

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 Recertification Survey was initiated on 09/23/14 and concluded on 09/25/14. Deficiencies were cited with the highest Scope and Severity of an "E".

Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

F 202 483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES
SS=D

When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

- F 202
F202
- Residents #21, #22, and #23 suffered no ill effects from the lack of documentation. Facility unable to correct deficient practice for the identified physician order and transfer/discharge summaries.
 - Audits will be conducted by DON, RN Unit Managers, and/or Medical Records Clerk on all discharged/transferred residents for the previous month the week of 10/20/14 to ensure transfer/discharge summaries are in place.
 - Administrator and/or the DON will re-educate all attending physicians the week of 10/27/14 on transfer/discharge summaries are necessary. DON, RN Unit Managers and/or Medical Records Clerk will audit all discharged transferred residents charge for completion of a transfer/discharge summary from a physician daily for 1 month and then weekly for 1 month.
 - All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure the residents' Physician or Physician Extender documented in the medical record when a discharge and/or transfer was appropriate for three (3) of twenty-three (23) sampled residents (Residents #21, #22 and #23).

Resident #21 was transferred to an acute care facility for a high level of care with no documented evidence by the Physician regarding the reason for a higher level of care was appropriate and/or necessary.

Resident #22 was transferred to an acute care facility for a higher level of care with no

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Adam Lewandowski Administrator
TITLE
DATE 10/31/14

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.

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 202	<p>Continued From page 1</p> <p>documented evidence by the Physician regarding a discharge and/or transfer summary to indicate the resident's disposition.</p> <p>Resident #23 was discharged home with home health services with no documented evidence by the Physician regarding discharge and/or transfer summary indicating the resident's disposition.</p> <p>The findings include:</p> <p>Interview, on 09/25/14 at 1:30 PM and 3:00 PM, with the Director of Nursing (DON) revealed the facility did not have a Transfer/Discharge policy; however the expectation was for the nurse to write a Physician's Order for transfer or discharge of a resident.</p> <p>Review of the facility's, "Bill of Resident Rights", effective 07/01/09, revealed it was the facility's policy to protect and promote residents' rights. Review of the residents' rights revealed the definition of transfer and discharge included movement of a resident to a bed outside of the certified facility whether that bed was in the same physical plant or not. The facility was to permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility. Continued review revealed residents would not be transferred or discharged from the facility unless: the transfer or discharge was appropriate because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility; the safety of individuals in the facility was endangered; the resident failed after reasonable and appropriate notice to pay for a stay at the</p>	F 202	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>monthly with the presence of the Medical Director Quarterly. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director.</p> <p>5. Date of Compliance:</p>	11/10/14

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 202	Continued From page 2 facility; or the facility ceased to operate. Further review revealed when the facility transferred or discharged a resident because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility or the resident's needs could not be met in the facility, there was to be documentation in the clinical record to indicate such. In addition, review revealed the documentation was to be made by the resident's Physician when the transfer or discharge was necessary because the resident's health improved or his/her needs could not be met by the facility. 1. Review of the medical record for Resident #21 revealed the facility admitted the resident on 04/03/14, and transferred him/her on 07/05/14 to an acute care facility for a high level of care. However, review revealed no documented evidence the facility obtained a Physician's Order for the transfer. Record review revealed Social Services (SS) documented a discharge summary in the Departmental Notes; however, there was no documented evidence the Physician documented in the record to indicate if the resident was transferred because the sake of the resident's welfare and his/her needs could not be met in the facility, or whether other resident's health or safety was endangered. Record review revealed no documented evidence by the Physician of why the resident's transfer to a higher level of care was appropriate and/or necessary. 2. Review of the medical record for Resident #22 revealed the facility admitted the resident on 07/29/14, and transferred the resident to an acute care facility on 08/01/14 for a higher level of care. Record review revealed Social Services (SS)	F 202			

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 202 Continued From page 3
documented a discharge summary in the Departmental Notes; however, there was no documented evidence the Physician documented in the record to indicate if the resident was transferred because the sake of the resident's welfare and his/her needs could not be met in the facility, or whether other resident's health or safety was endangered. Record review revealed no documented evidence the facility obtained a Physician's Discharge/Transfer Summary to indicate Resident #22's disposition from the facility.

