STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445335

(x2) MULTIPLE CONSTRUCTION A. BUILDING SEP 16 2011 B. WING

(x3) DATE SURVEY COMPLETED 08/30/2011

NAME OF PROVIDER OR SUPPLIER

OAKWOOD COMMUNITY LIVING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 1536 WOODLAWN DYERSBURG, TN 38024

(x4) ID PREFIX TAG

F 278 SS=0

483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to accurately complete the Minimum Data Set (MDS) for pressure ulcers for 1 of 11 (Resident #3) sampled residents.

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

Cheryl Annas

DATE 11/15/11

RECEIVED

This Plan of Correction is being submitted as required by Federal regulations. The submission of this Plan of Correction is not to be construed as an admission by the facility as to the accuracy of the citations nor finding of facts. Please accept this as our Plan of Correction.

F278 SS=0

The assessment will accurately reflect the resident's status

1. The MDS for Resident #3 was corrected by the MDS nurse on 9/12/11.

2. The MDS assessments for other residents with pressure ulcers residing in the facility were reviewed by DON on 9/13/11 to ensure accurate coding of pressure ulcers. No other inaccuracies were found.

3. The MDS nurse was re-educated by the DON on 9/12/11 regarding the accurate coding of pressure ulcers on the MDS. The MDS nurse will confer with the DON and/or the Treatment Nurse and will review the most current pressure ulcer documentation prior to coding pressure ulcer staging on the MDS. The MDS nurse and the treatment nurse were educated regarding this system by the DON on 9/12/11.

TITLE NHA

DATE 11/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the facility 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 due the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are due 15 days following the due date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This Marx was faxed 11/15/11 at 4PM

FORM CMS-2567(02-10) Previous Versions Obsolete

Event ID: CG4711

Facility ID: TN2302

If continuation sheet Page 1 of 11
F 278Continued From page 1

The findings included:

Medical record review for Resident #3 documented an admission date of 1/10/10 with diagnoses of End Stage Dementia, Diabetes, Parkinson's and Hypertension. Review of the annual MDS dated 8/19/11 documented, "...M0800. Worsening in Pressure Ulcer Status Since Prior Assessment... Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment... If no current pressure ulcer at a given stage, enter 0... Stage 4..." This assessment indicated Resident #3 had a stage 4 pressure ulcer. Review of the treatment record dated 8/17/11 documented, "...Size [cm] [centimeters] L [length] x W [width] x D [depth] 0.50 x 0.80 x 0.00... Stage Unstageable: Suspected deep tissue injury... Tunneling None... Ulcer Margin Closed wound... Area Improving. Cont [continue] tx [treatment]..."

Observation in Resident #3's room on 8/29/11 at 11:55 AM, revealed Resident #3 had a very small red circular area less than 0.50 centimeters (cm) in length and width with depth with closed skin.

During an interview at the south nurses' station on 8/29/11 at 8:40 PM, Nurse #4 stated "...the pressure ulcer measurements are now 0.3 cm in length and width with no depth, closed, red area... It [pressure ulcer] was never a stage 4. It was a deep tissue injury. It healed from within. It didn't open..." Nurse #4 confirmed the MDS was inaccurate.

F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

F 278 4. The MDS completed for residents with pressure ulcers will be reviewed by the DON monthly for 3 months then quarterly for 3 quarters to assure the accuracy of pressure ulcer coding on the MDS. The results of these reviews will be reported to the QA committee monthly for 3 months and then quarterly for 3 quarters by the DON. The QA committee will make any needed changes to policy and procedure based on the results of the reports. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Maintenance Supervisor, Social Services, Dietary manager, Activity Director and Housekeeping supervisor.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CIA
IDENTIFICATION NUMBER:
445335

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
08/30/2011

NAME OF PROVIDER OR SUPPLIER
OAKWOOD COMMUNITY LIVING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1538 WOODLAWN
DYERSBURG, TN 38024

(X4) ID PREFIX TAG
F 314

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

ID PREFIX TAG
F 314

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

ID PREFIX TAG
F 314 SS=D

The facility will 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 review of the National Pressure Ulcer Advisory Panel Pressure Ulcer Prevention quick reference guide, policy review, medical record review and interview, it was determined the facility failed to complete weekly skin audits and quarterly Braden skin assessments, and failed to provide complete skin audits and treatment documentation for pressure ulcers for 1 of 7 (Resident #11) sampled residents with pressure sores.

