<table>
<thead>
<tr>
<th>F 000</th>
<th>INITIAL COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amended 2537 to reflect recertification survey date and facility name.</td>
<td></td>
</tr>
<tr>
<td>During the annual recertification survey conducted on January 19 to 21, 2010, at Woodbury Health Center deficiencies were cited under 42 CFR PART 483.13, Requirements for Long Term Care.</td>
<td></td>
</tr>
<tr>
<td>F 278</td>
<td>RESIDENT ASSESSMENT</td>
</tr>
<tr>
<td>The assessment must accurately reflect the resident's status.</td>
<td></td>
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<tr>
<td>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</td>
<td></td>
</tr>
<tr>
<td>F 278</td>
<td>RESIDENT ASSESSMENT</td>
</tr>
<tr>
<td>The assessment must accurately reflect the resident's status.</td>
<td></td>
</tr>
<tr>
<td>A registered nurse must sign and certify that the assessment is completed.</td>
<td></td>
</tr>
<tr>
<td>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</td>
<td></td>
</tr>
<tr>
<td>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.</td>
<td></td>
</tr>
<tr>
<td>Clinical disagreement does not constitute a material and false statement.</td>
<td></td>
</tr>
</tbody>
</table>

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 dischargeable 90 days following the date of survey unless a plan of correction is provided. For nursing homes, the above findings and plans of correction are dischargeable 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.
**F 278** Continued From page 1

Based on medical record review and interview, the facility failed to ensure adequate pain assessment on the Minimum Data Set for four residents (#2, #4, #11, #14) of twenty-three residents reviewed.

The findings included:

Medical record review revealed resident #2 was admitted to the facility on August 6, 2009, with diagnoses including Cardiopulmonary Accident, Peripheral Vascular Disease, Deep Venous Thrombosis, Dementia, and Methicillin Resistant Staphylococcus Aureus Bilateral Lower Extremities. Review of the Minimum Data Set (MDS) dated December 3, 2009, revealed the resident experienced pain less than daily for the previous seven days. Review of the Medication Administration Records (MAR) revealed the resident received Lortab 7.5/500 milligrams on November 26, 2009, at 2:30 p.m. and 8:00 p.m., November 27, 2009, at 12:00 a.m. and 4:00 a.m., November 28, 2009, at 12:00 a.m. and 5:00 a.m., November 29, 2009, at 12:00 a.m. and 5:00 a.m., November 30, 2009, at 12:00 a.m. and 5:00 a.m., December 1, 2009, at 6:00 a.m., and December 2, 2009, at 11:30 a.m.

Medical record review revealed resident #4 was admitted to the facility on June 5, 2009, with diagnoses including Dementia, Atherosclerotic Vascular Disease, Peripheral Vascular Disease, Gastroesophageal Reflux Disease, Emphysema, Osteoarthritis, and Osteoporosis. Review of the MDS dated December 8, 2009, revealed the resident did not experience pain in the last seven days. Review of the MARs revealed the resident received Lortab 5 milligrams on December 3, 2009, at 12:00 a.m. and 8:00 a.m., December 4,
NAME OF PROVIDER OR SUPPLIER
WOODBURY HEALTH CENTER

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

F 278
Continued from page 2

2009, at 12:00 a.m. and 6:00 a.m. December 5, 2009, at 12:00 a.m. and 6:00 a.m. and December 6, 2009, at 12:00 a.m. and 6:00 a.m.

Medical record review revealed resident #11 was initially admitted to the facility on June 28, 2008, and readmitted on May 1, 2009, with diagnoses including cerebrovascular accident, Parkinsonism, dysphagia, diabetes, coronary artery disease, congestive heart failure, hypertension, dementia, gastroesophageal reflux disease, osteoarthritis, and osteoporosis. Review of the MDS dated January 12, 2010, revealed the resident experienced pain less than daily over the previous seven days. Review of the MARs revealed the resident received Loratadine 5 milligrams on January 5, 2010, at 12:00 a.m., January 7, 2010 at 11:30 p.m., January 8, 2010, at 6:00 a.m., January 9, 2010, at 12:00 a.m. and 6:00 a.m., January 10, 2010, at 12:00 a.m. and January 11, 2010, at 12:00 a.m.