F 202

3. Review of the medical record for Resident #23 revealed the facility admitted the resident on 07/17/14, and discharged the resident home with home health services on 08/14/14. However, record review revealed no documented evidence the Physician documented whether the resident's health had improved to the extent he/she was discharged because he/she no longer needed the services of the facility. Record review revealed no documented evidence the facility obtained a Physician's Discharge/Transfer Summary indicating Resident #23's disposition from the facility.

Interview with the Medical Director on 09/25/14 at 5:05 PM, revealed he was aware a Transfer/Discharge Summary was necessary when residents were transferred or discharged from the facility. Further interview revealed he dictated the Transfer/Discharge Summaries on the computer within thirty (30) days of the transfer or discharge which was to be printed and placed in the resident's medical record.

Continued interview with the Director of Nursing (DON) on 09/25/14 at 1:30 PM, revealed she was

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 202	Continued From page 4 not aware residents' Physicians were required to document the reason a resident was transferred and or discharged in the medical record. Per interview, the DON acknowledged the facility had failed to obtain the appropriate documentation from the Physician after the facility transferred or discharged Resident #21, Resident #22 and Resident #23 which she now knew was necessary.	F 202	Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and procedures, it was determined the facility failed to ensure the second floor beauty shop door was closed and secured when unattended. Observation at 3:40 PM revealed the Beautician exited the elevator on the facility's first floor with a bag of soiled linen and was observed to return to the beauty shop at 3:50 PM. However, observation of the beauty shop on the second floor at 3:43 PM revealed the beauty shop was unattended, unsecured with lights on and the door left open with chemicals, medication and beautician tools accessible to anyone entering the	F 323	1. Beautician was re-educated by RN Education Director of Training on 9/24/14 on safely securing the beauty shop, storage of chemicals, and use of O2 within the beauty shop. Social Service Director and Director of Housekeeping removed all expired chemicals from beauty shop on 9/24/14. 2. Administrator, DON, RN Unit Managers and/or Maintenance Director will complete audit of building the week of 10/20/14 to ensure all areas that pose an accident threat to residents are safely secured and chemicals are safely secured. 3. Maintenance Director will install a spring loaded lock with automatic door closure on beauty shop door on 10/17/14. RN Education Director of Training will educate all staff including contract services the week of 10/27/14 on safely securing all rooms to ensure a safe environment. DON, Administrator, and/or Education Director of Training will re-educate all staff the week of 10/27/14 on safely securing chemicals. DON, Administrator, and/or RN Unit		

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 323	<p>Continued From page 5 beauty shop.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Beauty/Barber Equipment and Area: Cleaning of", undated, revealed beauty shop equipment and chemicals were to be locked in a protected area. Continued review revealed the door of the beauty shop was to be locked when no one was present in the shop.</p> <p>Observation on 09/24/14 at 3:40 PM revealed the Beautician was observed to exit the elevator on the facility's first floor with a bag of soiled linen. Continued observation revealed at 3:50 PM the Beautician was observed to return to the beauty shop. However, observation of the beauty shop at 3:43 PM revealed the door was open and not locked and the beauty shop was unattended. During the observation of the unattended, unlocked beauty shop at 3:43 PM, revealed an open storage closet located inside the shop which contained: a container of Barbicide (a sanitizing solution for combs and brushes), an unlabeled bottle of a white, milky substance; three (3) hair permanent kits with a label advising to keep out of reach of children; a bottle of medicated dandruff shampoo with a label advising to keep out of reach of children; an unlabeled bottle of an unidentified clear substance; Lysol disinfectant spray; a hair treatment kit; and a curling iron. Continued observation revealed in and on the counter tops was: a medication bottle with various shapes, sizes and colors of tablets; a container of Hydrocide (a germicide/disinfectant) with a warning to seek immediate medical attention; a spray bottle of Oasis Neutral disinfecting cleaner with a warning label that stated "corrosive" and</p>	F 323	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>Managers will audit resident rooms and hallway to ensure environment is secure and chemical free at random times daily for 1 month then weekly for 1 month.</p> <p>4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held monthly with the presence of the Medical Director Quarterly. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director.</p> <p>5. Date of Compliance: 11/10/14</p>

