DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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RECEIVED
OCT 20 2011
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		C 09/29/2011

NAME OF PROVIDER OR SUPPLIER: WOODCREST MANOR CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 09/27-29/11. Deficient practice was identified with the highest scope and severity at "F" level. An abbreviated standard survey (KY17118) was also conducted at this time. The complaint was unsubstantiated with no related deficiencies.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to provide medically related social services for two (Residents #1 and #17) of twenty-six sampled residents. Resident #1's upper dentures were missing, and Resident #17's lower dentures were missing. The facility failed to make the necessary dental appointments for the two residents since the dentures had been missing. The findings include: A review of the admission agreement (facility's responsibilities) regarding residents' personal property revealed the facility was responsible for the loss of personal property retained in the resident's possession if the loss was caused by the negligence of the facility.	F 250	F250 1. Resident #1 and #17 have obtained replacement dentures. 2. 100% audit will be conducted by SSD or designee on all residents identified as to having dentures to ensure all are in place and in working order. All residents that are found to have problems with their dentures will be referred to dietician, speech therapist, and schedule appointment with dentist for possible denture replacement as needed. 3. Re-education of Social Service employees by DON and EDT related to their responsibility to follow up once notified of missing dentures, including notifying Administrator, Director of Nursing, family, physician and dietician. Social Services will also track and follow up timely that the center has responded appropriately to make sure resident has no negative outcomes. All center staff re-educated to notify Social Services once any	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: NHA (X6) DATE: 10/20/11

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.

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F 250	Continued From page 1 1. A review of the medical record for Resident #1 revealed the facility admitted the Resident on 08/03/11, with diagnoses that included Diabetes Mellitus, Chronic Normocytic Anemia, Hypertension, Coronary Artery Disease, Depression, and Anxiety. A review a quarterly Minimum Data Set (MDS) assessment dated 09/23/11, revealed Resident #1 was alert and oriented, could make himself/herself understood, and understood others. During the initial tour an interview was conducted with Resident #1 at 2:15 PM on 09/27/11. The resident stated in interview the resident's gums were sore and he/she had trouble chewing food because the resident's dentures had been missing for approximately two weeks. The resident also stated staff was having a hard time keeping the resident's blood glucose levels up to normal limits and staff had to give the resident orange juice earlier in the day on 09/27/11. The resident stated he/she had reported the missing dentures to the facility but the facility had not responded to the resident's concerns related to his/her missing dentures. Resident #1 stated the dentures were on the overbed table during a meal service (about two prior to the interview) and after staff picked up the tray the resident was unable to locate the dentures. An interview was conducted with the Social Worker (SW) at 4:30 PM on 09/28/11. The SW stated she was aware Resident #1's dentures were missing. The SW stated the dentures had been missing since 09/19/11. The SW further	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* resident's dentures are missing or broken. Administrator and/or designee will monitor weekly for 1 month and then twice a month for next 30 days and once a month for next 30 days by interviewing 10 staff and 10 residents for any knowledge of residents with any denture issues. 4. All monitoring findings will be reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA members consist of Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Social Services, Dietary Service Manager, MDS nurse, Education/Training Director, Therapy Manager and Maintenance Director. 5. Date of Compliance: 11/13/11	

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F 250	Continued From page 2 stated the Staff Development Coordinator (SDC) had scheduled Resident #1 a dentist appointment for 09/23/11. The SW stated she was not aware Resident #1 was having difficulty chewing due to the resident's gums being sore. An interview was conducted with the Staff Development Coordinator (SDC) at 5:10 PM on 09/29/11. The SDC stated Resident #1 had a scheduled dentist appointment on 09/23/11, for a tooth to be refilled which had already been scheduled prior to the resident losing his/her dentures. The SDC stated he/she "was not aware [Resident #1's] dentures were missing until yesterday (09/28/11)." The SDC stated on 09/28/11, the SW made Resident #1 a dentist appointment for the following Monday (10/03/11). 2. An interview conducted on 09/29/11, at 3:00 PM, with Resident #17 revealed his/her lower dentures had been missing for approximately two weeks. Resident #17's family member was present during the interview and stated the missing dentures were reported to staff on 09/19/11. The resident's family member also stated Resident #17 was "not one to leave (his/her) teeth lying around;" furthermore, Resident #17 stated that he/she only removed his/her dentures at night to soak in a denture cup, then put the dentures back in his/her mouth in the morning after the nurse aides had brushed the dentures. The family member stated a care plan meeting was conducted on 09/21/11, and he/she was informed a formal investigation took place to locate the resident's missing dentures throughout the facility but the dentures were not located. The resident's family member also stated during the care plan meeting he/she was advised to make	F 250		