Medical record review revealed resident #14 was admitted to the facility on April 20, 2009, with diagnoses including dementia, depression, hypertension, osteoarthritis, and osteoporosis. Review of the MDS dated October 19, 2009, revealed the resident experienced pain less than daily over the previous seven days. Review of the MARs revealed the resident received hydrocodone 5/325 milligrams on October 13, 2009, at 12:00 a.m. and 6:00 a.m., October 16, 2009, at 12:00 a.m. and 6:00 a.m., October 17, 2009, at 12:00 a.m. and 6:00 a.m., and October 18, 2009, at 12:00 a.m. and 6:00 a.m.

During interview with the Director of Nursing (DON) in the administrator's office on January 21, 2010, at 12:20 p.m., the DON confirmed the pain...
F 278. Continued From page 3

assessment on the MDS and the actual pain medication administration documented on the MARs did not match for residents #2, #4, #11, and #14.

F 280. 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS

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

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

This REQUIREMENT is not met as evidenced by:
Based on record review, facility document review, and interview, the facility failed to revise a care plan addressing pain for one (#7), and failed to update the care plan to reflect new interventions for one resident (#6) of twenty-three residents reviewed.

The findings include:
- twenty-three resident
- F 278
- F 280

1. Resident #7 was assessed and the care plan was corrected on 1/21/10 by the Minimum Data Set nurse.

2. All residents have the potential to be affected by this citation. A chart audit of all resident's care plans will be completed by the Director of Nursing, Assistant Director of Nursing, Minimum Data Set nurse, and Registered Charge Nurse to ensure accuracy of care plan by 2/5/10.

3. All licensed nursing staff will be in-serviced by the Director of Nursing and Assistant Director of Nursing on "Revising care plans and updating care plan to reflect new interventions" by 2/5/10. The Director of Nursing, Assistant Director of Nursing, Minimum Data Set nurse and Administrator will review all new orders as the clinical morning meeting. The Director of Nursing and Assistant Director of Nursing will follow up to ensure all new interventions are placed on the care plan and revising care plan as indicated. Those attending the clinical meeting are the Director of Nursing, Assistant Director of Nursing, Administrator, Rehab services, Minimum Data Set nurses and Quality Assurance nurse.
The findings included:

Medical record review for resident #7 revealed facility admission on August 29, 2009, with diagnoses including Peripheral Vascular Disease, Deep Leg Phlebitis, Rheumatoid Arthritis and Fractured Carpal Bone. Medical record review of physician orders dated January 2010 revealed Lortab 5/500 one po q (by mouth every) 6 hours PRN (as needed) pain.

Medical record review of the November and December, 2009, Medication Administration Record (MAR) revealed Lortab administered typically twice daily for pain in left lower extremity exclusively for approximately two weeks, bilateral lower extremity exclusively for approximately two weeks, and the back exclusively for approximately two weeks. Review of the January, 2010, MAR revealed Lortab was administered typically twice daily for complaint of pain in the left foot.

Review of the facility care plan dated September 2, 2009, revealed "at risk for pain... history of ear complications with tubes-Rheumatoid Arthritis-Osteo... Dx (diagnosis) Fx (fractured) wrist with left arm pain at times." Care plan approaches included "PRN meds per MD order, report increased pain not relieved by meds... comfort measures to help relieve pain-reposition."

Interview with the Director of Nursing on January 20, 2010, at 12:53 p.m. at the B wing nursing station, confirmed the care plan was not revised.
F 280 Continued from page 5
to address the pain sites and alternative approaches.

Medical record review revealed resident #8 was initially admitted to the facility on September 24, 2007, and readmitted on September 4, 2009, with diagnoses including Diabetes, Depression, Hypertension, Atrial Fibrillation, Congestive Heart Failure, Transient Ischemic Attack, Peripheral Vascular Disease, Gastroesophageal Reflux Disease, Osteoarthritis, Osteoporosis, and Dysphagia.

Review of the facility fall investigation document revealed the resident sustained a fall on January 11, 2010. Further review revealed “Resident found lying in floor in room. Took off body alarm and attempted to walk across room with bedside table” and the immediate intervention was “chair alarm placed under resident.” Continued review of the facility fall investigation document revealed interventions following the fall were to include “Physical or Occupational Therapy to screen; Resident to be (OOB) out of bed for breakfast and to (DR) dining room and up in chair in hallway afterwards to be monitored by staff.”