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 323	<p>Continued From page 6</p> <p>"danger to humans and animals". Further observation revealed (2) pair of scissors, (2) electric razors and a curling iron and a hair dryer plugged into a power strip. Also observed was an unlabeled plastic bag with "Ship Shape" product in it and a container of "Steri-Dri" (a fungicidal, bacteriostatic, fumigant sanitizer). In addition, observation revealed a gallon pump bottle of hair conditioner, a container of styling gel and a bottle of shampoo under the sink.</p> <p>Review of the "Steri-Dri" fungicidal, bacteriostatic, fumigant sanitizer label revealed "keep out of reach of children", and the product was a "hazard to humans and domestic animals". Continued review of the product label revealed it might be "fatal" if swallowed and do not get "in eyes, on skin or clothing".</p> <p>Review of the Material Safety Data Sheet (MSDS) for the "Ship Shape" dated 10/31/11, revealed to "avoid ingestion and skin contact". Continued review revealed if ingested the product could cause possible gastrointestinal irritation or disturbance such as cramps and stomach pain. Further review revealed if the product came in contact with the eyes it could cause burning sensation, watering or redness.</p> <p>Review of the MSDS for the Oasis Pro 20 Neutral Cleaner and Disinfectant, issued 04/21/06, revealed do not ingest as the product was harmful if swallowed causing burns to mouth, throat and stomach. The MSDS noted the product was "corrosive" to the eyes and skin, and do not get in the eyes, on skin or on clothing. Continued review revealed avoid breathing vapor or mist as the product might cause respiratory tract irritation.</p>	F 323		

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 323	<p>Continued From page 7</p> <p>Review of the MSDS for the "Hydrocide Germicide & Disinfectant", revised 06/05/07, revealed the product was "corrosive" and if swallowed to "consult Physician immediately".</p> <p>Interview with the Beautician on 09/24/14 at 3:50 PM and 4:17 PM, revealed she didn't recall receiving safety education regarding ensuring the beauty shop was locked when it was unattended. Continued interview revealed it was her normal process to leave the door open and the shop unattended when she went to get a resident to bring to the beauty shop, or to take a resident back to his/her room or activity. She stated she also left the beauty shop door open and the shop unattended when she had to take soiled linens down to the laundry on the first floor. The Beautician stated she had "never really thought of" leaving the beauty shop door open and the shop unattended "as a safety issue". Further interview revealed she did not think the residents were capable, if they entered the unattended and unlocked beauty shop, of removing the tops from the chemical containers or the medication bottle located in it. However, she stated the "Ship Shape" was a corrosive brush/comb cleaner, and the gallon pump bottle of hair conditioner, container of styling gel and bottle of shampoo under the sink all were there when she came to work at the facility approximately five (5) years ago. The Beautician further stated she had not disposed of the items that was there when she came because the products "might" be used by herself or someone else.</p> <p>Interview with the Director of Nursing (DON) on 09/24/14 at 4:30 PM, revealed the Beautician had received safety education upon hire five (5) years</p>	F 323		

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 323 Continued From page 8
ago; however, there was no documented evidence of the education available due to the facility no longer being owned by the same company and did not have access to any prior documents. She stated the Beautician had received additional safety education on 09/24/14 which included ensuring the beauty shop door was locked and secured when the shop was unattended.

F 323

~~Disclaimer~~ Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=E

F 431

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.

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

- F431
1. All expired biological products listed in statement of deficiencies (14 laboratory specimen collection containers) were removed from the medication room on 9/25/14.
 2. 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. Education will be provided by DON and/or RN Education Director of Training the week of 10/27/14 of licensed staff and central supply clerk on protocol for the removal of expired medication and/or supplies. Supply Clerk to be responsible to check all medication room supplies expiration dates weekly beginning the week of 10/20/14. Charge Nurses to be responsible to check all medication room medication expiration dates weekly beginning the week of 10/20/14. DON and/or RN Unit Manager will audit medication supply room for expired items weekly for 2 months beginning the week of 11/3/14.

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 431 Continued From page 9
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 Pharmacy Services and Procedures Manual, it was determined the facility failed to store biological products in a safe manner. Observation revealed fourteen (14) laboratory (lab) specimen collection containers were expired in one (1) of two (2) medication rooms.

The findings include:

Review of the facility's, "Pharmacy Services and Procedures Manual, Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles", dated 12/01/07, revealed the facility should ensure drugs and biologicals that have an expired date on the label, have been retained longer than recommended by manufacturer or supplier guidelines or have been contaminated or deteriorated, were to be stored separately from other medications until destroyed or returned to the supplier.

Review of the facility's, "Position Description" for the Central Supply Clerk (CSC), undated, revealed the CSC stored and distributed medical instruments, equipment, and supplies in accordance with "all company, federal, state, and local standards". The Position Description revealed essential functions of the position were:

F 431

Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held monthly with the presence of the Medical Director Quarterly. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director.