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F 250	Continued From page 3 Resident #17 an appointment with a dentist to have the resident's lower dentures made and the facility had not offered to compensate for the dentures. The facility failed to make the necessary appointment for the resident to obtain dental services to replace the resident's missing dentures.	F 250	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to obtain physician's orders for one of twenty-six sampled residents (Resident #4) to ensure the resident's immediate care needs were provided upon admission. The facility admitted Resident #4 on 09/22/11, at 5:30 PM, and noted the resident had two open areas to the left buttock, one open area to the right buttock, two unhealed areas to the right below-the-knee amputation site, two open areas to the right thigh, two open areas to the left thigh, two open areas to the left upper flank area, and an open area to the left breast. However, the facility failed to obtain physician's orders to provide treatment to the areas that were noted to be present upon admission until 09/23/11, at 6:30 PM, twenty-five hours after admission. The findings include: A review of the facility policy titled Wound	F 271	F271 1. Resident #4 was corrected and a thorough skin assessment was completed on 9/23/11 (on the 7a-3p shift) and placed in the medical record. MD orders were obtained and implemented on 9/23/11 (on the 7a-3p shift by the Unit Manager on duty). 2. An audit of all admissions or readmissions from 8/28/11 through 9/27/11 will be completed by DON or designee to verify any residents that had admitted wounds received timely and appropriate MD orders. Any areas of concern will be addressed with physician for appropriate orders and families notified. 3. Re-education by DON and EDT of licensed staff related to the admission process related to the skin policy, which includes the initial skin assessment to identify all admit wounds, completion of appropriate paperwork for tracking wounds progress and getting orders for	

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F 271	Continued From page 4 Prevention and Treatment (last revised date April 2009) revealed facility staff was to obtain a physician's order as applicable to provide necessary treatment and services to promote healing and prevent infection for resident wounds. Record review revealed the facility admitted Resident #4 on 09/22/11, at 5:30 PM, with diagnoses of Right Below-the-Knee Amputation, Diabetes, End Stage Renal Disease with Hemodialysis, and Calciphylaxis. Due to the resident's recent admission, a Minimum Data Set (MDS) assessment was not available for review. A review of the facility's admission skin assessment for Resident #4 revealed a 7 centimeter (cm) x 5 cm area and a 2.8 cm x 1.3 cm area to the resident's left buttock. Continued review of the admission skin assessment for Resident #4 revealed a 6 cm x 2 cm area to the right buttock, and a 1.7 cm x 3.6 cm area and a 5.8 cm x 5.8 cm area to the resident's right thigh area. The admission skin assessment further revealed two areas to the resident's left thigh, one that measured 1.6 cm x 2.8 cm and the other area was not clearly documented. The upper left flank area also had two areas present, one that measured 15 cm x 10 cm and another that measured 10 cm x 4 cm. The admission skin assessment for Resident #4 further revealed the resident had a right below-the-knee amputation with two open areas present to the operative site, one present to the left side that measured 7 cm x 3 cm and documented to be one cm in depth, and the other on the right side of the operative site was noted to be 7 cm x 5 cm. In addition, based on documentation on the admission skin	F 271	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* treatments when necessary. New and readmitted residents will have skin assessments completed by DON and/or designees to validate the initial skin assessment was correct on every new and readmitted resident for the first 30 days, then every other new and readmitted resident for next 30 days, then every third new or readmitted resident for next 30 days. All paperwork will also be validated to be correct and appropriate treatments in place. 4. All admission and readmission DON and or designee skin assessments and paperwork validation information will be reviewed at monthly QA meeting for compliance and/or the need to update plan to reach 100% compliance. Nursing staff not following skin assessment policy will receive re-education and/or disciplinary action. 5. Date of Compliance 11/13/11	

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F 271	Continued From page 5 assessment, the resident had an open area to the left breast that measured 3.2 cm x 2.4 cm. A review of physician's orders written on 09/22/11, the day of Resident #4's admission, revealed the physician had not prescribed wound care treatments for the resident's wounds. Continued review of the medical record revealed Licensed Practical Nurse (LPN) #1 had completed the resident's admission assessment to the facility. However, based on documentation, the LPN failed to contact the resident's physician to obtain treatment for residents' wounds at the time of admission. An interview with LPN #1 on 09/29/11, at 3:15 PM, revealed she had not called the physician to obtain orders for treatment to the wounds present upon admission to Resident #4. Further interview revealed LPN #1 stated she had received two admissions during her shift and due to timeframes had failed to contact the physician to obtain treatment orders for the resident's wounds. An interview with the Director of Nursing (DON) on 09/29/11, at 5:50 PM, revealed the nurse that admitted a resident with wounds was responsible to contact the physician and obtain orders to provide treatment to the wounds.	F 271		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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F 281	Continued From page 6 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for one of twenty-six sampled residents (Resident #4). The facility admitted Resident #4 on 09/22/11, with an open abdominal wound requiring a wound vac, a Stage IV pressure ulcer to his/her coccyx, unhealed areas to the right below-the-knee amputation site, lesions to the right proximal and distal thigh, a lesion to the left breast, and a lesion to the right upper thigh, left upper posterior thigh, and left flank area. The facility failed to develop an Admission/Initial plan of care related to the need for treatment and/or monitoring of the resident's wounds for signs and symptoms of infection. The findings include: A review of the facility's Admission Process policy (dated July 2010) revealed the facility staff is to initiate a plan of care based on the resident's identified needs within 24 hours of the resident's admission to the facility. A review of the medical record revealed the facility admitted Resident #4 on 09/22/11, with diagnoses of Status Post Colon Resection, Calciphylaxis, End Stage Renal Disease with Hemodialysis, Right Below-the-Knee Amputation, and Diabetes. Due to the recent admission status of Resident #4, a Minimum Data Set (MDS) assessment was unavailable for review. Review of the Admission/Initial Care Plan titled Skin Integrity Assessment, dated 09/25/11, revealed no documented evidence the facility developed a Plan of Care to address the	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F281 1. Resident #4 care plans were reviewed and completed appropriately on 9/29/11. 2. Audits of all admissions and readmissions from 8/28/11 through 9/27/11 will be completed by DON or designee to identify any residents with incomplete skin care plans. Any areas of concern will be addressed at time of audit. 3. Re-education by DON and EDT of licensed staff related to the admission process required nursing care plans to be completed. Licensed staff will be re-educated on how to correctly complete care plans. All admissions and readmissions to the center will be audited the day after admission for thoroughness and accuracy of admission paperwork by DON or designee. New and readmitted residents will have care plans audited by DON and/or designees to validate the accuracy and thoroughness of care plans in place on every new and readmitted resident for the first 30 days, then every other new and readmitted	