Review of the care plan revision dated January 11, 2010; revealed “PT (Physical Therapy) to eval. (evaluate); Resident up for meals in dining room.” Continued review of the care plan revealed no documentation about the application of the chair alarm; resident to be up in chair in hallway and staff to monitor resident.
**F 280** Continued From page 6

During interview with the Director of Nursing (DON) in the Administrator's office on January 21, 2010 at 12:30 p.m., the DON confirmed the care plan had not been revised to include application of the chair alarm; resident to be up in chair in hallway and resident to be monitored by staff.

**F 282 483.25(k)(3)(i) COMPREHENSIVE CARE PLANS**

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, facility document review, and interview, the facility failed to follow the care plan addressing falls for two (#5 and #12) of twenty-three records reviewed.

The findings included:

Medical record review for resident #5 revealed admission to the facility on February 8, 2008, with diagnoses including Diabetes Mellitus, Osteoarthritis, Senile Dementia, Alzheimer's Disease and Difficulty Walking.

Review of the Fall Risk Assessment dated July 9, 2009, August 25, 2009, October 7, 2009, and January 6, 2010, revealed the resident was classified as high risk with scores of 17, 19, 18, and 14 respectively.

Review of the Side Rail Assessment dated April 13, 2009, revealed "continues with low bed, half side rails (HOB) (head of bed) and mat on floor".

1. The care plan for Resident #5 was reviewed for fall interventions with new fall interventions implemented by the Director of Nursing on 1/21/10. Care plan for Resident #12 was reviewed for fall interventions with new fall interventions implemented by the Director of Nursing on 1/21/10.

2. All residents have the potential to be affected by this citation. An audit of all resident records will be completed by the Director of Nursing, Registered Charge Nurse, and Minimum Data Set nurse by 2/5/10 to ensure all resident care plans have appropriate interventions and are being followed.

3. Licensed and Certified Nursing Assistants were co-serviced on the "Following care plan interventions for falls" by the Director of Nursing and Assistant Director of Nursing by 2/5/10. The Director of Nursing, Assistant Director of Nursing, Minimum Data Set nurse, and Administrator will review all new orders at the clinical morning meeting. The Director of Nursing, Minimum Data Set nurse, and Assistant Director of Nursing will follow up to ensure all new interventions are in place. Those attending the clinical meeting are the Director of Nursing, Assistant Director of Nursing, Administrator, Rehab services, Minimum Data Set nurses, Quality Assurance Nurse, Business Office Manager, Marketing Director, Activities Director, Dietary Manager, Medical Records Nurse, and social services.
F 282 Continued From page 7

when in bed”. Further review revealed the
assessment was updated on July 8, 2009, and
October 8, 2009, with “no changes”.

Review of the care plan dated January 12, 2009,
updated April 13, 2009, and July 9, 2009,
revealed a problem of “at risk for falls/injury...”
Review of the care plan approaches revealed
“half siderails up & soft mat in floor beside
bed...motion alarm used in bedchair as needed
for safety...ensure resident...wears properly
fitting non-slip soled shoes or non-slip socks for
transfers...” Further review of a care plan update
on 8/25/09 Observed out of bed on the floor
abstraction to (L) knee” revealed approaches of
“safety mat at bedside, PT (physical therapy) to
evaluate, soft boister pads FOB (foot of bed).”

Medical record review of a nursing note dated
revealed “August 26, 2009, 03:39 AM Late Entry
for 8/25/09 at 600am-Ras (resident) found in floor
by CNA (Certified Nurse Aid). Resident lying on
back. Redness noted to left knee. Denies
pain...”

Review of a facility falls investigation document
dated August 25, 2009, revealed at 6 AM the
location of the fall was the resident’s room: and
the section for physical restraints, medications
taken during last 8 hours and bed height were not
completed (blank). Further review revealed the
bedrails “down” and the “resident found in floor by
CNA’s lying on back with legs stretched out in
front...” Further review revealed the falls
committee comments regarding follow-up and
corrective action taken revealed were OT and PT
(Occupational Therapy and Physical Therapy) to
screen and mat on floor beside bed.
| Statement of Deficiencies and Plan of Correction | Provider/Supplier Identification Number: | Multiple Construction
A. Building  | Date Survey Completed: 01/21/2010 |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Provider or Supplier</strong></td>
<td><strong>Street Address, City, State, Zip Code</strong></td>
<td><strong>Woodbury Health Center</strong></td>
<td>119 West High Street, Woodbury, TN 37190</td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>DM ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F282. Continued From page 8</td>
<td>Interview with the Director of Nursing on January 21, 2010, at 10:35 a.m., in the conference room, revealed the &quot;alarm as needed&quot; meant the alarm was applied when staff was not present and during care provisions the alarm would be removed. Further interview confirmed the falls investigation document dated August 25, 2009, revealed the bedrails were in the down position and did not follow the approach on the care plan. Further interview confirmed the care plan interventions were not followed for the placement of the alarm and mat.</td>
<td>2/6/10</td>
</tr>
</tbody>
</table>

