

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

PRINTED: 11/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185445</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODCREST NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3876 TURKEYFOOT ROAD</b> <b>ELSMERE, KY 41018</b>
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>An off-site revisit survey was conducted. Based on the acceptable plan of correction received on 11/12/15, the facility was deemed to be in compliance as alleged on 11/21/15.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) 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.

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*Unnecessary*  
*11/15/15*  
*Acceptable*  
*Assessment*  
*11/14/15*

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NAME OF PROVIDER OR SUPPLIER  WOODCREST NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018
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F 000 INITIAL COMMENTS

A Standard Recertification Survey was initiated on 10/13/15 and concluded on 10/16/15. Deficiencies were cited with the highest scope and severity cited at an "E".

F 329 SS=D 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review it was determined the facility failed to

F 000

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 329

Woodcrest Nursing and Rehabilitation assures that each Resident' drug regimen is free from unnecessary drugs and that when administering pain medications this is documented evidence staff are adequately monitoring for effectiveness of the pain medication.

11/14/2015

F 329

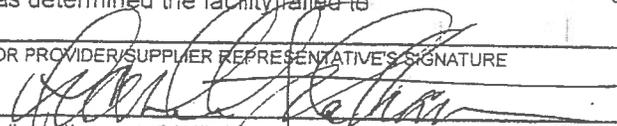
1. No residents were identified as having a negative outcome due to the alleged deficient practice.

Pain evaluations were completed by the Director of Nursing (DON) for Resident Sample #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, the week of October 19, 2015 with pain regimen updated as indicated.

2. Any Resident with a PRN pain medication order could be affected by this alleged deficient practice.

A complete census pain evaluation began on November 5, 2015 by the licensed

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



TITLE

Administrator

(X6) DATE

11/12/15

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F 329 Continued From page 1  
ensure each resident's drug regimen was free from unnecessary drugs for two (2) of twenty-one (21) sampled residents (Residents #6 and #13). Although staff were administering pain medications; there was no documented evidence staff were adequately monitoring for the effectiveness of the pain medication.

The findings include:

Interview on 10/16/15 at 11:05 AM, with the facility's Director of Nursing (DON) revealed the facility did not have a written pain assessment protocol/policy.

1. Review of Resident # 6's medical record revealed the facility admitted the resident on 08/01/07 with diagnoses including; Depression, Testicular Malignancy, Cerebral Spine Injury, Dysphagia, Coronary Artery Disease, Prostate Cancer, Atrial Fibrillation, and Obstructive Pulmonary Disease. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 08/24/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15) indicating moderate cognitive impairment. Further review of the MDS revealed the facility assessed the resident as having almost constant pain, rating the pain at an eight (8) out of ten (10) on the rating scale, with zero (0) being the least pain and ten (10) being the worst pain, in the past five (5) days.

Review of Resident # 6's Physician's orders, dated September 2015 and October 2015, revealed orders for Oxycodone /Acetaminophen (narcotic pain medication) 10/325 milligrams one (1) tablet once every four (4) hours PRN (as

F 329 nurses and will be completed by November 13, 2015. Any identified issues will be addressed immediately, such as contacting physician.

3. The Medication Administration Record (MAR) is being changed to have added a Pain Assessment for PRN medications to include location and non-verbal pain rating, non- pharmacologic intervention and post pain rating. This will begin by November 13, 2015.

A statement is to be added to the MAR starting November 13, 2015 for any resident with scheduled pain medication to check pain regularly every shift. Cognitive Residents will be able to provide pain ratings however for those Residents are not able to voice their pain rating nurses will utilize the Wong-Baker pain scale.

Education on the changes on the MARs and how to address will be completed by licensed nurses by November 12, 2015. The education will be presented and coordinated by the Staff Development Coordinator. The center does not utilize certified medication aides to pass pain medications. There is no nursing agency usage at this time. All newly hired licensed nurses or potential agency nurses utilized after November 12, 2015, will be provided this education during orientation, prior to assuming medication pass duties.

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F 329 Continued From page 2  
needed) for pain.

Review of Resident #6's Medication Administration Record ( MAR) dated September 2015 and October 2015, revealed the Resident was documented as having received Oxycodone /Acetaminophen 10/325 milligrams one (1) tablet on twenty four (24) occasions from 09/01/15 through 10/13/15. There was no documentation on the MAR to indicate if the medication was effective for the PRN pain medication administered.