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F 281	Continued From page 7 resident's open abdominal wound, requiring a wound vac, or the resident's Stage IV pressure ulcer to the coccyx, or the other wounds requiring treatment observed to be on the admission nursing skin assessment. An interview with Licensed Practical Nurse (LPN) #3 on 09/29/11, at 1:35 PM, revealed although Resident #4 was admitted on 09/22/11, when LPN #3 came on shift on 09/25/11, Resident #4 did not have a care plan related to Skin Integrity in place. Continued interview with LPN #3 revealed she initiated the Skin Integrity Care Plan on 09/25/11, but did not address the resident's abdominal wound with wound vac, the Stage IV ulcer to the resident's coccyx, or the other wounds requiring treatment. An interview on 09/29/11, at 3:15 PM, with Licensed Practical Nurse (LPN) #1, who admitted Resident #4, revealed she had not initiated a care plan related to the resident's wounds present on admission because she had two admissions during her shift and had not had time to do so. An interview with the Director of Nursing (DON) on 09/29/11, at 5:50 PM, revealed care plans should be initiated within 24 hours of a resident's admission. Continued interview with the DON revealed Resident #4's abdominal wound and other wounds noted on the admission nursing assessment should have been included on the resident's admission plan of care.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* resident for next 30 days, then every third new or readmitted resident for next 30 days. All paperwork will also be validated to be correct and appropriate treatments in place. 4. All audit findings will be reviewed at monthly QPI meeting for further review and update as indicated. Nursing staff not following care plan process will receive re-education and/or disciplinary action. 5. Date of Compliance 11/13/11	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		

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F 312	Continued From page 8 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide the necessary services to maintain good grooming and hygiene for one of twenty-six sampled residents (Resident #4). On 09/27/11 and 09/28/11, Resident #4 was observed to have long fingernails with a dark brown substance noted underneath the nails. In addition, the resident was observed to have a heavy growth of long gray hairs from the resident's chin. The findings include: A statement from the Director of Nursing (DON) on 09/29/11, revealed the facility did not have a policy related to Nail Care of diabetic residents or providing assistance with grooming for residents that required assistance. A review of the procedure of nail care presented by the DON, titled Lippincott's Textbook for Nursing Assistants (no date noted) revealed in many facilities the task of nail care must be performed by a nurse. A review of the grooming procedure, also titled Lippincott's Textbook for Nursing Assistants (no date noted) revealed that some women experience the growth of coarse facial hair as they age, and they should be assisted with removing it as necessary. A review of the medical record revealed the facility admitted Resident #4 to the facility on	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F312 1. Resident #4 facial hair was properly groomed and nails addressed on 9/29/11. 2. 100% audit on all residents nails and grooming was completed by DON on 9/30/11 to identify any residents with grooming issues. Any grooming issues were immediately corrected the day of audit. 3. Re-education was provided by DON and EDT to all licensed and certified nursing assistants related to nail care and facial hair removal on all residents. DON and or designee will monitor all residents for appropriate grooming of nails and facial hair 5 days a week for 30 days, 3 days a week for next 30 days and 1 day a week for next 30 days. 4. All grooming monitoring findings will be reviewed at monthly QA for compliance and or the need to update plan to reach 100% compliance. Any staff member found to not be providing resident grooming requirements will be re-educated and/or receive disciplinary action. 5. Date of compliance 11/13/11	

