**NAME OF PROVIDER OR SUPPLIER:** WOODBURY HEALTH CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 115 WEST HIGH STREET
WOODBURY, TN 37190

**DATE SURVEY COMPLETED:** 07/27/2012

<table>
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<tr>
<th>X4 ID</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 272</td>
<td>463.20(b)(1) COMPREHENSIVE ASSESSMENTS</td>
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</table>

- The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.
- A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
  - Identification and demographic information;
  - Functional status;
  - Cognitive patterns;
  - Communication;
  - Vision;
  - Mood and behavior patterns;
  - Psychosocial well-being;
  - Physical functioning and structural problems;
  - Continence;
  - Disease diagnosis and health conditions;
  - Dental and nutritional status;
  - Skin conditions;
  - Activity pursuit;
  - Medications;
  - Special treatments and procedures;
  - Discharge potential;
  - Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
  - Documentation of participation in assessment.

**This plan of correction is submitted as required under state and federal law. The facility's submission of this Plan of Correction does not constitute any admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the plan of correction cannot be used against the facility in any subsequent administrative or civil proceedings.**

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:**

**TITLE:** Administrator

**DATE:** 8-10-12

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 required to continued program participation.
This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for one resident (#1) of thirty-three residents reviewed.

The findings included:

Resident #1 was admitted to the facility on November 28, 2011, and readmitted on December 27, 2012, with diagnoses including Cervical Spondylosis with Myelopathy, Trigeminal Neuralgia, Dementia, Anxiety, and Hypertension.

Medical record review of the quarterly MDS dated June 25, 2012, revealed no unhealed pressure ulcer and no ulcers or skin problems.

Medical record review of the Care Plan dated June 26, 2012, revealed "1-23-12 (Lt) (left) hip abrasion...see weekly wound report..."

Medical record review of the Weekly Wound Report dated June 15, 2012, revealed "(Lt) hip...size 1 x 1.5 cm (centimeter)...data ID'd (identified) 1-23-12...

Medical record review of an Integumentary/Skin Concerns dated June 15, 2012, revealed "...residents noted to have abraded area to left lower hip with measurements of 1 x 1.5 cm..."

Observation on July 25, 2012, at 10:00 a.m., in the resident's room, revealed the resident had a 2.0 x 2.5 cm stage two pressure ulcer.

F272

F272

Resident #1 was assessed by the Director of Nursing on 7/25/12. The M-section of the minimum data set (MDS) was corrected on 8/6/12 to reflect the accuracy of the resident's integumentary system by the MDS Nurse Coordinator. Physician and family were notified.

The Director of Nursing evaluated the M-section of the MDS for all residents on wound report for accuracy on 8/6/12. No other residents were found to be affected.

All licensed nurses were inserviced by the Director of Nursing on proper documentation on the MDS 7/25/12 - 8/13/12.
**F 272** Continued From page 2

Interview with the Director of Nursing on July 25, 2012, at 11:30 a.m., in the conference room, confirmed resident #1 had a stage two pressure ulcer on the left buttock and the MDS was not accurate.

**F 279 SS=0**

483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to develop a comprehensive care plan for one resident (#1) of thirty-three residents reviewed.

**F 279**

The Director of Nursing and/or Assistant Director of Nursing will review 20 residents M-section of the MDS weekly X 4 weeks. Then 10 residents monthly X 2 months and/or 100% compliance. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.
F 279
Continued From page 3

The findings included:

- Resident #1 was admitted to the facility on November 28, 2011, and readmitted on December 27, 2012, with diagnoses including Cervical Spondylitis with Myelopathy, Trigeminal Neuralgia, Dementia, Anxiety, and Hypertension.

- Medical record review of the quarterly Minimum Data Set (MDS) dated June 25, 2012, revealed no unhealed pressure ulcer and no ulcers or skin problems.

- Medical record review of the Care Plan dated June 26, 2012, revealed "...1-23-12 (L) left hip abrasion...see weekly wound report...7-8-12...new order wet to dry dressing normal saline..."