5. Date of compliance: 11/10/14

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 431 Continued From page 10
to ensure equipment was available for facility staff; take inventory and rotate stocked items daily; and maintain monthly inventory of all nursing supplies. Continued review revealed the education and/or requirements for the CSC were two (2) years experience in Central Supply Service or as a Registered Central Service Technician course with certification; or equivalent combination of education and experience. Further review revealed no documented evidence the current CSC signed and dated in the acknowledgement of receiving and reviewing the position description.

Observation on 09/25/14 at 11:45 AM, of the first floor medication (med) room revealed eight (8) viral transport specimen swab tubes with expiration dates of 08/20/14, one (1) wound culture swab specimen container with an expiration date of 09/21/14, two (2) stool specimen collection containers for culture and sensitivity with expiration dates of 02/2014, and three (3) stool specimen containers for ova and parasite with expiration dates of 10/2013.

Interview with the CSC on 09/25/14 at 12:10 PM, revealed she had been in the position less than one (1) month and was trained by the previous CSC for only two (2) days before he left the position. Continued interview with the CSC revealed this was the only training she received for the position, as no one else in the facility had trained her on the new position. The CSC revealed she was unaware there were specimen containers in the drawers in the first floor med room and also was unaware that specimen tubes expired.

F 431

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 431	<p>Continued From page 11</p> <p>Interview with the Human Resource (HR) Manager on 09/25/14 at 2:15 PM, revealed the CSC had been in the position of Central Supply Clerk since 08/15/14, just a little over a month. The HR Manager revealed the CSC also worked in transportation and Medical Records. She stated she had trained the CSC "pretty much", but did not go over the entire med rooms with her. Per interview, there was no documentation of what she had trained the CSC on. The HR Manager stated she had just heard about the problem with the specimen containers being expired. According to the HR Manager, since the current CSC had in the position for such a short time educating her on the items in the med rooms could have been missed; however, stated the former CSC had missed the expired items also. She stated she "personally" did not "check on" the CSC as the Director of Nursing (DON) was the CSC's supervisor.</p> <p>Interview, on 9/25/14 at 3:00 PM, with the DON revealed the new CSC was trained by the outgoing CSC and the HR Manager. She stated the CSC reported to her, and the CSC was being trained as things came up. The DON revealed someone did not do the job as thoroughly as they should have; however, she was not a "micro manager" and assumed "you should know how to do your job and just do it". Per interview, the facility had no documentation the CSC was trained on checking for the expiration of specimen containers. She stated an expired lab specimen container could result in an inaccurate lab result for a resident.</p>	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 441 Continued From page 12
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.

This REQUIREMENT is not met as evidenced by:

F 441

Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

- F441
- All facility concentrator filters were immediately changed on 9/23/14. Facility was unaware of the observation of appropriate handling of food and was unable to correct immediately.
 - All facility concentrator filters were immediately changed on 9/23/14. 100% audit on all facility concentrators will be conducted by DON the week of 10/20/14 to ensure filters are changed and clean. Observation in Dining rooms and of room trays conducted daily by DON, ADON, Administrator, RN Education Director of Training, RN Unit Managers, and/or Shift Supervisor beginning the week of 10/20/14 to ensure the correct handling of food during its service.
 - Re-education of Central Supply Clerk was conducted by DON on 10/8/14 on the process of changing concentrator filters weekly. Re-education of all nursing staff to be conducted by DON and/or RN Education Director of Training the week of 10/27/14 on proper handling of food. DON and/or RN Unit Managers will audit

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 441 Continued From page 13

Based on observation, interview and review of facility policy and Position Description, it was determined the facility failed to maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection regarding the cleaning or changing of oxygen concentrator filters as scheduled.

Observations during initial tour on 09/23/14 revealed eleven (11) of eleven (11) residents with oxygen (O2) in use on the facility's second floor had O2 concentrators with significant dust buildup on the filters.

In addition, the facility failed to maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection regarding staff serving residents' food.

Observation revealed staff touched resident food with their bare hands.

The findings include:

1. Review of the facility policy titled, "Respiratory Equipment", undated, revealed it was the Charge Nurse's responsibility to ensure respiratory equipment was changed every Sunday night on the 11:00 PM to 7:00 AM shift.