The findings included:
Review of the "National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Prevention QUICK REFERENCE GUIDE" documented, "...3. Inspect skin regularly for signs of redness in individuals identified as being at risk of pressure ulceration. The frequency of inspection may need to be increased in response to any deterioration in overall condition... Ongoing assessment of the skin is necessary to detect early signs of pressure damage... 7. Document all skin assessments... Accurate documentation is essential for..."
Continued From page 3 monitoring the progress of the individual."

Review of the facility's "Pressure Ulcer Risk Assessment" policy documented, "...Upon admission, each resident will have Braden Scale completed by a licensed nurse. Reassessment will be done quarterly and as needed... 1. CNA's [certified nursing assistant's] will observe skin daily and report problems to the charge nurses... 3. The licensed nurse will conduct body audits weekly on residents... 4. The procedure for skin assessments and audits will be checked by the Director of Nursing (DON) or designee to ensure that it is followed properly."...

Medical record review for Resident #11 documented an admission date of 7/12/10 with a readmission date of 1/24/11 with diagnoses of Congestive Heart Failure, End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Insulin Dependent Diabetes Mellitus Type II, Depressive Disorder, Gastroesophageal Reflux Disease, Peripheral Vascular Disease and Morbid Obesity. Review of the comprehensive care plan dated 7/12/10 and updated 10/11/10 documented, "...Braden assessment quarterly and [as needed]... Body audit weekly and [as needed]... The facility was unable to provide quarterly Braden scale skin assessments for Resident #11.

Review of the "Weekly Body Audit" dated 7/18/10 to 11/29/10 and 1/2/11 to 1/26/11 documented incomplete weekly skin audits. The facility was unable to provide "Weekly Body Audit" skin assessments from 11/29/10 to 1/1/11.

Review of the "TREATMENT RECORD" for November 2010 and January 2011 failed to observations were completed as needed. The review was completed on 9/15/11.

3. Nurses and CNAs were re-educated on 9/15/11 by the DON regarding the skin care program to include updating the Braden Scale, completing weekly body audits, and documenting skin assessments and treatments.

Medical Records was re-educated by the DON on 9/15/11 regarding maintaining complete treatment records for residents. The Treatment nurse was re-educated by the DON on 9/15/11 regarding complete, consistent documentation for residents with pressure ulcers.

The Medical Records Nurse will review records quarterly following the MDS schedule to ensure the Braden Scale is completed on admission and updated quarterly. A schedule for completing body audits is in place. Nurses and CNAs were instructed regarding the schedule and the procedure for completing and documenting body audits on 9/15/11 by the DON. Medical Records will complete 2 chart audits weekly and report results to the DON. The chart audit will encompass the Braden Scale, the body audits, the treatment record, and the skin observations. Medical Records will report the results of the chart audits to the DON monthly. Medical Records was educated regarding the process by the DON on 9/15/11.
Continued from page 4

document complete description of each skin condition under treatment. The facility was unable to provide a "TREATMENT RECORD" for October 2010 and December 2010.

Review of the "Skin Conditions (observations)" for 7/1/2010 through 1/29/11 documented inconsistent and incomplete skin assessments and treatment.

During an interview in the DON's office on 9/30/11 at 12:30 PM, the DON was asked if Resident #11's "Treatment Record" and the "Skin Conditions (observation)" sheets were complete and accurate. The DON confirmed they were not and stated, "...not complete...inconsistencies between nurses and how it's documented..." The DON confirmed she was unable to locate the "TREATMENT RECORD" for October 2010 and December 2010. The DON was asked about the weekly skin audits. The DON confirmed they were not complete and that she was unable to locate any skin audits from 11/29/10 to 1/1/11. The DON was asked if Braden scale (skin assessments) was done quarterly. The DON stated, "I did not find them [Braden scale skin assessments]."