- Medical record review of the Weekly Wound Report dated June 15, 2012, revealed "... (L) hip...size 1 x 1.5 cm (centimeter)...date ID'd (identified) 1-23-12...

- Medical record review of a Integumentary/Skin Concerns dated June 15, 2012, revealed "...resident is noted to have abraded area to left lower hip with measurements of 1 x 1.5 cm..."

- Medical record review of a Physician Order Sheet and Progress Note dated July 20, 2012, revealed "...open wound...(L) lower buttocks area with 2-3 cm open wound..."

- Observation on July 25, 2012, at 10:00 a.m., in the resident's room, revealed the resident had a 2.0 x 2.5 cm stage two pressure ulcer on the left buttck.
**F 279** Continued From page 4
Interview with the Director of Nursing on July 25, 2012, at 11:30 a.m., in the conference room.
confirmed resident #1 had a stage two pressure ulcer on the left buttock and confirmed the facility failed to complete a comprehensive care plan for the stage two pressure ulcer.

**F 282** 453.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

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 and interview, the facility failed to implement the Care Plan for one (#13) of thirty-three residents reviewed.

The findings included:

- Resident #13 was admitted to the facility on February 23, 2006, and readmitted on November 9, 2009, with diagnoses including Cellulitis of the Trunk, Hypertension, Ulcerative Colitis, and Osteoarthritis.

Medical record review of the Minimum Data Set dated July 8, 2012, revealed the resident had no natural teeth or tooth fragments.

Medical record review of the Care Plan dated July 10, 2012, revealed "...Risk for choking/aspiration due to several teeth missing & (and) has a chewing problem...Serve mechanically-altered diet & observe for texture tolerance...Dental

**F 279** Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.

**F 282** Resident #13 was assessed on 7/25/12 by the Director of Nursing, Social Services Director, and the Certified Dietary Manager (CDM). Attempt was made to schedule dental consult. Resident refused dental consult. Physician and responsible party were notified.
Continued from page 5
consult as needed for any pain or mouth problems...

Medical record review revealed no documentation the resident had received a dental examination.

Interview on July 23, 2012, at 2:23 p.m., with the resident, in the resident's room, revealed the resident had only three teeth, and the teeth were broken.

Interview on July 25, 2012, at 8:26 a.m., with the Assistant Director of Nursing, in the conference room, confirmed the resident had not had a dental consultation since admission to the facility.

A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, review of facility policy, and interview, the facility failed to provide a restorative nursing program for two (#74, #31) of thirty-three residents reviewed.

The findings included:
Resident #74 was admitted to the facility on March 19, 2012, with diagnoses including Osteoarthritis, Hypertension, Hypothyroidism, Peripheral Vascular Disease, and Depressive Disorder.

All residents will be reviewed by the Director of Nursing and the Assistant Director of Nursing to ensure that appropriate dental consults were scheduled by 8/6/12. No other residents were found to be affected.

All licensed nursing staff, and the Social Services Director were in-serviced by the Director of Nursing and the Assistant Director of Nursing on proper implementation of care plans related to dental care on 8/3/12 – 8/13/12.

The Director of Nursing and/or Assistant Director of Nursing will review 20 resident medical records to ensure appropriate dental consults had occurred weekly X 4 weeks. Then 10 residents monthly X 2 months and/or 100% compliance. Results obtained will be reported to the The Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff.
Medical record review of the Minimum Data Set dated March 26, 2012, revealed the resident required extensive assistance of two persons for bed mobility, transfers, walking, locomotion, and toilet use.

Medical record review of the Minimum Data Set dated June 18, 2012, revealed the resident required extensive assistance of one person for bed mobility, transfers, walking, locomotion, dressing, toilet use, and personal hygiene.

Medical record review of a physician's order dated May 29, 2012, revealed "Discharge pt (patient) from skilled PT (Physical Therapy) to RNP (Restorative Nursing Program)."

Observation on July 24, 2012, at 4:15 p.m., revealed the resident sitting on the side of the bed talking with the resident's roommate.