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F 312	Continued From page 9 09/22/11, with diagnoses of End Stage Renal Disease, Morbid Obesity, Diabetes, and Weakness. Due to the resident's recent admission, the facility had not completed a Minimum Data Set (MDS) assessment of the resident, therefore, an MDS assessment was not available for review. In addition, review of an Activity of Daily Living care plan revealed facility staff had not completed and/or initiated the care plan during the seven-day period since the resident's admission to the facility on 09/22/11. Resident #4 was observed on 09/27/11, at 4:30 PM and 5:40 PM, to be lying in bed. The resident's fingernails were observed to be long with a dark brown substance underneath the fingernails. The resident was also observed to have a heavy growth of long gray hairs from his/her chin area. Further observations on 09/28/11, at 8:45 AM, 9:30 AM, 11:05 AM, 12:40 PM, 1:20 PM, 3:30 PM, 4:30 PM, and 5:30 PM, revealed the resident's nails continued to be long and in need of trimming, and his/her chin area continued to need grooming. An interview with Certified Nurse Aide (CNA) #1 on 09/28/11, at 4:10 PM, revealed she had not checked Resident #4's fingernails during her 7 AM-3 PM shift on 09/28/11. Further interview revealed she had noticed the resident's facial hair and stated, "I did not have the time to shave (him/her)." The CNA stated she should have told the nurse she did not have time to shave the resident but had failed to do so. An interview with CNA #5 on 09/29/11, at 5:35 PM, revealed she had provided care for Resident #4 on the 11 PM-7 AM shift on 09/28/11, and had	F 312		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 10 not "noticed" the resident's fingernails to be long and in need of cleaning and trimming. However, CNA #5 stated she did attempt to shave the resident's facial hair from his/her chin and the resident had refused. CNA #5 stated she had not informed the nurse of the resident's refusal of care. An interview with Licensed Practical Nurse (LPN) #3 on 09/28/11, at 4:20 PM, revealed she was assigned to provide nursing care to Resident #4 on 09/28/11, on the 7 AM-3 PM shift. Further interview revealed she had not noticed Resident #4's nails were in need of cleaning and trimming but had observed the gray facial hair to the resident's chin. LPN #3 continued to state she had not instructed the CNA to provide the needed grooming but stated she should have. An interview with LPN #2 (Unit Manager) on 09/28/11, at 4:25 PM, revealed she had not been aware that Resident #4's nails were dirty and in need of trimming, but had noticed that his/her facial hair was in need of trimming, "just" prior to the interview. Further interview with LPN #2 revealed CNAs should report to the nurses when a diabetic resident needs nail care. LPN #2 stated the facility did not have a system in place to ensure diabetic residents received nail care and had relied on CNAs to inform the nursing staff on the resident's shower/bath days if a resident needed nail care. An interview with the Director of Nursing (DON) on 09/29/11, at 5:50 PM, confirmed the facility did not have a policy or a schedule/system to ensure diabetic residents' fingernails remained clean and trimmed. However, according to the DON,	F 312		

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F 312	Continued From page 11 CNAs were expected to notify the nurse if a diabetic resident's nails needed to be trimmed. The DON also stated residents should receive nail care and assistance with grooming when needed.	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 314 SS=D	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 observation, interview, and record review it was determined the facility failed to ensure residents with pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for one of twenty-six sampled residents (Resident #4). The facility admitted Resident #4 to the facility on 09/22/11, and assessed the resident to have a Stage IV pressure sore to the coccyx. However, facility staff failed to contact the resident's physician until 09/23/11, to obtain treatment orders to enhance wound healing and to prevent infection. In addition, Resident #4 was observed at various times on 09/28/11, to be lying on his/her back and had not been turned and repositioned.	F 314	F314 1. MD notified of resident #4 treatment needs on 9/23/11. Resident turn and repositioning occurred as ordered immediately after DON was made aware on 9/28/11. 2. Audits of all admissions from 8/28/11 through 9/27/11 will be completed by DON or designee to identify any residents that had noted wounds received timely and appropriate MD orders. Any areas noted to be incomplete will be corrected. 3. Re-education by DON and EDT of licensed personal related to the admission process: required orders to be obtained and paperwork to be completed. Re-education of licensed and certified staff related to the turning and repositioning policy and notification of charge nurse if unable to provide required care. Turning and repositioning rounds and education began immediately to ensure protocol followed. All admissions to the center will be audited the day after admission for thoroughness and	