Review of the facility's, "Position Description-Central Supply Clerk", undated, revealed Central Supply Clerk's "position purpose" was to store and distribute medical instruments, equipment and supplies within the

F 441

Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

concentrator filters the week of 10/27/14 once weekly for 2 months and then monthly thereafter.

Ongoing daily meal audits beginning the week of 10/20/14 to be conducted by the DON, ADON, Administrator, RN Education Director of Training, RN Unit Managers, and/or Shift Supervisor conducted daily till 11/30/14 and then 3 times a week for 1 month.

4. Quality Assurance Committee members reviewed minimally 5 days a week for 30 days or additionally as necessary until 11/30/14; then one time weekly until 12/31/14 or as needed; then monthly thereafter or as needed sooner. QA meetings are held monthly with the presence of the Medical Director Quarterly. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director.

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 441	<p>Continued From page 14</p> <p>facility's standards. Review revealed the Central Supply Clerk's job duties included making sure staff had supplies. Additional review revealed the Central Supply Clerk was required to have proficiency in the following: basic microbiology, soaps and detergents, quality assurance, isolation techniques and safe practices and infection control.</p> <p>Observations during initial tour on 09/23/14 revealed eleven (11) of eleven (11) residents on the facility's second floor with O2 in use had O2 concentrators with significant dust buildup on the filters.</p> <p>Interview with the second floor Unit Manager (UM) on 09/23/14 at 11:23 AM, revealed the facility had a service which came weekly and provided maintenance for the concentrators which included changing the tubing, filters and water bottles. She indicated the dust buildup on the the filters was unacceptable as it was an infection control issue. Continued interview revealed the large amount of dust buildup would indicate the filters had not been changed for greater than one (1) week.</p> <p>Interview with the facility's Central Supply Clerk (CSC) on 09/25/14 at 12:10 PM revealed she had been in the position for about a month, and had been trained by her predecessor for just two (2) days before he left. Continued interview revealed she had not received any further education on her job duties after the former CSC left.</p> <p>Interview with the Human Resources (HR) Manager on 09/25/14 at 2:15 PM, revealed she had "trained" the current CSC "pretty much"; however, did not have documentation of what she</p>	F 441	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>5. Date of Compliance:</p>	11/10/14

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 441 Continued From page 15 covered in the training. Continued interview revealed the Director of Nursing (DON) was the CSC's supervisor.

F 441

Interview with the DON on 09/25/14 at 3:00 PM and 5:10 PM, revealed the CSC was under her supervision, and the current CSC had been trained by the former CSC. The DON indicated the CSC position was "on the job" training and she taught the CSC as situations arose. She stated she was not a "micro manager", and her assumption was staff knew what their job was and "just did it". Per interview, the facility was "responsible" for "changing the foam filters", tubing and water bottles on the O2 concentrators. She stated there was a "service" which performed "preventative maintenance and repair only" of the O2 concentrators. The DON revealed the O2 concentrator filters were to be changed "weekly" on day shift by the CSC. She revealed she had also observed the "dirty" O2 concentrator filters after the Surveyor interviewed the second floor UM. The DON indicated she "immediately" had all the O2 concentrator filters changed for those in use as this was an infection control issue.

2. Review of the facility's policy titled, "QA Systems Process Overview", revised March 2013, revealed infection control was an area monitored by the Quality Assurance (QA) Committee through the QA process. Continued review of the Policy revealed "all staff" would be inserviced on their role in the facility's QA System "bi-annually".

Review of the facility's, "Quality Assurance Policy", revised September 2013, revealed the Interdisciplinary Team (IDT) was to meet "at least weekly" and at a minimum was to consist of the

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 441 Continued From page 16
 Administrator, DON or Nursing Representative, Social Services, Therapy, Dietary and Activities. Continued review of the Policy revealed "sections of the meeting" were at least, but not limited to fall/incidents, skin, weight variances, restraint reduction, pain and infection control.

Review of the facility's Plan of Correction (POC), dated 09/19/13, revealed the facility implemented education for all licensed and certified staff related to the proper handling of food during the meal service.

Observations on 09/23/14 at 1:02 PM during the lunch meal service revealed State Registered Nursing Assistant (SRNA) #3 touched the dinner roll with her bare hands when she removed it from the wrapper and placed it on a resident's plate.

Interview with SRNA #3 on 09/23/14 at 1:05 PM revealed she was unaware it was a concern because she had just washed her hands. However, further interview revealed she indicated she should not have touched the bread with her bare hands as it would be an infection control issue.