Review of the facility's policy Restorative Nursing Guidelines revealed "...1. The Rehab Department will notify the Restorative Department of planned discharge with a minimum of 3 days notice. 2. It is the responsibility of the Rehab Department to give training to the Restorative CNA (Certified Nursing Assistant) on the Plan of Care for each resident discharged to the Restorative Program..."

Interview on July 25, 2012, at 1:35 p.m., with Registered Nurse #1/Restorative Nurse, in the business office, revealed when therapy is discontinued and a restorative nursing program is ordered, instructions on the RNP is to be provided to the restorative nurse from the therapy.

Development Coordinator.

Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director.

Resident #74 was evaluated by the Restorative Nurse and the Director of Nursing on 8/3/12 and restorative care began immediately. Resident #31 was evaluated by the Rehabilitation department on 8/3/12 and therapy began immediately. Physician and responsible party notified.

All residents were evaluated by the Director of Nursing and the Restorative Nurse to ensure they were receiving restorative services as ordered on 8/3/12. No other residents were found to be affected.
**F 311 Continued From page 7**

department. Continued interview confirmed when the resident was discharged from physical therapy on May 29, 2012, no instructions for a RNP was received, and confirmed the resident had not received a restorative nursing program.

Interview on July 25, 2012, at 1:55 p.m., with the Physical Therapy Assistant/Rehab Manager in the conference room, confirmed when the resident was discharged from physical therapy on May 29, 2012, no instructions were provided to the nursing department for restorative services.

Resident #31 was admitted to the facility on April 4, 2012, with diagnoses including Bipolar Disorder, Hypertension, Congestive Heart Failure, and Failure To Thrive.

Medical record review of a physician's order dated May 29, 2012, revealed, "...Discharge pt (patient) from skilled PT (physical therapy) as of 5/28/12 to RNP (restorative nursing program)...."

Medical record review of the Minimum Data Set dated April 16, 2012, revealed the resident required limited assistance with one person assist for transfer. Medical record review of the Minimum Data Set dated July 8, 2012, revealed the resident required extensive assistance with one person assist for transfers.

Observation on July 23, 2012, at 11:03 a.m., revealed the resident seated in a chair in the resident's room.

Interview on July 25, 2012, at 9:15 a.m., with the

**All licensed nurses and the Director of Rehab Services were in-serviced on the Restorative Nursing Guidelines by the Director of Nursing on 8/3/12 - 8/13/12.**

The Director of Nursing and/or Assistant Director of Nursing will review 20 residents provider orders to ensure referral to restorative nursing is provided as ordered weekly X 4 weeks. Then 10 residents monthly X 2 months and/or 100% compliance. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSO 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>COMPLETION DATE</th>
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</table>
| F 311         | Continued From page 6
Restorative Nurse, in the conference room, confirmed the resident never received restorative nursing. | F 311         |                                                                                     | 07/27/2012 |
| F 314         | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to correctly identify the location and assess a pressure ulcer for one resident (#1) of thirty-three residents reviewed.

The findings included:

Resident #1 was admitted to the facility on November 28, 2011, and readmitted on December 27, 2012, with diagnoses including Cervical Spondylosis with Myopathy, Trigeminal Neuralgia, Dementia, Anxiety, and Hypertension.

Medical record review of the Care Plan dated June 26, 2012, revealed "...1-23-12 (L) (left) hip abrasion...see weekly wound report...7-8-12...new order wet to dry dressing normal saline..."

Medical record review of the Weekly Wound
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

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<th><strong>X1</strong> PROVIDER/ SUPPLIER/CIA IDENTIFICATION NUMBER:</th>
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**NAME OF PROVIDER OR SUPPLIER**  
WOODBURY HEALTH CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
119 WEST HIGH STREET  
WOODBURY, TN 37190

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

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

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<td>F 314</td>
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Report dated June 15, 2012, revealed "...L hip size 1 x 1.5 cm (centimeter)...date ID'd (identified) 1-23-12..."  
Medical record review of a Integumentary/Skin Concerns dated June 15, 2012, revealed "...resident is noted to have abrasied area to left lower hip with measurements of 1 x 1.5 cm..."  
Medical record review of a Weekly Skin Integumentary Assessment dated July 19, 2012, revealed "...skin intact...abrasied area..."  
Medical record review of a Physician Order Sheet and Progress Note dated July 20, 2012, revealed "...open wound...L lower buttocks area with 2-3 cm open wound..."  
Medical record review of a Weekly Skin Integumentary Assessment dated July 28, 2012, revealed "...abrasions..."  
Observation on July 26, 2012, at 10:00 a.m., in the resident's room, revealed the resident had a 2.0 x 2.5 cm stage two pressure ulcer on the left buttoc.