Review of the PRN Analgesic /Pain Flow Sheet revealed only two (2) pain assessments were documented for the twenty four (24) pain medication administrations during the time period of 09/01/15 through 10/16/15. Also, on 09/04/15 at 4:10 PM it was documented the resident received Percocet (Oxycodone /Acetaminophen) for a pain rating of six (6) out of ten (10); however, there was no documented evidence on the PRN Analgesic/Pain Flow Sheet the resident was further assessed for the effectiveness of the medication.

Interview on 10/ 16/15 at 9:35 AM, with Licensed Practical Nurse (LPN) # 1, revealed she did not usually document pain assessments either before or after administering prescribed analgesics. LPN # 1 revealed she was aware the nurses were to use the PRN Analgesic/Pain Flow Sheet to record resident's response to pain medication. However, LPN #1 further stated, she was usually too busy with other resident assignments to document on the Pain Flow Sheet before and after the administration of pain medications.

2. Review of Resident #13's medical record

F 329 4.  
The DON and Unit Managers will monitor, starting the week of November 10, 2015, a review of the MAR twice per week for one month (50% of current patient count each time to total 100% weekly), then once per week for one month (25% of current patient count each time to total 100% for month). Discrepancies will be addressed immediately and brought to the monthly Quality Assurance Meeting for any further action that may be warranted. The QA members include but is not limited to the Administrator, Director of Nursing, Medical Director and three staff members.

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revealed the facility admitted the resident on 06/04/2015 with diagnoses which included; Acute Cerebrovascular Accident with Right Hemiparesis, Dementia, Chronic Obstructive Pulmonary Disease and Debility. Review of the Quarterly MDS Assessment dated 08/05/2015, revealed the facility assessed the resident as having a BIMS score of four (4) out of fifteen (15) indicating severe cognitive impairment. Further review of the MDS, revealed the facility assessed the resident as having occasional pain; however, the resident was unable to state the severity of the pain.

Review of Resident # 13's Physician's orders dated September 2015, revealed orders for Acetaminophen/Codeine #3, 300 milligrams/30 milligrams one (1) tablet by mouth every four (4) to six (6) hours PRN for pain.

Review of the Medication Administration Record (MAR) dated September 2015, revealed Resident #13 received Acetaminophen/Codeine #3, 300 milligrams/30 milligrams one (1) tablet PRN for pain on 09/08/15 at 8:00 AM, and on 09/12/15 at 10:00 PM. However there no documentation on the MAR to indicate if the medication was effective for pain. In addition, review of the PRN Analgesic /Pain Flow Sheet revealed no documented evidence the resident had received the PRN pain medication on 09/08/15 and 09/12/15. Also, review of the Narrative Notes dated 09/08/15 and 09/12/15 revealed no documented evidence of a post pain assessment on those dates.

Further review of Resident #13's Nurse's Notes dated 09/05/15 at 6:12 PM, revealed Resident #13 received Tylenol #3 (Acetaminophen/Codeine

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F 329

#3) for leg pain. Review of the Nurse's Notes dated 09/06/15 at 4:03 PM revealed PRN pain medication was administered for complaints of leg pain. However, there was no documented evidence of any PRN pain medication administered on the MAR dated September 2015. In addition, review of the PRN Analgesic /Pain Flow Sheet revealed no documented evidence the resident received PRN pain medication for the month of September 2015. Also, there was no follow up related to assessing the resident for the effectiveness of the PRN pain medication in the Nurse's Notes after the pain medication was received on 09/05/15 and 09/06/15.

Interview on 10/ 16/15 at 4:15 PM, with Licensed Practical Nurse (LPN) # 3, revealed she usually documented pain assessments in the Medicare Notes or in the Nurse's Notes section of the resident's chart. LPN # 3 stated the nurses were to use nursing judgement when assessing and documenting the resident's pain.

Interview on 10/16/15 at 4:20 PM, with Registered Nurse #5/ Unit Manager (UM), revealed the nurses were to assess for pain every shift using nursing judgement and document the pain assessment in the Nurse's Notes. RN #5/UM further stated the facility did not have a formal policy or process for pre and post pain assessments.