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F 314	Continued From page 12 The findings include: Review of the facility policy "Wound Prevention and Treatment" (revised date of April 2009) revealed residents with pressure ulcers would receive continued preventive interventions and necessary treatment and services to promote healing and to prevent infection. A review of the clinical record revealed the facility admitted Resident #4 on 09/22/11, at 5:30 PM, with diagnoses of Diabetes, End Stage Renal Disease with Hemodialysis, and Morbid Obesity. Due to the resident's recent admission, there was not a Minimum Data Set (MDS) Assessment available. However surveyors' observations revealed Resident #4 required extensive assistance to turn and reposition while in bed. A review of the skin integrity assessment, prevention, and treatment plan of care for Resident #4 dated 09/25/11, revealed the facility had assessed the resident to be a moderate risk for pressure sore development. Facility staff developed a turning and repositioning schedule for the resident that included the use of foam wedges in order to maintain the resident in a 30-degree lateral position. However, further review of the skin integrity assessment for Resident #4 revealed facility staff failed to address an existing Stage IV pressure area to the resident's coccyx. A review of the resident's clinical record revealed facility staff admitted the resident to the facility on 09/22/11, at 5:30 PM. Documentation revealed facility staff failed to contact the resident's physician for treatment orders for an existing	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* accuracy of admission paperwork by DON or designee. Turning and repositioning observation rounds will be completed on all three shifts 4 times a week for 1 week, then 2 times a week for 2 weeks, then once a week thereafter for 90 days. 4. All audit findings will be reviewed at monthly QPI meeting for further review and update as indicated. Nursing staff not following skin policy will receive re-education and/or disciplinary action. 5. Date of Compliance 11/13/11	

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F 314	Continued From page 13 Stage IV pressure area until 09/23/11, at 6:30 PM, approximately 25 hours after the resident had been admitted to the facility. In addition, a review of Resident #4's treatment record revealed no documentation that staff had provided wound care to the resident's coccyx from the time of admission on 09/22/11, until 09/24/11, on the 3 PM-11 PM shift. Observations of Resident #4 on 09/28/11, at 8:45 AM, 9:30 AM, 10:45 AM, 12:00 PM, 1:20 PM, 3:30 PM, 4:30 PM, and 5:30 PM, revealed the resident had been positioned on his/her back. An interview with CNA #1 on 09/28/11, at 4:10 PM, revealed Resident #4 had not been turned or repositioned on the 7 AM-3 PM shift on 09/28/11. CNA #1 stated she had gone into Resident #4's room frequently during the shift and offered to turn him/her but the resident refused. CNA #1 stated she should have reported the resident's refusal to be turned/repositioned to the charge nurse, but had failed to do so during the 7 AM-3 PM shift on 09/28/11. An interview with CNA #4 on 09/28/11, at 5:15 PM, revealed he had been assigned to provide care for Resident #4 on the 3 PM-11 PM shift on 09/27/11. CNA #4 stated Resident #4 had refused to be turned and repositioned during his shift and that he had not reported the resident's refusal to the charge nurse. An interview with CNA #5 on 09/28/11, at 5:35 PM, revealed she was assigned to provide care for Resident #4 on the 11 PM-7 AM shift on 09/27/11. Further interview with CNA #5 revealed even though Resident #4 frequently refused to be	F 314		

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F 314	Continued From page 14 turned and repositioned, the CNA had not reported the behavior to the charge nurse. An interview with Licensed Practical Nurse (LPN) #2 on 09/29/11, at 10:50 AM, revealed Resident #4 should be turned and repositioned every two hours and she was not aware the resident refused to be turned and repositioned. In addition, the LPN, who is also the Unit Manager, stated the nurse that completed the resident's admission to the facility should have contacted the resident's physician and obtained treatment orders for the Stage IV pressure area to Resident #4's coccyx at the time of the resident's admission to the facility. An interview with the Director of Nursing (DON) on 09/29/11, at 5:50 PM, revealed she was unaware Resident #4 refused to be turned and repositioned, and also stated the CNAs that had been assigned to provide care to the resident should have charted and reported the resident's refusal to the charge nurse. The DON also stated the nurse that admitted Resident #4 to the facility should have called the physician and obtained orders to treat the resident's wound.	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by:	F 364	F364 1. Resident #26 has had no concerns with food temperature or taste since 9/28/11. No other resident was identified. 2. Interviews with all residents receiving pureed meals will be interviewed by Dietary Service Manager and/or Dietician regarding food temperature and taste. Any resident with concerns will have those concerns addressed immediately. 3. Re-education will be provided by Dietician to Dietary Service Manager and dietary staff on the food temperature requirements and palatability of food. Trays served in the dining room will be covered before serving tray to resident to help keep correct temperatures. Dietary Service Manager and/or Designee will interview 3 different puree diet residents 5 days a week for 30 days for satisfaction of food temperatures and palatability of their meal, then 2 residents 3 days a week for next 30 days, then 1 resident a week for next 30 days. Dietary Service Manager or	

