls and used regular eating utensils to consume his food. Further observation showed the resident did not have built-up eating utensils, and the resident did not have a non-slip product under his food bowls to prevent the bowls from sliding.</p> <p>The DOT confirmed Resident #46 did not have built-up eating utensils or a non-slip product under his food bowls to prevent the bowls from sliding.</p> <p>During an interview on 4/2/2024 at 8:35 AM, CNA #1 stated she provided care for Resident #46 routinely. She also stated the resident used a non-slip product under the food bowls to prevent the food bowls from sliding and the non-slip product was kept in a drawer in the resident's room. CNA #1 was not aware the resident had an order for built-up eating utensils to help maximize the resident's independence with self-feeding. The CNA stated the resident eats independently and .he [Resident #46] usually eats 100% .</p> <p>During an observation and interview in Resident #46's room on 4/2/2024 at 8:40 AM, the DOT provided the resident with built-up eating utensils and a non-slip product under the meal bowls. Resident #46 stated to the DOT and surveyors he liked the built-up utensils better than the regular eating utensils.</p> <p>During an interview on 4/2/2024 at 10:10 AM, the Occupational Therapist (OT) stated Resident #46 was currently receiving occupational therapy services for drop wrist (an impairment in hand extension at the wrist) and fine motor movement of bilateral upper extremities because staff reported the resident had a decline in self-feeding. The OT stated she ordered built-up eating utensils to maximize self-feeding and a non-slip product to be placed under the food bowls to prevent the bowls from sliding.</p> <p>During an interview on 4/3/2024 at 4:20 PM, the DON confirmed Resident #46's comprehensive care plan was not implemented to include a non-slip product under the food bowls to prevent the bowls from sliding and built-up eating utensils.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480</p> <p>Based on medical record review, observations, and interviews the facility failed to follow a physician's order for 1 resident (Resident #19) related to fall interventions and adaptive eating utensils for 1 resident (Resident #46) of 15 residents reviewed for physician orders.</p> <p>The findings include:</p> <p>Resident #19 was admitted to the facility on [DATE] with diagnoses including Parkinsonism and Repeated Falls.</p> <p>Review of a Fall Scene Investigation Report dated 1/11/2024, showed .Resident lost their balance . Ambulating .at time of fall .Alone and unattended .cause of the fall .unsteady Gait .interventions to prevent future falls .floor mats to bedside .</p> <p>Review of a nursing note dated 1/11/2024, showed .resident .was laying on the floor .going to the bathroom when he fell .no .report of injuries .Immediate .Action .Floor mats at right and left side of bed .</p> <p>Review of a physician's order dated 1/11/2024, showed .Floor mats to R [right] and L [left] side of bed .</p> <p>Review of Resident #19's comprehensive care plan dated 1/26/2024, showed .Potential for falls .related to falls .Intervention .1/11/24 Mats to bedside bilaterally .Intervention .2/12/24 Add [non-slip product used to prevent sliding] to w/c [wheelchair] seat .</p> <p>Review of a Fall Scene Investigation Report dated 2/12/2024, showed .Resident slipped .Lost strength .What was resident doing .prior to fall .Reaching for something .Slide out .fall from wheelchair .assistance .at time of fall .Alone and unattended .</p> <p>Review of a facility investigation report dated 2/12/2024, showed .recommendations .taken .add [nonslip product used to prevent sliding] to w/c .</p> <p>Review of a physician's order dated 2/13/2024, showed .[non-slip product used to prevent sliding] to w/c seat .</p> <p>During an observation on 4/1/2024 at 9:18 AM, Resident #19 was observed lying in bed, the w/c was at bedside, and the w/c did not contain a no non-slip product in the seat. Further observation showed a fall mat was placed on the floor at the resident's left side and there was no fall mat placed on the floor at the resident's right side.</p> <p>During an observation on 4/1/2024 at 4:19 PM, Resident #19 was observed lying in bed, the w/c was at bedside, and the w/c did not contain a no non-slip product in the seat. Further observation showed a fall mat was placed on the floor at the resident's left side and there was no fall mat placed on the floor at the resident's right side.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/2024 at 8:30 AM, Certified Nursing Assistant (CNA) #1 stated she was familiar with Resident #19 and cared for him routinely. CNA #1 stated .I have worked this hall for a year . I have never known him [Resident #19] to have [non-slip product] to his [Resident #19] wheelchair or for him to have fall mats on both sides [both sides of the bed] .</p> <p>During an interview on 4/2/2024 at 8:36 AM, the Director of Therapy (DOT) stated .I put the [non-slip product] in his wheelchair seat yesterday evening [4/1/2024] .</p> <p>During an interview on 4/3/2024 at 4:22 PM, the Director of Nursing (DON) confirmed the facility failed to follow physician orders for Resident #19 related to bilateral fall mats to both sides of the bed and a non-slip product to the wheelchair.