Further interview on 10/16/15 at 4:27 PM, with the DON, revealed the nursing staff could utilize the Nurse's Notes to document pain assessments; however, her expectation was for the nursing staff to utilize the facility's PRN Analgesic/Pain Flow Sheet when administering PRN pain medication to indicate the resident's pain rating before and

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after the pain medication.

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

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

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F 431

F 431

Woodcrest Nursing and Rehabilitation assures that drugs and biologicals are properly stored.

1.  
No residents were identified being affected by the alleged deficient practice. A complete audit of all treatment carts and medication rooms was completed on 10/14/15 to verify being locked as appropriate and to asses for any expired items to be removed. The audit was completed by the Unit Managers and Staff Development Coordinator. Re-education of Nurses concerning the requirement to keep treatment carts locked when unattended and the elimination of expired, as well as opened, unlabeled and undated items began on 10/14/15. The education of all nurses will be completed on or before November 12, 2015. After this date, all newly hired nurses or potential agency nurses will be provided this education during orientation prior to assuming duties working with the treatment carts. Education will be coordinated by the Staff Development Coordinator.

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This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure proper storage of drugs and biologicals.

Observation on 10/14/15 revealed the treatment cart was unlocked and unattended on the One West Hall for more than forty (40) minutes. In addition, there was expired and opened/undated biologicals in the treatment cart.

The findings include:

Review of the facility's "Medication Storage" Policy, dated 12/01/2007, revealed the facility should ensure that all drugs and biologicals, including treatment items, were securely stored in a locked cabinet/cart or locked in a medication room, inaccessible by residents and visitors. Further review of the Policy, revealed once a drug or biological was open, the facility should follow the manufacturer/supplier guidelines with respect to expiration dates for opened medications.

Observation on 10/14/15 at 5:00 AM revealed the treatment cart on the One West Hall was observed unlocked and unattended for more than forty (40) minutes.

Observation inside the treatment cart revealed: two (2) Coloplast body cream packets stating for external use only and keep out of reach of children; twenty nine (29) A&D ointment (skin protectant with Vitamin A and Vitamin D) packets; twelve (12) Sting free Alcohol free skin prep

F 431 2.

Any resident passing an unlocked treatment cart could be affected by having the ability to open the cart. Likewise use of out of date supplies or opened, unlabeled and undated item could affect any resident being treated with same.

3.

A monthly treatment cart audit will be completed by the Unit Manager (UM) or other assigned licensed nurse beginning by November 10, 2015. The audit will include checking for expired, opened or undated items and validating carts are appropriately locked. This monthly audit will include all 6 treatment carts (100%). Any deficiency will be corrected immediately and will be reported to the Monthly Quality Assurance (QA) Meeting of discrepancies for follow up actions

4.

The Director of Nursing (DON) and Unit Managers will monitor the total 6 treatment carts (100%) during regular rounds Monday through Friday in addition to auditing 100 % of treatment carts (6) 3 times per week for one month, 2 times per week for one month and once per week for one month to assure that they are locked when unattended, and expired, opened/undated items are removed if present. The formal monitoring will start on or before November 11, 2015. Findings will be addressed immediately with the Nurse or Nurses involved and findings presented to the Monthly Quality

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packets stating avoid eye contact; one (1) Moisture Barrier Cream stating avoid eye contact; five (5) Risamine ointments (ointment for itching and/or rash) stating avoid eye contact; one (1) Desonide ointment (steroid used to treat inflammation and itching) stating avoid eye contact; one (1) Ketoconazole Shampoo (used for the treatment of dandruff) stating for external use only; two (2) Sea Clens Wound Cleanser Spray bottles stating seek professional help immediately if ingested, for external use only; four (4) Iodine packets (mild antiseptic) stating avoid eyes, for external use only; two (2) H-Chlor 12 (Dakin's solution used to prevent and treat skin and tissue infections) stating for topical use only; one (1) tub (160 count) Sani Wipe Cloths (disinfectant) stating danger see package insert; three (3) Lemon Glycerine swab packets (3 per pack); one (1) Granulex Spray (wound agent), may cause harm if swallowed, if taken by mouth contact poison control; two (2) Coloplast Woun'Dres Jelly/paste; one (1) Antifungal cream; and one (1) tub Coloplast body cream.