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F 364	Continued From page 15 Based on observations and interviews, it was determined the facility failed to ensure food was prepared in a manner that conserved palatability and proper temperatures for ten facility residents that received pureed foods. Interviews with three residents that received pureed foods revealed the food items were often served cold and/or with no seasoning, and were not palatable. The findings include: During the group interview on 09/28/11, at 10:30 AM-11:05 AM, two unsampled residents that had received pureed food complained the food was often cold, had no seasoning, and could not be eaten. Observations of the lunch meal on 09/28/11, revealed residents were served ham with beans and seasoned greens. Based on observation, meals delivered to residents in the dining room were delivered with uncovered plates and meals delivered to residents in their rooms were delivered on trays in an enclosed cart with covered plates. Two test trays were requested from the kitchen to test for temperature and palatability. One tray was of regular consistency, and the second tray was of a pureed consistency. The regular consistency ham and beans was at an acceptable range at 158.6 degrees but the pureed ham and beans was 123.9 degrees Fahrenheit, 16 degrees below the acceptable range of 140 degrees Fahrenheit or above. The pureed greens were at an acceptable temperature of 143.3 degrees Fahrenheit but the regular consistency greens was 130.1 degrees and was below the acceptable range of 140 degrees Fahrenheit or above. The regular and	F 364	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Designee will monitor with test trays for correct temperature and palatability 5 days a week for 2 weeks, 3 days a week for 1 month, then weekly for next 60 days. Administrator will ask to attend Resident Council monthly for 90 days and discuss meal satisfaction with attendees. 4. All resident meal interviews related to temperatures and palatability and resident council concerns will be reviewed during monthly QA for compliance. Any areas of concerns will be addressed and plan updated for 100% compliance. 5. Date of compliance 11/13/11	

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F 364	Continued From page 16 pureed ham and beans were bland to taste and the pureed greens were not palatable. An interview with Resident #26 on 09/28/11, at 1:08 PM, revealed the resident was satisfied with the temperature of the pureed ham and beans but the resident was unable to identify the pureed greens by taste.	F 364	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to distribute and serve food under sanitary conditions. Food serving trays were noted to have a plastic covering and the edges of the trays were chipped and cracked around the edges. In addition, the plastic coating on the trays was observed to have areas that were missing from the edges and bottoms of the trays and created a surface that had the potential to harbor contaminates/bacteria; as a result, the facility could not ensure the serving trays were completely sanitized and that food was served under sanitary conditions.	F371 F 371	1. No resident was identified. 2. 100% audit will be conducted by Dietary Service Manager and Administrator of all serving trays and all trays with cracks or breaks will be thrown away. 3. Re-education will be provided by Dietician to dietary staff on identifying serving equipment that does not meet sanitary requirements and the removal of any item from usage and the ongoing replacement of these items as the older ones break down. New serving trays will be purchased to replace all thrown away. Dietary Service Manager and/or designee will audit all serving trays for wear and tear and removal from use 5 days a week for 30 days, 3 days a week for next 30 days and 1 day a week for next 30 days. 4. All audit findings will be reviewed at monthly QA for compliance. Any issues or concerns will be addressed and plan updated for 100% compliance. 5. Date of compliance 11/13/11	

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F 371	Continued From page 17 The findings include: Observation of a supper tray line on 09/27/11, at 5:12 PM, revealed food serving trays with chipped, cracked, and missing portions of the plastic coating around the edges and bottoms of the tray. Continued observations on 09/27/11, at 5:50 PM, of the supper meal served to residents in their room on the South Hall revealed residents were served food on serving trays that were also chipped, cracked, and missing portions of the plastic covering. The missing plastic covering created a surface that could harbor bacteria and had the potential to be ineffectively sanitized to destroy potential foodborne illness. Interview with the Dietary Manager (DM) on 09/29/11, at 4:05 PM, revealed the facility had not replaced the serving trays during the three years she had been employed at the facility.	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F431 1. All expired medications and/or medical supplies listed in statement of deficiencies were thrown away from the medication rooms. 2. All items in medication room were checked for temperature guidelines and temporary adjustments were made to accommodate temperature guidelines until medication room temperatures could be regulated. A 100% audit of all supplies in medication rooms will be checked by central supply clerk for expiration dates and any expired medical supplies/medications will be thrown away. 3. Center will repair HVAC to accommodate correct temperatures within medication rooms. Education will be provided by DON and EDT of licensed staff and central supply clerk on protocol for the removal of expired medication and/or supplies. Education of Maintenance Director and the assistant on their responsibility to monitor and log temperature of medication rooms weekly. Supply Clerk to be responsible to check all	

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F 431	Continued From page 18 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy it was determined the facility failed to store medications and biologicals in accordance with current accepted professional principles. Observation of the first and second floor medication rooms revealed the facility failed to monitor medication room temperatures to ensure medications were stored at the appropriate temperature in accordance with facility policies and the United States Pharmacopeia guidelines recommendations for temperature ranges of 59-77 degrees Fahrenheit. In addition, the facility failed to ensure expired medications and biological supplies were not available for resident use. The findings include:	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* medication room supplies and medication expiration dates weekly going forward. DON and/or designee will audit medication supply room for expired items 3 days a week for 30 days, 2 days a week for next 30 days and 1 time a week for next 30 days. Administrator will audit medication room temperatures once a week for 3 months. 4. All medication room audits for correct temperature and expired supplies/medications will be reviewed during QA for compliance. Any issues or concerns will be addressed and plan updated for 100% compliance. 5. Date of compliance 11/13/11	