Interview with the Director of Nursing on July 25, 2012, at 11:30 a.m., in the conference room, confirmed resident #1 had a stage two pressure ulcer located on the left buttoc not on the left lower hip and confirmed the facility failed to correctly identify the site and failed to assess the stage of the pressure ulcer.

**F 323**  
**483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/ DEVICES**  
**SS = D**

The facility must ensure that the resident monthly X 2 months and/or 100% compliance. Results obtained will be reported to the The Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.
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<th>PREFIX</th>
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<tbody>
<tr>
<td>F 323</td>
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<td>Continued From page 10</td>
<td>F 323</td>
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<td></td>
<td>Resident #71 was assessed on 7/25/12 by the Director of Nursing. Pressure alarm and pull cord was immediately placed in wheelchair. Physician and responsible party were notified. All other residents with ordered pressure alarms were assessed to ensure they were in place on 7/25/12 by the Director of Nursing and the Assistant Director of Nursing. No other residents were found to be affected. All licensed nurses were serviced by the Director of Nursing and the Assistant Director of Nursing regarding proper usage of ordered pressure alarms from 7/25/12 – 8/13/12. All residents with pressure alarms will be audited by the Director of Nursing and/or the Assistant Director of Nursing daily X 1 week, weekly X 3 weeks, then monthly X 2 months and/or 100% compliance. Results obtained will be reported to the The Quality Assurance/Performance</td>
<td>8/13/12</td>
</tr>
</tbody>
</table>

- 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, observation, and interview, the facility failed to ensure a safety device was in place for one resident (#71) of thirty-three residents reviewed.

- The findings included:
  - Resident #71 was admitted to the facility on May 4, 2012, with diagnoses including Left Fracture Hip, Hypertension, Anxiety, Depression, Anemia, Alzheimer's Disease, and Osteoarthritis.

- Medical record review of the Minimum Data Set (MDS) dated June 1, 2012, revealed the resident required extensive assistance of two for transfers.

- Medical record review of the Risk for Falls assessment dated June 8, 2012, revealed the resident was a high risk for falls.

- Medical record review of the Care Plan dated June 11, 2012, revealed "...Pressure alarm and pull cord on chair..."

- Observation on July 25, 2012, at 3:10 p.m., on the 100 hallway, revealed the resident seated in a wheelchair without a pressure alarm and pull cord.
<table>
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<th>Deficiency Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>F 323</td>
<td>Observation and interview, on July 25, 2012, at 3:15 p.m., with Registered Nurse (RN) #1, on the 100 hallway, revealed the resident seated in a wheelchair and confirmed the pressure alarm and pull cord were not in place.</td>
</tr>
<tr>
<td>F 412</td>
<td>The nursing facility must provide or obtain from an outside resource, in accordance with §483.55(b) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</td>
</tr>
<tr>
<td>F 323</td>
<td>Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.</td>
</tr>
<tr>
<td>F 412</td>
<td>Resident #31 was assessed on 7/25/12 by the Director of Nursing, Social Services Director, and the Certified Dietary Manager (CDM). Resident #31 was scheduled a dental consult. Physician and responsible party were notified. Resident #13 was assessed on 7/25/12 by the Director of Nursing, Social Services Director, and the Dietician. Attempt was made to schedule dental consult. Resident refused dental consult. Physician and responsible party notified.</td>
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F 412 Continued From page 12

only wears upper dentures..."

Observation and interview on July 23, 2012, at 11:03 a.m., revealed the resident seated in a chair, in the resident's room, and the resident stated does not wear lower dentures because they are too big.