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 -
Continued From page 5

(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained when 6 of 8 Certified Nursing Assistants (CNA) #1, 2, 3, 4, 5 and 6) and 2 of 4 nurses (Nurses #1 and 2) failed to practice sanitary hand hygiene or touched food with their bare hands.

regarding the facility Handwashing Policy. Nurses #1 and Nurse #2 were re-educated per the DON on 8/30/2011 regarding the facility Handwashing Policy. Staff were re-educated on 9/15/11 regarding facility Handwashing Policy per DON.

2. The DON and Dietary Manager observed meal service on 8/30/11 and 8/31/11 to identify other staff not practicing proper hand hygiene. Staff will be educated upon hire an annual regarding the facility Handwashing Policy.

3. DON or Designee will observe dining services weekly to assure compliance.

4. Findings will be reported to the QA committee quarterly per DON or designee. The QA committee will consist of the Administrator, Director of Nursing, Medical Director, Maintenance Supervisor, Social Services, Dietary Manager, Activity Director, and Housekeeping Supervisor.
The findings included:

1. Review of the facility’s "Handwashing" policy documented, "...Procedure... 2. Appropriate ten (10) to fifteen (15) second hand washing must be performed under the following conditions... f. Before touching, preparing, or serving food... g. After having... contact with a resident..."

2. Observations in the north dining hall on 8/28/11 at 5:05 PM, CNA #1 touched the shoulder of a resident, pulled up the stool, moved the table and prepared the meal tray without washing her hands.

3. Observations in the north dining hall on 8/28/11 at 5:05 PM, CNA #2 touched the resident’s brownie and straw with her bare hand, moved to the next resident and touched their shoulder and prepared their meal tray. CNA #2 rolled on a stool to the next resident at the table and touched their hand and shoulder then held their straw with her bare hand while the resident drank. CNA #2 never washed her hands.

4. Observations in the north dining hall on 8/28/11 at 5:05 PM, CNA #3 delivered the meal tray to the resident at the table, returned to the meal cart, pulled the next meal tray and delivered the meal tray to the next resident. CNA #3 repeated this action four times without washing her hands.

Observations in the north hall on 8/28/11 at 5:13 PM, CNA #3 entered room 24 A delivered the meal tray, set up the tray and did not wash her hands before or after. CNA #3 entered room 26...
<table>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
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<tr>
<td>F 441</td>
<td>Continued From page 7 delivered the meal tray, rolled the head of the bed up, set up the meal tray and did not wash her hands before or after. CNA #3 then proceeded to the north hall dining room pulled a tray off the tray cart and served a resident in the dining room without washing her hands. Observations in the south dining hall on 8/28/11 at 5:29 PM, CNA #3 did not wash her hands before or after setting up the meal tray for five different residents. CNA #3 touched a resident's brownie with her bare hand. 5. Observations in room 15 on 8/28/11 at 5:06 PM, CNA #4 delivered the meal tray, prepared the meal tray, returned to the meal cart and picked up another tray. CNA #4 did not wash her hands. Observations in room 21 on 8/28/11 at 5:07 PM, CNA #4 delivered a meal tray, prepared the meal tray, returned to the meal cart and picked up another tray. CNA #4 did not wash her hands. Observations in room 25 on 8/28/11 at 5:10 PM, CNA #4 delivered a meal tray, prepared the meal tray, returned to the cart and picked up another tray. CNA #4 did not wash her hands. Observations in room 8 on 8/28/11 at 5:14 PM, CNA #4 prepared the meal tray and touched the hamburger bun with her bare hand. CNA #4 did not wash her hands. Observations in the south dining hall on 8/28/11 at 5:24 PM, CNA #4 prepared the meal tray and touched the hamburger bun with her bare hand.</td>
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F 441  Continued From page 8

Observations in room 9 on 8/28/11 at 5:25 PM, CNA #4 prepared the meal tray and touched the hotdog bun with her bare hands.

Observations in room 7 on 8/28/11 at 5:30 PM, CNA #4 delivered a meal tray, prepared the meal tray, returned to the meal cart and picked up another tray. CNA #4 did not wash her hands.

Observations in room 4 on 8/28/11 at 5:32 PM, CNA #4 delivered a meal tray, prepared the meal tray, returned to the meal cart and picked up another tray. CNA #4 did not wash her hands.

