

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

PRINTED: 11/20/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185392	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/02/2012
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NAME OF PROVIDER OR SUPPLIER  WOODLAND OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101
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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
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F 000	INITIAL COMMENTS  A Recertification Survey was conducted 10/30/12 through 11/02/12. Deficiencies were cited with the highest scope and severity of an "E".	F 000	It is and was the policy of Woodland Oaks HCF to provide a safe/clean/comfortable/homelike environment for the residents at Woodland Oaks HCF.	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a clean, comfortable and homelike environment related to strong urine odors on the South Hall and North Hall shower rooms. The exact source of the urine odor was not determined, and the urine odor was present throughout the dates of the survey, 10/30/12 through 11/01/12.  The findings include:  Observation during initial tour, on 10/30/12 at 6:30 PM, revealed an overwhelming urine odor that was present in the shower room and disseminating through the halls on the 500 unit. Further observation revealed the shower room contained multiple bins of soiled linen and garbage stored which was stored in the shower room.  Observation, on 10/31/12 at 4:45 PM, revealed an overwhelming urine odor that was present in the	F 252	F252  1) All soiled Linen and garbage bins will be emptied prior to being stored in the shower rooms. No residents were affected by the deficient practice. No showers were being given. This was during meal service. No Residents were affected.  2) All soiled Linen and garbage bins will be discarded prior to be stored in the shower rooms. No residents were affected by the deficient practice. No showers were being given. This was during meal service. No Residents were affected.  3) All Soiled Linen and garbage bin will be emptied prior to being stored in the shower rooms. All Nursing Staff was in-serviced by Michele Spears, Director of CQI on November 1, 2012 to emptying linen and garage carts prior to them being stored in Shower room during meal service.	

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NOV 30 2012  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ann Nall</i>	TITLE Administrator	(X6) DATE 11/29/12
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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 252 Continued From page 1  
shower room on the 100/200 unit. Further observation revealed the shower room contained seven (7) bins with soiled linen and three (3) bins of trash that contained soiled depends.

Interview, on 10/31/12 at 4:55 PM, with State Registered Nurse Aide (SRNA) #1, revealed the presence of the urine odor was overwhelming and she thought the odor was from the trash and linen bins. Further interview revealed SRNA #1 was responsible for emptying the trash and linen bins when they became full. SRNA #1 stated the linen and trash bins were removed from the hallways and stored in the shower rooms. Additionally, SRNA #1 stated she would not want to shower in this shower room due to the urine odor.

Interview, on 11/01/12 at 11:50 AM, with Nurse Manager (NM) #6, revealed she agreed there was a strong urine odor in the 500 unit shower room. Interview further revealed NM #6 thought the overwhelming urine odor was from the full trash and linen bins. Continued interview revealed NM #6 would not want to bathe in the shower room due to the urine odor.

Interview, on 11/01/12 at 11:55 AM, with the Assistant Director of Nursing (ADON), revealed both of the facility's resident shower rooms had a strong urine odor. Further interview revealed she would not want to bathe in either of the facility's shower rooms due to the urine odor.

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS  
The facility must establish and maintain an Infection Control Program designed to provide a

F 252 4) The Assistant Director of Nursing will conduct an audit of the Shower Rooms twice weekly for the next 6 months to ensure that Soiled Linen and garbage bins have been emptied prior to them being stored in shower room during meal service. All findings will be reported to the CQI Committee monthly for the next 6 months.  
5) November 2, 2012

It is and was a policy of Woodland Oaks HCF to follow our Infection Control Policies.

F441

1) Resident #13 returned home on November 9, 2012. Resident "A" of the Unsampled Residents returned Home on November 12, 2012. Unsampled Resident "B" returned home on November 5, 2012. Resident #16 -has has no signs or symptoms of infection. On November 1, 2012, The Equipment that was stored on the floor was in plastic bags and not directly on the floor. This

11/2/12

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F 441	Continued From page 2 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: Based on observation, interview, record review,	F 441	was observed by the Assistant Director Nursing and pointed this out to the surveyor. Therefore there was a barrier between equipment and floor.  2) All Nurses were in-serviced on November 21, 2012 by the Director of CQI on never taking a medication cart or treatment cart in a Resident's room that is on Contact Precautions. All nurses were also in-serviced on November 21, 2012 by the Director of CQI and proper Hand Washing, Proper Dressing Change Technique, reviewed the Wound Care/Treatment Guidelines, and proper storage of resident use equipment. On November 1, 2012, The Equipment that was stored on the floor was in plastic bags and not directly on the floor. This was observed by the Assistant Director Nursing and pointed this out to the surveyor. Therefore there was a barrier between equipment and floor.  3) All nursing staff has been inserviced on proper infection control techniques by the Director of CQI.		

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F 441 Continued From page 3  
and review of the facility's policies, it was determined the facility failed to 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 for two (2) of twenty-one (21) sampled residents (Resident #13 and Resident #16) and two (2) unsampled residents (Unsampled Resident A and Unsampled Resident B).