Observations on 09/23/14 at 12:55 PM, during the lunch meal service, in the restorative dining area on the second floor revealed SRNA #1 picked up a resident's dinner roll with her bare hands to remove the roll from the package, and again to move the roll to a different area on the resident's plate.

Interview with SRNA #1 on 09/24/14 at 12:00 PM, revealed she made a mistake in touching the resident's roll with her bare hand. SRNA #1

F 441

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 441	<p>Continued From page 17</p> <p>stated she knew "better" than to do touch resident's food with her bare hands, as she could have "put germs" on the food and could have made the resident sick.</p> <p>Interview with Registered Nurse (RN) #2 on 09/24/14 at 12:06 PM, revealed it was her expectation for staff to follow infection control procedures by washing and sanitizing their hands, and not to touch resident food at any time with their bare hands. RN #2 stated staff touching resident food with a bare hand was an infection control problem.</p> <p>Interview with the DON on 09/25/14 at 4:09 PM, revealed staff should not touch resident food with their bare hands. The DON stated after talking to SRNA #3 she didn't think the incident with SRNA #3 touching the roll at lunch on 09/23/14, was a problem and "not the best scenario" because the SRNA had just washed her hands. Continued interview revealed SRNA's are taught how to remove food items from packages, and how to butter bread without touching the bread. She stated she was present in the dining room three (3) times a week to perform random audits, and had not identified any infection control issues. Per interview, she did not know where the facility's system had failed, even though the facility had previously been cited for hand washing issues on 09/17/13 and 03/27/14.</p> <p>Interview with the Administrator on 09/25/14 at 4:08 PM, revealed staff had received education on infection control, and he thought they knew "what to do"; however, he thought "they forget" what they are educated on. He stated he had performed observations of meals multiple times and observed that staff knew what to do and what</p>	F 441			

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 441	Continued From page 18 not to do. Per interview, he didn't know how the facility's system had failed.	F 441	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>F514</p> <ol style="list-style-type: none"> Residents #21, #22, and #23 suffered no ill effects from the lack of documentation. Unable to correct deficiency practice for the identified physician order and transfer/discharge summaries. Audits will be conducted by DON/RN Unit Managers on all discharged/transferred residents for the previous month the week of 10/20/14 to ensure physician orders and transfer/discharge summaries are in place. Administrator and/or the DON will re-educate all attending physicians the week of 10/27/14 on transfer/discharge summaries are necessary. DON and/or RN Education Director of Training will re-educate all licensed nursing staff the week of 10/27/14 on completion of physician orders for transfers. DON and/or RN Unit Managers will audit physician orders completion on transfers daily for 1 month then weekly for one month. DON and/or Medical Records Clerk will audit all discharged transferred residents charge for completion of a transfer/discharge summary from a 		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and "Bill of Resident Rights", it was determined the facility failed to ensure the medical record was maintained in accordance with accepted professional standards and practices which were complete and accurately documented for three (3) of twenty-three (23) sampled residents (Residents #21, #22 and #23). Record review revealed the facility failed to ensure Resident #21's, Resident #22's and Resident #23's contained documented evidence of the Physician's discharge and/or transfer summary. Additionally, the facility failed to	F 514			

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 514	<p>Continued From page 19</p> <p>ensure a verbal Physician's Order to transfer Resident #21 to an acute care facility was documented in the medical record.</p> <p>The findings include:</p> <p>A review of the facility's, "Bill of Resident Rights", effective 07/01/09, revealed it was the facility's policy to protect and promote residents' rights. The "Bill of Resident Rights" document revealed when the facility transferred or discharged a resident the information regarding the reason was required to be documented in the resident's medical record. Further review revealed the documentation was to be made by the resident's Physician when the transfer or discharge was necessary because the resident's health improved or the needs could not be met by the facility.</p> <p>Review of the facility's policy titled, "Telephone Orders", dated 03/10/09, revealed when calling the Physician for a verbal order, the verbal order should be written on an order sheet and signed by the staff taking the order.</p> <p>Interview with the Director of Nursing (DON) on 09/25/14 at 1:30 PM, revealed the facility did not have a policy related to ensuring complete and accurate medical records for residents.</p> <p>1. Medical record review revealed the facility admitted Resident #21 on 04/03/14. Record review revealed on 07/05/14, the facility transferred Resident #21 to an acute care facility for a higher level of care. However, further record review revealed no documented evidence the facility obtained a Physician's Order for the transfer of Resident #21. Additionally, review</p>	F 514	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>physician daily for 1 month and then weekly for 1 month.</p> <p>4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA meetings are held monthly with the presence of the Medical Director Quarterly. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director.</p> <p>5. Date of Compliance:</p>	11/10/14	

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 514 Continued From page 20
revealed no documented evidence the facility obtained a Physician's Transfer/Discharge Summary indicating Resident #21's disposition.