Interview on July 25, 2012, at 9:20 a.m., with the Assistant Director of Nursing, in the conference room, confirmed no dental services had been provided to the resident.

Resident #13 was admitted to the facility on February 23, 2008, and re-admitted on November 9, 2009, with diagnoses including Cellulitis of the Trunk, Hypertension, Ulcerative Colitis, and Osteoarthritis.

Medical record review of the Minimum Data Set dated July 8, 2012, revealed the resident had no natural teeth or tooth fragments.

Review of the Care Plan dated July 10, 2012, revealed "...Risk for choking/aspiration due to several teeth missing & (and) has a chewing problem...Serve mechanically-altered diet & observe for texture tolerance...Dental consult as needed for any pain or mouth problems..."

Interview on July 23, 2012, at 2:23 p.m., with the resident, in the resident's room, revealed the resident had only three teeth and the teeth were broken.

Interview on July 25, 2012, at 8:25 a.m., with the Assistant Director of Nursing, in the conference room.

All resident medical records were reviewed by the Director of Nursing and the Assistant Director of Nursing to ensure that appropriate dental consults had occurred on 8/3/12. No other residents were found to be affected.

All licensed nursing staff, and the Social Services Director were in-serviced by the Director of Nursing and the Assistant Director of Nursing on proper dental services on 8/3/12 – 8/13/12.

The Director of Nursing and/or Assistant Director of Nursing will review 20 resident medical records to ensure appropriate dental consults had occurred weekly X 4 weeks. Then 10 residents monthly X 2 months and/or 100% compliance. Results obtained will be reported to the The Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator.
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.

(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
Personal must handle, store, process and transport linens so as to prevent the spread of infection.

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<tr>
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<tbody>
<tr>
<td>F 412</td>
<td>Coordinator, Admission</td>
<td>Minimum Data Set</td>
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<tr>
<td>F 441</td>
<td>Coordinator, Rehabilitation</td>
<td>Manager, Medical Director,</td>
</tr>
<tr>
<td>SS=D</td>
<td>Social Services Director,</td>
<td>Environmental Services</td>
</tr>
<tr>
<td></td>
<td>Director, Maintenance Director,</td>
<td>Dietary Manager, and the</td>
</tr>
<tr>
<td></td>
<td>Activities Director.</td>
<td></td>
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<td></td>
<td>F441</td>
<td>Resident #1 was assessed by the Director of Nursing on 7/25/12. No adverse outcomes noted. The Assistant Director of Nursing was educated on infection control practices for hand washing by the Director of Nursing on 7/25/12. Physician and responsible party notified.</td>
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<tr>
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<td>All residents were assessed by the Director of Nursing on 7/25/12. No other residents were found to be affected.</td>
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<td>All licensed nurses and nursing assistants were in-serviced from 7/25/12 - 8/13/12 regarding infection control practices for hand washing by the Director of Nursing.</td>
</tr>
</tbody>
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F 441: Continued From page 14

infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, facility policy review, and interview, the facility failed to follow infection control practices for hand washing during a dressing change for one resident (#1) of thirty-three residents reviewed.

The findings included:

Observation on July 25, 2012, at 10:00 a.m., in the resident's bathroom, revealed the Assistant Director of Nursing (ADON) washed the hands disposed of the paper towels by placing the paper towels in the trash can and the hands came in contact with other soiled paper towels in the trash can.

Review of the facility's policy Handwashing/Hygiene, no date, revealed "...purpose to decrease the risk of transmission of infection by appropriate handwashing...dry hands with a...paper towel and discard...awareness of contact with contaminated articles."

Interview on July 25, 2012, at 10:00 a.m., with the ADON, at the time of the observation, revealed the trash can had been full, the paper towels used after washing the hands had been used to push the soiled paper towels down in the trash can and the hands had came in contact with soiled paper towels.

A hand washing audit will be conducted by the Director of Nursing on 20 staff members weekly X 4 weeks, then monthly X 2 months and/or 100% compliance. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Maintenance Director, Dietary Manager, and the Activities Director.