Medical record review for resident #12 revealed the resident was admitted to the facility on September 16, 2003, with diagnoses including Senile Dementia, Alzheimer's Disease, Peripheral Vascular Disease, Chronic Ischemic Heart Disease, Congestive Heart Failure, Renal Failure, Osteoporosis, and General Osteoarthritis.

Review of the facility Fall Risk Assessments dated August 6, 2009, September 16, 2008, October 22, 2009, November 3, 2009, revealed the resident was at "High Risk" for falls.

Review of the resident's care plan dated August 11, 2009; updated September 16, 2009, October 22, 2009, and November 5, 2009, revealed the problem of at risk for falls with approaches of "...alert assist bars up when in bed...mat in floor beside bed; bed in low position and wheellocks...motion alarm in chair and bed to alert staff if resident attempts to exit without assist..." Medical record review of a nursing note dated September 16, 2009, revealed at 4:45pm...
Resident observed by this nurse on mat in floor
with back against bed at bed side. No visible
injuries noted...

Review of the facility falls investigation document
dated September 18, 2009, at 4:43 p.m., revealed
the location of fall was the resident's room and
the resident was sitting on a mat. Further review
of the falls investigation document revealed the
sections for physical restraint, bedrails, and bed
height was not completed (blank) and the
immediate intervention implemented and
committee plan of action was a "pressure alarm
applied to bed."

Medical record review of a nursing note dated
October 22, 2009, revealed "Tech found pt
(patient) lying on mat in room this am..."

Review of the facility falls investigation document
dated October 22, 2009, at 7:00 a.m., revealed
the location of occurrence was the "pts (patients')
room." Further review of the falls investigation
document revealed physical restraint was
checked for "in use at time of incident" and "N/A"
(not applicable) was written above the check
mark. Further review revealed the type of
restraint was "bed alarm" with an N/A written
behind the word alarm and revealed the bedrails
were present and up and the bed height was
down. Continued review revealed the "Pt rolled
out of bed onto mat..." and the falls committee
action plan was "...assist hrs at head of bed..."

Interview with the Director of Nursing on January
21, 2010, at 8:15 a.m., in the conference room,
revealed the "N/A" on the October 22, 2009,
document for the physical restraint in use at time
of incident and bed alarm meant it wasn't in use.
Continued From page 10
and that it was an error.

Interview with the Director of Nursing on January 21, 2010, at 10:35 a.m., in the conference room, revealed the document section addressing physical restraints was to include the presence of an alarm.

Interview with LPN #1 by phone, on January 21, 2010, at 12:40 p.m., revealed the alarm was still attached to the resident so it wasn’t sounding and the assist bars at the head of the bed were in the up position.

Interview with the Director of Nursing, Regional Nurse and Administrator on January 21, 2010, at 1:10 p.m., in the Director of Nursing office, confirmed the facility failed to follow the care plan/recommended interventions to prevent falls.

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.

This REQUIREMENT is not met as evidenced by:
- Based on medical record review, facility document review, observation and interview, the facility failed to provide adequate supervision/assistive devices to prevent falls for two (#5 and #12) residents of twenty-three residents reviewed.

The findings included:
Medical record review revealed resident #5 was admitted to the facility on February 8, 2008, with diagnoses including Diabetes Mellitus, Osteoarthrosis, Senile Dementia, Alzheimer's Disease and Difficulty Walking.

Review of the Fall Risk Assessments dated July 9, 2009, August 25, 2009, October 7, 2009, and January 6, 2010, revealed the resident was classified as high risk for falls.

Review of the Side Rail Assessment dated April 13, 2009, revealed "continues w/ low bed, half side rails HOB (head of bed) and mat on floor when in bed". Further review revealed the assessment was updated on July 9, 2009, and October 8, 2009, with "no changes".