2. Medical record review revealed the facility admitted Resident #22 on 07/29/14. Record review revealed the facility transferred the resident to an acute care facility on 08/01/14 for a higher level of care. However, further record review revealed no documented evidence the facility obtained a Physician's Transfer/Discharge Summary indicating Resident #22's disposition.

3. Medical record revealed the facility admitted Resident #23 on 07/17/14. Record review revealed on 08/14/14, the facility discharged Resident #23 home with home health services. However, further record review revealed no documented evidence the facility obtained a Physician's Transfer/Discharge Summary indicating Resident #23's disposition.

Interview, on 09/25/14 at 5:05 PM, with the facility's Medical Director revealed he was aware when a resident was transferred or discharged a Transfer/Discharge Summary was necessary. The Medical Director stated he dictated the summaries for residents who were discharged or transferred within thirty (30) days on the computer, and copies of the dicatated summaries were to be placed in residents' medical records.

Interview, on 09/25/14 at 1:30 PM, with the Director of Nursing (DON) revealed the resident transfer and/or discharge disposition was documented in the Nurse's Notes in residents' medical records. The DON revealed she was unaware the Physician was required to document the necessity of a resident discharge and/or

F 514

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 514 Continued From page 21
transfer in residents' medical records. Additional interview on 09/25/14 at 3:00 PM, revealed a Physician's Verbal/Telephone Order should have been obtained and documented for Resident #21 to transfer the resident to an acute care facility; however, this had not been done for Resident #21.

F 514
Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

F 520 483.75(o)(1) QAA
SS=E COMMITTEE-MEMBERS/MEET
QUARTERLY/PLANS

F520
1. IDT meeting revised on 10/20/14 to include review of audits conducted for infection control practices. Quality Assurance Committee will meet weekly for 12 weeks beginning the week of 11/3/14 and/or as needed and with the Medical Director in attendance once a month for the 12 weeks, then monthly as needed with Medical Director attending quarterly.
2. IDT team at a minimum two team members that consist of Administrator, DON, ADON, EDT, RN Unit Supervisors, Social Services, Therapy Director, Dietary Director, Activities Director. All facility concentrator filters were immediately changed on 9/23/14. 100% audit on all facility concentrators will be conducted by DON the week of 10/20/14 to ensure filters are changed and clean. Observation in Dining rooms and of room trays conducted daily by DON, ADON, Administrator, RN Education Director of Training, RN Unit Managers, and/or Shift Supervisor beginning the week of 10/20/14 to

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 520

Continued From page 22
by:
Based on interview and review of the facility's Plan of Correction (POC) with an alleged compliance date of 11/01/13, it was determined the facility failed to have an effective Quality Assessment and Assurance (QA) Program to monitor and implement the POC which was developed to address the findings of the Recertification Survey conducted 09/19/13 at 42 CFR 483.65 Infection Control (F441).

The findings include:

Review of the facility's policy titled, "QA Systems Process Overview", revised 03/13, revealed infection control was to be an area monitored by the QA committee through the facility's QA process.

Review of the facility's POC with an alleged compliance date of 11/01/13, revealed the facility implemented education for all licensed and certified staff related to the proper handling of food during the meal service. The POC revealed audit observation of meals would be completed daily for seven (7) days, then four (4) times a week for three (3) weeks, then weekly for three (3) weeks. Further review revealed all monitoring findings would be reviewed at monthly QA meetings for compliance and/or the need to update the facility's plan to reach one hundred percent compliance.

However, observations on 09/23/14 revealed staff handling resident's food with their bare hands during the noon meal service. Interviews with State Registered Nursing Assistant (SRNA) #3 on 09/23/14 at 1:05 PM and SRNA #1 on 09/24/14 at 12:00 PM revealed SRNA #3 was not aware

F 520

Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

ensure the correct handling of food during its service. The IDT meetings revised on 10/20/14 to include review of audits conducted for infection control practices. Quality Assurance Committee will meet weekly for 12 weeks beginning the week of 11/3/14 and/or as needed and with the Medical Director in attendance once a month for the 12 weeks, then monthly as needed with Medical Director attending quarterly.