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F 431	Continued From page 19 A review of the facility's policy (revision date of 08/09/11) related to Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles revealed that the facility should ensure that medications and biologicals that have an expired date on the label are stored separate from other medications until destroyed or returned to the supplier. The policy also revealed the facility should ensure medications and biologicals were stored at temperature ranges of 59-77 degrees Fahrenheit as recommended by the United States Pharmacopeia guidelines. An observation on 09/29/11, at 4:00 PM, of the first floor medication room revealed numerous biological supplies that had exceeded the manufacturer's recommended expiration dates. Based on observation, twelve vacutainers had an expiration date of February 2011, three vacutainers had expiration dates of May 2011, and two Iodoform packing strips had expiration dates of January 2011. In addition, the temperature of the first floor medication room was 84 degrees Fahrenheit and exceeded the temperature ranges established by the facility for the storage of medications and biologicals. An observation on 09/29/11, at 5:35 PM, of the second floor medication room revealed numerous biological supplies that had exceeded the manufacturer's recommended expiration dates. Based on observation, one Monoject safety syringe expired in July 2011; three Monoject safety syringes expired in June 2010; one Monoject safety syringe expired in July 2009; one Monoject safety syringe expired in April 2009; four Iodoform packing strips expired in January	F 431		

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F 431	Continued From page 20 2011; four Heparin single-use syringes expired in August 2011; four Heparin single-use syringes expired in June 2011; and twenty Heparin single-use syringes expired in May 2010. In addition, the temperature of the second floor medication room was 82 degrees Fahrenheit and exceeded the temperature ranges established by the facility for the storage of medications and biologicals. An interview on 09/29/11, at 5:45 PM, with LPN #2 revealed she was unsure who was responsible to monitor expiration dates on medications/biological supplies in the medication room. The LPN also stated nurses were to check expiration dates on medications prior to administration and on biological supplies prior to their use. An interview on 09/29/11, at 6:10 PM, with the Director of Nursing (DON) revealed the facility did not have a policy related to who was responsible to monitor the medication rooms for expired medications or the temperature of the medication rooms. The DON stated expiration dates of medications should be checked by the pharmacy and nurses were to check expiration dates before the administration of a medication. The interview also revealed the central supply clerk was to monitor expiration dates of biological supplies in the central processing area and stated the clerk had not been instructed to monitor supplies in the medication rooms. In addition, the DON stated maintenance personnel were to monitor the temperature of the medication rooms.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F441 1. Resident #25 was monitored and suffered no adverse reaction related to LPN #4 not wearing gloves. 2. 100% audit to be conducted by DON or designee on licensed staff related to administration of injections to identify any nurse not wearing gloves during time of injection. 3. LPN #4 was re-educated 1:1 by DON on 9/29/11 related to infection control policy to wear gloves during injection. Re-education by DON and EDT of all licensed staff related to infection control policies was completed. Specifically administration of injections. Random observation of nurses administrating injections will be completed by DON or designee to ensure proper procedures are followed will be conducted 3 times a week for 30 days, then 2 times a week for next 30 days and then 1 time a week for next 30 days. 4. All random observation of administration of injectable medications will be reviewed during monthly QA for compliance. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/29/2011
NAME OF PROVIDER OR SUPPLIER WOODCREST MANOR CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	

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F 441	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy it was determined the facility failed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infections for one of twenty-six residents (Resident #25). During observation of a medication pass, Licensed Practical Nurse (LPN) #4 administered a subcutaneous injection for Resident #25 and failed to wear gloves as required by the facility infection control policy. The findings include: A review of the facility infection control policy (with a revision date of November 2009) revealed facility staff was required to utilize standard precautions at all times and utilize transmission based precautions as applicable. During observation of a medication pass on 09/12/11, at 5:12 PM, LPN #4 administered Novolin R insulin subcutaneously to Resident #25. LPN #4 was observed to wash her hands prior to and after administration of insulin. However, the LPN failed to wear gloves as recommended by standard/transmission based precautions when she administered the medication. During an interview on 09/29/11, at 5:15 PM, LPN #4 stated she had been trained to wear gloves for the administration of medications by injection, and usually wore gloves when she administered injections. However, the LPN stated she got "nervous" and "forgot."	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* issue or concern will be addressed and plan updated to reach 100% compliance. Any nursing staff not following infection control policy related to injectable medications will be re-educated and/or receive disciplinary action. 5. Date of compliance 11/13/11	
F 492	483.75(b) COMPLY WITH	F 492		

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F 492 SS=E	Continued From page 23 FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to comply with applicable state laws, specifically 603 KAR 5:072 Mandatory annual bus inspection, related to the required annual inspection of the facility's fifteen-passenger bus. The findings include: A record review revealed the latest inspection of the facility's 15-passenger bus had been completed by the Kentucky Transportation Cabinet on 10/22/07. An interview conducted with the Administrator on 09/27/11, at 3:00 PM, revealed the facility bus had been inspected annually by the facility maintenance staff and the Administrator was not aware the facility bus was required to be inspected by the Kentucky Transportation Cabinet's Division of Motor Vehicle Enforcement on an annual basis.	F 492	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F492 1. No resident was affected by annual inspection not being completed. 2. Annual inspection completed on 9/28/11. 3. Education will be conducted by NHA to Maintenance Director regarding annual vehicle inspection. Center has added the annual vehicle inspection to the preventative maintenance program. 4. Will be reviewed at monthly QA meeting for further review and update as indicated. 5. Date of compliance 11/13/11	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2011
FORM APPROVED
OMB NO. 0938-0391