6. Observations in the south dining hall on 8/28/11 at 5:29 PM, CNA #5 did not wash her hands before or after setting up the meal tray for a resident.

Observations in the south dining hall on 8/28/11 at 12:20 PM, CNA #5 did not wash her hands before or after setting up the meal tray for five different residents.

7. Observations in the south dining hall on 8/28/11 at 5:29 PM, CNA #6 did not wash her hands before or after setting up the meal tray for three different residents.

Observations in the south dining hall on 8/29/11 at 12:20 PM, CNA #6 did not wash her hands before or after setting up the meal tray for eight different residents.

Observations in room 7 on 8/29/11 at 12:30 PM, CNA #6 delivered a meal tray, prepared the meal tray, returned to the meal cart and picked up another tray. CNA #6 did not wash her hands.
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<td>Observations in room 18 on 8/29/11 at 12:35 PM, CNA #6 delivered a meal tray, prepared the meal tray, applied the clothing protector to the resident, pulled a chair up to the overbed table and started feeding the resident. CNA #6 did not wash her hands.</td>
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<td>8. Observations in the north dining hall on 8/28/11 at 5:05 PM, Nurse #1 touched the resident’s brownie with her bare hand.</td>
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<td>Observations in the south dining hall on 8/28/11 at 5:29 PM, Nurse #1 did not wash her hands before or after setting up the meal tray for three different residents.</td>
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<td>Observations in the south dining hall on 8/29/11 at 12:20 PM, Nurse #1 did not wash her hands before or after setting up the meal tray for two different residents.</td>
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<td>9. Observations in the south dining hall on 8/28/11 at 5:29 PM, Nurse #2 did not wash her hands before or after setting up the meal tray for three different residents.</td>
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<td>10. During an interview in the Director of Nursing’s (DON) office on 8/30/11 at 8:45 AM, the DON was asked what was the expectation of staff washing their hands during the meal tray pass. The DON stated, &quot;...Expect them to wash hands with any patient contact, before serving trays, after touching the resident, expect staff not to touch the food with their bare hand...&quot;</td>
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<th>F 504</th>
<th>483.75/(X)(I) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN</th>
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<td>The facility will provide or obtain laboratory services only when ordered by the attending physician.</td>
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The facility must provide or obtain laboratory services only when ordered by the attending physician.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined a blood sample for laboratory tests was obtained without a physician’s order for 1 of 11 (Resident #3) sampled residents.

The findings included:

Medical record review for Resident #3 documented an admission date of 1/10/09 with diagnoses of End Stage Dementia, Diabetes, Parkinson's and Hypertension. Review of the laboratory (lab) test dated 5/26/11 documented a Complete Blood Count (CBC), Hemoglobin A1C and Comprehensive Metabolic Panel (CMP). The facility was unable to provide a physician’s order for the CBC, Hemoglobin A1C and CMP that were done on 5/26/11.

During an interview in the south nurses’ station on 8/29/11 at 3:40 PM, the Director of Nursing (DON) was asked about a physician’s order for the lab work done on 5/26/11. The DON stated, "As of now, I don’t know why they were done" and confirmed there was no order for the CBC, Hemoglobin A1C and CMP.

1. Resident #3’s attending physician and responsible party were notified per the change nurse on 8/29/2011 of lab work completed on 5/26/2011 without an order for.

2. Resident’s labs were reviewed for previous 6 months on 9/1/11 per Medical Records Nurse to assure laboratory test completed were ordered per each resident’s attending physician. Nurses were re-educated on 9/15/2011 per DON regarding procedure to obtain orders form the attending physicians for any resident laboratory test to be drawn.

3. Nurses will be educated upon hire and annually per DON or Designee regarding procedure to obtain orders from the attending physicians for any resident laboratory test to be drawn. The Medical Records Nurse will review resident’s laboratory test monthly to assure orders received from the attending physicians. The DON will review residents laboratory test monthly for 3 months then quarterly to assure compliance.

4. The QA committee consists of the administrator, Director of Nursing, Medical Director, Maintenance Supervisor, Social Services, Dietary manager, Activity Director and Housekeeping supervisor.