3. IDT team at a minimum two team members that consist of Administrator, DON, ADON, EDT, RN Unit Supervisors, Social Services, Therapy Director, Dietary Director, Activities Directo. All facility concentrator filters were immediately changed on 9/23/14. 100% audit on all facility concentrators will be conducted by DON the week of 10/20/14 to ensure filters are changed and clean. Observation in Dining rooms and of room trays conducted daily by DON, ADON, Administrator, RN Education Director of Training, RN Unit Managers, and/or Shift Supervisor

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 520 Continued From page 23
touching a resident's food was a concern as she had just washed her hands; however, knew she should not have touched the bread with her bare hands as it was an infection control issue. SRNA #1 revealed she knew she should not touch a resident's food with her bare hand and knew she made a mistake in touching the resident's roll. SRNA #1 stated she could have contaminated the resident's bread by touching it with her bare hands and could have made the resident sick.

Interview, on 09/25/14 at 4:09 PM, with the Director of Nursing (DON) revealed she was part of the facility's QA Committee. She stated staff should not touch food with bare hands, as they had been educated related to touching food with bare hands, infection control and cross contamination as per the facility's POC for the 09/19/13 survey. The DON revealed the facility was no longer conducting formal audits as outlined in the POC; however, she was present in the dining room three (3) times a week conducting random audits and had not noticed any infection control issues by staff when serving residents' meals. Further interview revealed she was not sure where the facility's system had failed.

Interview, on 09/25/14 at 4:08 PM, with the Administrator revealed he was part of the facility's QA Committee, and staff had received education on infection control as per the POC for the 09/19/13 survey, and audits were implemented. The Administrator stated he had performed numerous resident meal audits of staff serving residents' meals and had not observed any issues, and did not know how the facility's system had failed during this survey. He stated during the observations he had observed that staff knew

F 520

~~Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.~~

beginning the week of 10/20/14 to ensure the correct handling of food during its service. The IDT meetings revised on 10/20/14 to include review of audits conducted for infection control practices. Quality Assurance Committee will meet weekly for 12 weeks beginning the week of 11/3/14 and/or as needed and with the Medical Director in attendance once a month for the 12 weeks, then monthly as needed with Medical Director attending quarterly. Administrator or DON will audit Quality Assurance Committee meetings and IDT meetings for completed follow-up minimally weekly for 12 weeks beginning the week of 11/3/14 or additionally as necessary until; then monthly thereafter or as needed sooner. Handling of food and concentrator filters will be an ongoing topic of discussion for all future Quality Assurance Committee meetings going forward.

4. All monitoring findings were reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100%

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/26/2014
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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 520	Continued From page 24 what to do and what not to do. Per interview, the Administrator stated he thought staff knew "what to do", but "forget" what they have been educated on.	F 520	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>compliance. QA process includes identifying data from audits, use root cause analysis to identify where goals are not met, develop performance improvement plans to fix root cause, monitor effectiveness of PIP, if outcomes not desirable begin process over, if results are desirable then formalize PIP by updating procedures. QA meetings are held monthly with the presence of the Medical Director Quarterly. The Quality Assurance Committee consists of facility and contracted staff. This includes Administrator, DON, Assistant Director of Nursing, Staff Development RN, Social Services Director, HR Manager, Activities Director, Dietary Director, and the Maintenance Director. Contracted membership includes the Medical Director.</p> <p>5. Date of Compliance:</p>	11/10/14

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

PRINTED: 10/09/2014
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION 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
--------------------	--	---------------	---	----------------------

K 000 INITIAL COMMENTS K 000

CFR: 42 CFR 483.70 (a)
BUILDING: 01
PLAN APPROVAL: 1998
SURVEY UNDER: 2000 Existing
FACILITY TYPE: SNF/NF
TYPE OF STRUCTURE: Two (2)stories, Type II (111) Unprotected
SMOKE COMPARTMENTS: Four (4)smoke compartments
COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM
FULLY SPRINKLED, SUPERVISED (DRY and Wet SYSTEM)
EMERGENCY POWER: Type II Diesel Generator

A Life Safety Code Survey was initiated and concluded on 09/24/14 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.

OCT 31 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
[Signature] Administrator 03/14 (X5) DATE

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.