<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA Identification Number:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>445401</td>
<td></td>
<td>C</td>
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</table>

<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORTHBROOKE HEALTH CARE CENTER</td>
<td>121 PHYSICIANS DR JACKSON, TN 38305</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>F 309</td>
<td>483.25 Provide Care/Services for Highest Well Being SS=G</td>
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This REQUIREMENT is not met as evidenced by:

Complaint Investigation for TN00030577

Based on review of the National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Stages / Categories, medical record review and interview, it was determined the facility failed to ensure all areas of the skin were examined during skin audits for 1 of 5 (Resident #5) sampled residents at risk for skin breakdown. The failure to identify a wound prior to the development of the wound being unstageable resulted in actual harm to Resident #5.

The finding included:

Review of the NPUAP Pressure Ulcer Stages / Categories documented, "...Unstageable / Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer [wound] is completely obscured by slough [yellow, tan, gray, green or brown] and/or eschar [tan, brown or black] in the wound bed... Suspected Deep Tissue Injury - depth unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due

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

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.

RECEIVED DEC 28 2012
### F 309

Continued from page 1
to damage of underlying soft tissue from pressure
and/or shear...

Medical record review for Resident #5
documented an admission date of 9/4/12 with
diagnoses of Fractured femur, Alzheimer's
Disease, Chronic Kidney Disease, Hypertension
and Systolic Heart Failure. Review of the
"Physician's Telephone Orders" dated 9/4/12
documented, "Wear right leg immobilizer at all x's
[times] May take off during bathing + [and] skin
audit." Review of physician's orders dated 9/19/12
documented, "Patient may weight bear as
tolerated in brace. Skin checks daily. May undo
and open brace periodically through day."

Review of the "Nurse's Event Note" dated
9/30/12, Nurse #1 documented, "...right leg
posterior area just above ankle. Deep tissue injury
from right leg immobilizer... removed right leg
knee immobilizer to examine leg. Found area
approx. [approximately] 7cm [centimeters] long x
[b] approx. 2cm wide, area discolored with no
open area noted at present."

Review of the "WOUND AND PRESSURE
ULCER INFORMATION" form dated 10/1/12 the
Assistant Director of Nursing documented,
"Length 11.7 cm x Width 1.5 cm x Depth udt
[unable to determine] cm... 4.5 cm area proximal
wound loose skin over dark appearing tissue
underneath. Middle area with dark black tissue
slightly soft and area at distal end hard black. Has
small arm [amount] red tissue surrounding dark
tissue."

Review of the "Physician's Telephone Orders"
dated 10/7/12 documented, "Res [resident]..."

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| 3. On 10/1/12, 10/15/12, 12/17/12
& 12/28/12, the ADON & DON
conducted in-service with licensed
nurses and CNA's regarding the
importance of recognizing potential
for breakdown, conducting complete
skin audits (removing immobilizers &
braces, unless contraindicated)
reporting concerns; proper
documentation of skin assessments,
and monitoring of interventions;
treatments designed to prevent skin
breakdown and promote healing &
proper staging of pressure ulcers.
4. The DON, and/or her designee
will conduct skin audits bi-weekly for
3 months and weekly thereafter on
current patients. CNA's will inspect
skin daily during routine care and
report any problems to their charge
nurse. The DON, ADON and Unit Mgr.
will conduct chart audits on identified
skin concerns to ensure proper
documentation and treatment. These
findings will be discussed daily during
morning QA meetings, reported to the
Skin & Nutrition Focus Team weekly,
and to the QA committee quarterly.

Completion date: 12/28/12
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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 2 transferred to [name of hospital] ER [emergency room] r/t [related to] DTI [deep tissue injury] RLE [right lower extremity]...&quot;</td>
<td>F 309</td>
<td></td>
<td></td>
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Review of the hospital emergency department report dated 10/1/12 documented, "...PHYSICAL EXAMINATION... Musculoskeletal / Extremity: Right Lower Extremity: stage 2- [to] 3 later lower leg ulcer. 5-8 cm..."

Review of the hospital "History and Physical" dictated on 10/3/12 documented, "ASSESSMENT: 1. Right lower extremity ulcer with surrounding cellulitis..."

Review of the hospital "Discharge Summary" dictated 10/6/12 documented, "Discharge Diagnosis: 1. Infected right lower extremity non healing ulcer with surrounding cellulitis. Cultures grew coagulase-negative staph..."

During an interview conducted via phone on 11/17/12 at 1:30 PM, Nurse #1, who first identified the wound stated the distal end of the wound appeared to have necrotic tissue when it was first identified on 9/30/12.

During an interview conducted via phone on 12/12/12 at 10:35 AM, Physician #1 stated the resident had the wound when she was admitted to the hospital. The physician also stated the wound was infected.