Observation of medication pass revealed the nurse was using the medication cart inside Unsampled Resident A's room, and then pushed the medication cart into other residents' rooms including; Resident #16 and Unsampled Resident B, to administer medication. Unsampled Resident A was in contact isolation (precautions taken to prevent the spread of infection) for Vancomycin Resistant Enterococcus (VRE-a bacteria that is resistant to Vancomycin antibiotic) Urinary Tract Infection.

In addition, observation during a dressing change for Resident #13 who was on contact isolation and on intravenous antibiotics for Methicillin Resistant Staff Aureus (MRSA) (term used to describe a number of strains of bacteria, staphylococcus aureus that are resistant to a number of antibiotics including methicillin) revealed the nurse used poor infection control technique.

Also, observation of the clean linen and supply closet on the south hall revealed equipment ready for resident use; however, the equipment was stored directly on the floor including mattresses and a pump for the mattresses.

F 441 4) The Assistant Director of Nursing will conduct a weekly audit of 1 wound per week on Wound Treatments to ensure the Wound Care/Treatment Guidelines and Proper Technique is performed correctly. She will also conduct an audit of the clean utility rooms on a weekly basis for 6 months to ensure that no resident is stored directly on the floor without a barrier.

5) November 22, 2012

11/22/12

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F 441	<p>Continued From page 4</p> <p>The findings include:</p> <p>Review of the facility's Contact Precautions Policy/Procedure, dated 2007, revealed the intent of the facility was to use Contact Precautions, in addition to Standard Precautions, for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. Continued review revealed if the resident left the room, precautions should be maintained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental surfaces or equipment. Further review revealed dedicated resident-care equipment should be considered for the resident; however, if use of common equipment or items was unavoidable, the items should be adequately cleaned and/or disinfected before use for another resident.</p> <p>Observation, on 10/31/12 at 11:38 AM, during Medication Pass, revealed Licensed Practical Nurse (LPN) #2 had the medication cart inside Unsampld Resident A's room, on the Rehab Unit. Continued observation revealed a Contact Precautions (precautions to be taken to prevent the spread of bacteria/infection) sign on the door to the resident's room and Personal Protective Equipment (PPE) (gloves, gowns and masks) was outside of the resident's room. Continued observation revealed a biohazard bag was on the floor, just inside the door of the resident's room. Further observation revealed LPN #2 pushed the medication cart out of Unsampld Resident A's room, down the hall and into Resident #16's room and then into Unsampld Resident B's room.</p>	F 441		
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F 441

Continued From page 5

Record review revealed the facility admitted Unsamped Resident A on 10/25/12 with diagnoses which included Renal Failure, Hepatic Encephalopathy and Strep Bacteremia. The resident also had a diagnosis of a Urinary Tract Infection (UTI) with Vancomycin Resistant Enterococcus (VRE- a bacteria that is resistant to Vancomycin).

Interview, on 10/31/12 at 4:59 PM, with LPN #2 verified Unsamped A was on contact precautions for a VRE UTI. Continued interview revealed she thought there would not be a problem with taking the medication cart inside Unsamped A's room if the resident's room was clean and the cart was taken just inside the door of the resident's room. She further stated the resident wore briefs due to incontinence. Further interview revealed she could see that taking a medication cart into the resident's room would be an Infection Control issue because the resident could have an incontinence episode while going to the bathroom. She stated the biohazard bag should not have been put on the floor of the resident's room and that was an infection control problem also.

Interview, on 11/02/12 at 12:25 PM, with the Assistant Director of Nursing (ADON) revealed equipment had to be cleaned after contact with the resident. She stated Unsamped Resident A had VRE of the urine and the medication cart should not have been taken into the resident's room.

2. Review of the Wound Care/Treatment Guidelines Policy, revised 2007, revealed

F 441

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F 441 Continued From page 6  
supplies should be placed on a clean surface and a blue pad or wax paper provided a clean barrier.

Review of Resident #13's medical record revealed diagnoses which included Right Total Hip Arthroplasty and Methicillin Resistant Staff Aureus (MRSA) infection of the right hip wound.

Review of the Physician's Orders, dated November 2012, revealed orders for Vancomycin (antibiotic) 1750 milligrams (mg's) twice a day intravenously and change dressing to right hip daily with dry Island Dressing.

Observation, on 11/01/12 at 9:15 AM, revealed a sign on Resident #13's door which stated, "contact precautions", and a pouch was on the outside of the door which contained personal protective equipment (PPE); masks, gowns, gloves, and red biohazard bags. Further observation on the same date/time of a treatment performed by Licensed Practical Nurse (LPN) #9 for Resident #13, revealed the nurse removed the soiled dressing from the resident's right hip wound and with the same soiled gloves picked up the spray bottle of Derma Klensz Wound Care and sprayed a 4 x 4 guaze pad. The nurse then washed his hands and proceeded to don gloves and cleanse the wound with the wet guaze pad. LPN #9 then with the same soiled gloves pulled a pair of scissors from his pocket and proceeded to cut the Island Dressing to the correct size and then placed the contaminated scissors back in his pocket. The spray bottle of wound cleanser which was contaminated was placed back in the treatment cart.