RECEIVED NOV - 3 2011 Division of Health Care Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		09/28/2011

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70 (a) BUILDING: 01 PLAN APPROVAL: 1998 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Two stories, Type II (111) Unprotected SMOKE COMPARTMENTS: Four smoke compartments COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY and Wet SYSTEM) EMERGENCY POWER: Type II Diesel Generator --Amended Statement of Deficiencies-- A life safety code survey was initiated and concluded on 09/28/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for 127 beds and the census was 115 on the day of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 11/3/11

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.

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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. Smoke barriers must be maintained to ensure they limit the transfer of smoke and fire into corridors and resident rooms. The deficiency had the potential to affect two (2) of four (4) smoke compartments, sixty (60) residents, staff, and visitors. The findings include: Observation on 09/28/11, at 10:22 AM, with the Maintenance Supervisor revealed the smoke barrier located by room 101 had a penetration around a cable wire extending through the smoke barrier. The observation was confirmed with the	K 025	K025 1. Smoke barrier located by room 101 was sealed using fire caulk. 2. 100% center audit was competed by maintenance director or designee to ensure no penetrations in smoke barriers. 3. Re-education by NHA and EDT of maintenance department on the policy related to smoke barrier penetration. Maintenance director or designee will complete weekly audit on smoke barriers looking for penetrations for 1 month then monthly. 4. All audit findings will be reviewed at monthly QA meeting for further review and update as indicated. 5. Date of compliance 11/13/11	

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K 025	Continued From page 2 Maintenance Supervisor. Interview on 09/28/11, at 10:22 AM, with the Maintenance Supervisor, revealed he was unaware of the penetration. Reference: NFPA 101 (2000 Edition). 8.2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions.	K 025		

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K 025	Continued From page 3 8.2.4 Smoke Partitions. 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke. 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception:* Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous membrane. (b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a plenum.	K 025	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that sprinkler heads were maintained as required. The findings include:	K 062	K062 1. No resident was affected by corrosion on outside sprinkler heads. 2. 100% audit to be conducted by Maintenance Director or designee to identify corrosion on outside sprinklers. 3. Facility will replace 8 identified dry sprinklers on outside canopy. Re-educate by NHA and EDT of maintenance director and assistant on importance of maintaining sprinkler heads and the decreased ability to react as intended with the build np of corrosion. Maintenance director or designee will audit sprinkler heads quarterly to ensure the sprinklers are free of corrosion. 4. All audit findings will be reviewed at monthly QA meeting for further review and update as indicated. 5. Date of compliance 11/13/11	

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K 062	Continued From page 4 During the Life Safety Code survey tour on 09/28/11, at 11:30 AM, with the Maintenance Supervisor observation revealed corrosion was noted on the eight sprinkler heads in the canopy of the front entrance. Not maintaining sprinkler heads can decrease their ability to react as intended. Interview with the Maintenance Supervisor on 09/28/11, at 11:30 AM, revealed he thought he could clean them. He was unaware they had to be replaced. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. No resident was affected by hallways/corridors being filled with equipment. 2. The Administrator and DON will conduct a 1 time tour of center to identify any equipment on the floor and to identify issues with equipment stored on the floor. 3. Re-education by DON, NHA and EDT of all staff to the appropriate storage of equipment and also to the issue of keeping hallways/corridors free of equipment, so that there is correct egress from the center. Center's management team will tour hallways daily for 2 weeks, then 3 times a week for 4 weeks, then 1 time per week. 4. All findings will be reviewed at monthly QA meeting for further review and update as indicated. 5. Date of compliance 11/13/11	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of	K 072		

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K 072	Continued From page 5 egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect four (4) of four (4) smoke compartments, all residents, staff, and visitors. The facility is licensed for 127 beds; the census on the day of the survey was 115. The findings include: Observation during the Life Safety Code survey tour on 09/28/11, between 10:00 AM and 1:30 PM, with the Maintenance Supervisor revealed a resident lift, wheelchair, and scooter stored and not in use by rooms 101 and 103 and a resident lift by rooms 109, 126, 141, and 149. Also, medication carts were stored and not in use near rooms 122 and 124, outside the shower room in the East Hall. The items observed in the corridors were stored and not in use for a period of more than 30 minutes. Means of egress must be kept clear at all times in case of fire or other emergency. Interview with the Maintenance Supervisor confirmed the items located in the corridors and indicated that they were not usually there all the time. Reference: NFPA 101 (2000 Edition). 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		