Medical record review revealed a nursing note dated "August 26, 2009, 03:39 AM Late Entry for 8/25/09 at 500am-Res (resident) found in floor by CNA (Certified Nurse Aid). Resident lying on back. Raddness noted to left knee. Denies pain..."

Review of a facility falls investigation indicated on August 25, 2009, at "5 AM" revealed the location of the fall was the resident's room. Further review of the document revealed the section for physical restraints, medications taken during last 8 hours and bed height were not completed (blank) and the bedrails were "down". Further review revealed the "resident found in floor by CNA's lying on back with legs stretched out in front. Red abrasion to L (left) knee. No bleeding noted". Further review revealed "Roommate was yelling a few minutes earlier and resident possibly became anxious and fearful."
### F 323:3

Residents who have a fall will have a new fall assessment completed and the Incident report will be reviewed by the IDT. An in-service will be done for all staff by the Administrator and/or Director of Nursing on “Fall Prevention” by 2/5/10.

4. All falls will be audited and reviewed by the IDT to ensure all residents have been assessed for a new intervention to prevent a further fall. The audit will be done by the Director of Nursing or RN supervisor daily times 2 weeks, then weekly times 3 months and/or 100% compliance. Results of this audit will be reviewed by the Quality Assurance Committee. Members of the committee are Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Business Office Manager, Minimum Data Set nurse, Activity Director, Rehab Manager, Maintenance Director, Social Services, and Dietary Manager.

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<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LAC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>DO COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 323 Continued From page 12 | the immediate intervention implemented was "got up in wheelchair and brought to nurse's desk for supervision" and the falls committee implemented OT and PT (Occupational Therapy and Physical Therapy) to screen and treat on floor beside bed. Review of the care plan dated January 12, 2009, revealed a problem of "at risk for falls/fitness ... Review of the care plan approach revealed...fall alert" used in bed, chair as needed for safety...ensure resident...wear proper fitting non-skid soled shoes or non-skid socks for transfers..." Further review of the care plan revealed an update on "8/25/09: Observed out of bed on the floor abrasion to (L) knee with approaches "safety mat at bedside, PT to evaluate, soft bolster pads PFB (foot of bed)." Observation on January 20, 2010, at 2:35 p.m., revealed the resident in bed, low position; padded head sidewall, the up position; and an alarm attached and mats on the floor on both sides of the bed. Interview with the Director of Nursing on January 21, 2010, at 10:36 a.m., in the conference room, confirmed the August 25, 2009, confirmed the facility failed to provide adequate supervision/assistive devices to prevent falls.

Medical record review revealed resident #12 was admitted to the facility on September 18, 2003, with diagnoses of Senile Dementia, Alzheimer's Disease, Peripheral Vascular Disease, Chronic Ischemic Heart Disease, Congestive heart Failure, Renal Failure, Osteoporosis, and General Osteoarthritis.
F 323  Continued From page 13


Review of the resident's care plan dated August 11, 2009, updated September 16, 2009, and October 22, 2009, indicated the problem at risk for falls and revealed the approaches of "...half assist bars up when in bed...mat in floor beside bed; bed in low position and wheels locked...mood on chair and bed to alert staff if resident attempts to get out without assist..."

Medical record review of a nursing note dated September 16, 2009, revealed "At 4:45PM Resident observed on mat in floor with back against head at bedside. No visible injuries noted..."

Review of the facility's fall investigation document dated September 16, 2009, at 4:45 p.m., revealed the location of the fall was the resident's room, and the resident was found sitting on a mat. Further review of the falls investigation document revealed the sections for physical restraint, bedrails, and bed height was not completed (blank). Further review revealed the immediate intervention implemented and falls committee plan of action was a "pressure alarm applied to bed."

Medical record review of a nursing note dated October 22, 2009, revealed "Trolley found patient lying on mat in room with arms...Two small purple/blue bruises on right posterior thigh noted, small purple/blue bruise noted on left posterior arm. Skin tear, 1/2 inch noted on pts left arm."
Review of the facility's falls investigation document dated October 22, 2009, at 7:00 a.m., revealed the location of the fall was the "pit room," and described the injury as "pi bruises on right leg, right arm, skin tear left arm." Further review revealed the physical restraint was checked for "in use at time of incident" and "N/A" (not applicable) was written above the check mark. Further review revealed the type of restraint was "bed alarm" with an N/A written behind the word alarm and revealed the bedrails were present and up and the bed height was down. Continued review revealed the "Pi rolled out of bed onto mat..." and the falls committee action plan was "...assist bars at head of bed..."