Interview, on 11/01/12 at 9:30 AM, with LPN #9

F 441

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F 441	<p>Continued From page 7</p> <p>revealed he usually placed the scissors on the bedside table with the other items needed for the dressing change and wiped the scissors with a bleach wipe after use. LPN #9 stated he should have washed his hands after removing the soiled dressing and prior to handling the wound cleanser. Further interview revealed he should have washed his hands after cleansing the wound and prior to reaching into his pocket for scissors. Continued interview revealed the spray bottle of wound cleanser was contaminated and should not have been placed back in the treatment cart.</p> <p>Interview, on 11/2/12 at 2:30 PM, with the Assistant Director of Nursing (ADON) in the absence of the Director of Nursing (DON), revealed LPN #9 should not have handled the wound cleanser with soiled gloves. Further interview revealed the nurse should have washed or sanitized his hands prior to obtaining scissors from his pocket and should not have placed soiled scissors in his pocket.</p> <p>3. Observation, on 10/31/12 at 9:30 AM and again on 11/01/12 at 11:50 AM, revealed the clean linen and storage area on the south hall contained multiple mattresses and air pumps for the mattresses stored directly on the floor.</p> <p>Interview with Nurse Manager (NM) #6, on 11/01/12 at 11:50 AM, revealed the mattresses and air pumps for the mattresses had been cleaned and were ready for resident use. Further interview revealed although this equipment was on the floor, this was normal practice for the storage of this equipment. (uncovered and on the floor). Further interview with NM #6 revealed the equipment should not have been stored on the</p>	F 441			

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F 441 Continued From page 8  
floor due to this being an infection control issue.

Interview with the Assistant Director of Nursing, on 11/01/12 at 11:55 AM, revealed the cleaned and ready for resident use equipment should not have been stored on the floor due to sanitary conditions and this being a potential infection control issue.

F 441

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1992. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 10/31/2012. Woodland Oaks Health Care Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred ten (110) beds and the census was one hundred five (105) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>Woodland Oaks does not believe and does not admit that any deficiencies existed, either before, during, or after the survey. Woodland Oaks reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position. Woodland Oaks reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver or any potentially applicable peer review, quality assurance or self-critical examination privileges which Woodland Oaks does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Woodland Oaks offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to our residents.</p> <p>K056</p> <p>1) The exterior exit of the employee entrance and the Ambulance Exterior exit canopy's that were 5 feet by 4 feet had sprinkler heads installed on November 2, 2012 prior to the survey exit by Sentry Fire Protection, Inc.</p>	
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NOV 30 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Hall</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/29/12</i>
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K 000  K 056 SS=D	<p>Continued From page 1 Fire)</p> <p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all areas were completely protected with the sprinkler system, according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) of four (4) smoke compartments, twenty (20) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 10/31/2012 at 12:10 PM, revealed a canopy located above the exterior exit of the employee entrance. The canopy measured</p>	K 000  K 056	<p>2) All canopies and exterior roofing were evaluated to ensure that all over 4 feet were sprinkled on November 2, 2012 by the Director of Maintenance.</p> <p>3) There are no more areas that are in need to be sprinkled. All areas are sprinkled according to NFPA 13 (1999 edition) 5-13.8.1.</p> <p>4) The Director of Maintenance at Woodland Oaks Health Care Facility conducts a monthly inspection of the Sprinkler system and will ensure all areas that have a 4 foot canopy or exterior roofing are sprinkled and working properly. Sentry Fire Protection, Inc. conducts an inspection every 6 Months of the sprinkler system and will ensure all areas that have a 4 foot canopy or exterior roofing are sprinkled and working properly.</p> <p>5) November 3, 2012.</p>	11/3/12
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185392	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WOODLAND OAKS B. WING _____	(X3) DATE SURVEY COMPLETED  10/31/2012
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NAME OF PROVIDER OR SUPPLIER  WOODLAND OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101
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K 056 Continued From page 2  
approximately five (5) feet by four (4) feet and did not contain sprinkler protection. Further observation revealed the same for the Ambulance Entrance exterior exit. The canopies were constructed of combustible wooden trusses. Canopies or exterior roofing measuring wider than four (4) feet must be sprinkler protected. The observation was confirmed with the Maintenance Director.

Interview, on 10/31/2012 at 12:10 PM, with the Maintenance Director, revealed the facility had discussed adding sprinkler protection to the canopies but have not yet.

Reference: NFPA 13 (1999 edition)  
5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.  
Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.

K 056