</p> <p>50407</p> <p>Resident #46 was admitted to the facility on [DATE] with diagnoses including Need for Assistance with Personal Care, Osteoarthritis, Dementia with Agitation, and Lack of Coordination.</p> <p>Review of Resident #46's comprehensive care plan dated 3/22/2024, showed .built up utensils on tray with meals .[non-slip product used to prevent sliding] .under food .bowls with every meal to maximize independence with self feeding .</p> <p>Review of a physician's order dated 3/22/2024, showed .Built-up utensils .[non-slip product used to prevent sliding] under food .bowls .w [with] every meal to maximize independence w .self-feeding .</p> <p>Review of Resident #46's meal ticket (communication tool used to alert staff of dietary needs) showed no special assistive devices were documented to be utilized by Resident #46 during meals.</p> <p>Review of Resident #46's weights showed the resident's weights were stable and had a 1.67 % gain in 3/2024.</p> <p>Observation on 4/1/2024 at 1:11 PM, of Resident #46 in his room, during lunch, showed the resident was eating independently. The resident was served food in bowls and used regular eating utensils to consume his food. Further observation showed the resident did not have built-up eating utensils, and the resident did not have a non-slip product under his food bowls to prevent the bowls from sliding.</p> <p>Observation on 4/2/2024 at 8:12 AM, of Resident #46 in his room, during breakfast, showed the resident was eating independently. The resident was served food in bowls and used regular eating utensils to consume his food. Further observation showed the resident did not have built-up eating utensils, and the resident did not have a non-slip product under his food bowls to prevent the bowls from sliding.</p> <p>During an observation and interview on 4/2/2024 at 8:25 AM, in Resident #46's room with the DOT showed Resident #46 was eating independently. The resident was served food in bowls and used regular eating utensils to consume his food. Further observation showed the resident did not have built-up eating utensils, and the resident did not have a non-slip product under his food bowls to prevent the bowls from sliding.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DOT confirmed Resident #46 did not have built-up eating utensils or a non-slip product under his food bowls to prevent the bowls from sliding.</p> <p>During an interview on 4/2/2024 at 8:35 AM, CNA #1 stated she cared for Resident #46 routinely. She also stated the resident used a non-slip product under the food bowls to keep the bowls from sliding and the non-slip product was kept in a drawer in the resident's room. CNA #1 was not aware the resident had an order for built-up eating utensils to help maximize the resident's independence with self-feeding. The CNA stated the resident eats independently and .he [Resident #46] usually eats 100% .</p> <p>During an observation and interview in Resident #46's room on 4/2/2024 at 8:40 AM, the DOT provided the resident with built-up utensils and a non-slip product under the meal bowls. Resident #46 stated to the DOT and surveyors he liked the built-up utensils better than the regular eating utensils.</p> <p>During an interview on 4/2/2024 at 10:10 AM, the Occupational Therapist (OT) stated Resident #46 was currently receiving occupational therapy services for drop wrist (an impairment in hand extension at the wrist) and fine motor movement of bilateral upper extremities because staff reported the resident had a decline in self-feeding. The OT stated she ordered built-up eating utensils to maximize self-feeding and a non-slip product to be placed under the food bowls to prevent the bowls from sliding.</p> <p>During an interview on 4/2/2024 at 10:40 AM, the Dietary Manager stated she was not aware Resident #46 had a physician's order for built-up utensils to be utilized with every meal.</p> <p>During an interview on 4/3/2024 at 4:20 PM, the DON confirmed the facility failed to follow physician orders for a non-slip product under the food bowls to prevent the bowls from sliding and built-up eating utensils for Resident #46.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to provide tracheostomy (a surgical procedure where a tube is inserted in the neck to allow air to enter the lungs) care (a procedure performed routinely to keep the part of the tracheostomy tube/faceplate that is fixed against the neck, tracheostomy dressing, ties or straps, and surrounding area clean) according to the facilities policy and physicians order for 1 resident (Resident #45) of 1 resident reviewed for tracheostomy care.</p> <p>The findings include:</p> <p>Review of the facilities policy titled, Tracheostomy Care, revised 8/2013, showed .Remove neck ties [used to hold the tracheostomy tube in place] and replace with clean ones .</p> <p>Resident #45 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, Cardiac Arrest, Anoxic Brain Damage, Chronic Respiratory Failure, and Tracheostomy.