Interview with the Director of Nursing on January 21, 2010, at 8:30 a.m., in the conference room, revealed the "N/A" on the October 22, 2009 incident report meant the physical restraint in use at time of incident and bed alarm meant it wasn't in use and that it was an error.

Interview with LPN #1 by phone on January 21, 2010, at 12:40 p.m., revealed the alarm was still attached to the resident so it wasn't sounding and the bedrails were in the up position.

Interview with the Director of Nursing, Regional Nurse and Administrator on January 21, 2010, at 1:10 p.m., in the Director of Nursing office, confirmed the facility failed to provide adequate supervision/assistive devices to prevent falls.

483.65(a) INFECTION CONTROL

The facility must establish and maintain an infection control program designed to provide a
Continued from page 15

F 441

Safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility. It decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, facility policy review, and interview, the facility failed to follow the facility's policy for Infection Control during a dressing change for one (#1) resident of twenty-three residents reviewed.

The findings included:

Resident #1 was admitted to the facility on March 17, 2008, with diagnoses including Organic Brain Syndrome, Hypertension, and Severe Dementia.

Medical record review of a physician order dated January 12, 2010, revealed "Tx (treatment) changes to bil (bilateral) heel swab R (right) heel, medial aspect, with Betadine swab and cover with dry 4x4 gauze and wrap with gauze to secure BID (two times per day), L (left) heel, open area center of heel, cleanse with wound cleanser, apply wound gel to open area and cover with dry 4x4 gauze and wrap with gauze to secure. Swab dorsal feet with Betadine and wrap bx (treatment changes BID (two times a day)."

Observation of the resident in the resident's room on January 20, 2010, at 10:10 a.m., revealed

F 441

1) The Charge Nurse #1 was immediately intervened by the Assistant Director of Nursing (ADON) on 1/20/10 regarding the proper procedure for hand washing during a dressing change and proper procedures to follow during dressing changes to ensure adequate infection control is maintained.

2) On 1/21/10, the Director of Nursing began monitoring infection control during a dressing change.

3) An in-service was conducted 1/25/10 by the Director of Nursing to all Licensed Nursing Staff regarding maintaining infection control during a dressing change.

4) The Director of Nursing and/or Registered Nurse Supervisor will audit 5 residents weekly for infection control being maintained during a dressing change for 1 month then monthly times 2 months and/or 100% compliance. Results of this audit will be reviewed by the Quality Assurance Committee. Members of the committee are Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Business Office Manager, Minimum Data Set nurses, Activity Director, Rehab Manager, Maintenance Director, Social Services, and Dietary Manager.

2/18/10
**Woodbury Health Center**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>Summary Statement of deficiencies (Each deficiency must be preceded by full regulatory or LID identifying information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td></td>
<td></td>
<td>Continued From page 15 Charge Nurse #1 and the Assistant Director of Nursing (ADON) providing a dressing change to resident #1. Observation revealed Charge Nurse #1 did not wash the hands, placed items on a clean field and donned gloves. Continued observation of the dressing change revealed Charge Nurse #1 provided a dressing change to the right heel changed gloves then cleaned the left heel with wound cleanser. Further observation of Charge Nurse #1 revealed, the Charge Nurse failed to change gloves or wash the hands after clearing the left heel before applying a clean dressing change to the left heel. Review of the facility's policy for &quot;Treatment of Pressure Sores, Chapter 3&quot; revealed &quot;1. Wash hands...4. Put on gloves...5. Remove soiled dressing...6. Remove gloves and discard...8. Wash hands...10. Wash hands...11. Apply new gloves and Perform wound care as ordered...&quot; Interview with Charge Nurse #1 and ADON outside the resident room on January 20, 2010, at 10:22 a.m., revealed the facility policy for Treatment of Pressure Sores was not followed and infection control was not maintained during the dressing change.</td>
</tr>
</tbody>
</table>

**Address:**
119 West High Street
Woodbury, TN 37190

**Completion Date:** 01/21/2010

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**Form Approved OMB No. 0938-0981**

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**Event ID:** DM011  
**Facility ID:** TH0002