</p> <p>Review of a physician's order dated 6/21/2021, showed .trach [tracheostomy] care every shift, include inner cannula [a tube within the outer tube which can be removed and cleaned] change every shift and trach collar [used to hold a tracheostomy tube in place] change once daily on day shift .</p> <p>Review of Resident #45's quarterly Minimum Data Set (MDS) assessment dated [DATE], showed the resident had severe cognitive impairment and received tracheostomy care.</p> <p>Observation on 4/2/2024 at 1:30 PM, in Resident #45's room, showed Licensed Practical Nurse (LPN) #1, performed tracheostomy care. LPN #1 followed the facilities procedure to include: The LPN donned Personal Protective Equipment (equipment used to minimize exposure to hazards that can cause serious illness, to include gown, gloves, mask, and goggles), assessed and observed the resident's respiratory status, oxygen saturation and auscultated (listened to the residents breath sounds with a stethoscope) the resident's lungs. Further observation showed LPN #1 performed endotracheal suctioning (common invasive procedure done to keep the airway patent by mechanically removing accumulated pulmonary secretions to all patients with artificial airways), The LPN removed the disposable inner cannula, cleaned and disinfected the stoma site (opening made in the skin in front of the neck to allow you to breathe), reinserted the new sterile inner cannula, and applied a new dressing to Resident #45's tracheostomy site. LPN #1 did not remove the residents neck ties and apply new ones or replace the resident's soiled tracheostomy collar.</p> <p>During an interview on 4/2/2024 at 3:09 PM, the Director of Nursing confirmed it was her expectation the nursing staff were to follow the facility's policy and physician orders related to providing tracheostomy care for Resident #45.</p> <p>During an interview on 4/2/2024 at 3:14 PM, LPN #1 confirmed she did not apply fresh neck ties or replace Resident #45's soiled tracheostomy collar during tracheostomy care.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49568</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure food items were sealed properly and the facility failed to ensure the kitchen was maintained in a good-working and sanitary order, which had the potential to affect 57 of 58 residents.</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, [NAME] Kitchen Sanitization Policy, showed .All kitchen areas shall be kept clean .regular cleaning of kitchen and dining areas .maintain cleanliness throughout their work areas .</p> <p>Review of the facility's policy titled, Food Receiving and Storage, dated 10/2017, showed .Other opened containers must be dated and sealed or covered during storage .</p> <p>Observation of the food preparation room on 4/1/2024 at 9:05 AM, with the Certified Dietary Manager (CDM), showed the following items were not sealed and open to air :</p> <ul style="list-style-type: none"> One 21-ounce (oz) bottle of garlic powder One 16-oz bottle of whole celery seed One 26-oz bottle of mesquite seasoning One 6-oz bottle of rubbed sage <p>Observation of the dry storage area on 4/1/2024 at 9:20 AM, with the CDM , showed One 80-oz bag of Instant Grits, 1/2 full, was not sealed and open to air .</p> <p>Observation of the kitchen entry door area on 4/1/2024 at 9:25 AM, with the CDM , showed a thick, black dirt-like debris present to the bottom, inside corner of the doorway. Further observation showed the dry wall had chipped away from the wall and was matted to the floor and the entry door bottom crevice was observed to have dirt and food debris present.</p> <p>During an interview on 4/1/2024 at 9:40 AM, the CDM stated dry cereals and dried seasoning are to be fully sealed after use. The CDM confirmed the kitchen floors needed to be deep cleaned and the area around the kitchen entry door needed to be repaired. The CDM further confirmed the food items had not been stored properly and the kitchen floor was not maintained in a sanitary condition.</p> <p>During an interview on 4/2/2024 at 10:15 AM, the Maintenance Director confirmed the bottom wall on the kitchen entry door needed to be repaired and was not maintained in a good-working or sanitary condition.</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>49568</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure garbage and refuse were properly contained in 2 of 2 dumpsters (dumpster A and B).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Food-Related Garbage and Refuse Disposal, dated 10/2017, showed . Garbage and refuse containing food wastes .stored .in a manner .inaccessible to pests .kept closed and free of surrounding litter .</p> <p>Observation of the outside dumpster area on 4/1/2024 at 9:15 AM, with the Certified Dietary Manager (CDM), showed the facility had 2 dumpsters present for waste disposal. Further observation showed there were no intact drain plugs at the bottom of the dumpsters A and B. The open areas in each dumpster where the drain plugs were not intact, were approximately the size of a half a dollar. Observation showed the missing drain plugs in the dumpster left the waste contents open to air, elements, and potential exposure to pests.</p> <p>During an interview on 4/1/2024 at 9:30 AM, the CDM confirmed dumpster A and B's drain plugs were not intact and the garbage was not properly contained.</p>