In addition, there was thirty five (35) EZ lube Jelly packets with an expiration date of February 2013; and three (3) bottles of Sterile Water opened, unlabeled and undated.

Interview on 10/14/15 at 5:40 AM, with Registered Nurse (RN) #1, revealed the medication and treatment carts were to be locked when unattended by nursing staff because unlocked/unattended carts could pose a safety risk to residents who might be in the area. Further interview revealed nursing staff was responsible for routinely checking the carts for expired medications or biologicals and all opened items were to be labeled and or dated.

F 431: Assurance meeting for any additional actions that may be needed. The QA members include but is not limited to the Administrator, Director of Nursing, Medical Director and three staff members.

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F 431 Continued From page 8

Interview on 10/14/15 at 6:30 AM, with the Director of Nursing (DON), revealed all medication and treatment carts should be locked when not in use to ensure resident safety and should be checked routinely for expired medications and biologicals. Further interview revealed all multi-use biologicals in the carts should be labeled with an open date and should be discarded according to manufacturer/supplier guidelines, as per the facility's Medication Storage Policy.

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 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

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.

F 441

Woodcrest Nursing and Rehabilitation assures that it establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and helps to prevent the development and transmission of disease and infection.

11/14/2015

F 441

1. No residents were identified as having a negative outcome due to the alleged deficient practice.

Residents #13, #14 and #15 had their nebulizer equipment bagged and dated, as well as oxygen tubing and humidified water bottles changed and dated by the Staff Development Coordinator and Unit Manager as soon as notified of the issue October 15, 2015.

The unlabeled bedpan in room #207 and the unlabeled urinal in room #203 were replaced with labeled items upon notification of the issue October 15, 2015 by the Staff Development Coordinator and Unit Manager.

A complete audit of all treatment carts was completed by the Unit Manager, Staff

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NAME OF PROVIDER OR SUPPLIER  WOODCREST NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018
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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 441 Continued From page 9  
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 and review of facility policy, 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 three (3) of twenty one (21) sampled residents (Residents #13, #14, and #15.

Observation during the survey of Residents #13, #14 and #15's shared bathrooms, revealed bed pans and bath pans were on the shower benches, unbagged and unlabeled. In addition, observation of Resident #13, #14, and #15's rooms revealed nebulizer equipment which was unbagged and undated. Also, although interviews revealed the oxygen tubing and humidified water bottles were to be changed weekly; observation of Resident #15's room revealed oxygen tubing and a humidified water bottle which was undated, observation of

F 441 Development Coordinator and Minimum Data Set (MDS) Nurse on October 14, 2015 and any expired items were removed.

2.  
Any resident requiring nebulizer equipment, oxygen tubing and or humidified water bottles, bedpans or urinals could be affected by the alleged deficient practice. The Unit Manager and Staff Development Coordinator audited all resident rooms on October 15, 2015 and found no additional discrepancies.

3.  
Oxygen tubing and humidification bottles are to be changed by Central Supply weekly beginning the week of November 10, 2015. The Director of Nursing will educate Central Supply on or before November 10, 2015. Shelving will begin to be installed in each resident bathroom beginning on November 10, 2015 and completed by November 13, 2015 for storage of resident personal items to include bed pans and urinals.

A monthly treatment cart audit to be completed by the Unit Manager (UM) or assigned licensed nurse will begin by November 10, 2015. Any identified issues will be addressed immediately with a report submitted to the Monthly Quality Assurance (QA) Meeting of discrepancies for follow up actions.

Re-education of the nursing staff concerning the requirement to eliminate expired items and bathroom storage of personal items with proper bagging and labeling of oxygen tubing

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F 441 Continued From page 10  
Resident #13's room revealed oxygen tubing and a humidified water bottle which was dated 09/20/15, and observation of Resident #14's room revealed oxygen tubing and a humidified water bottle which was dated 09/27/15.

Additionally, observation on 10/13/15, revealed an unlabeled bed pan in the bathroom of Room #207 and an unlabeled urinal in Room #203.

Also, observation on 10/14/15 revealed the treatment cart on the One West Hall contained expired Enteral supplies.

The findings include:

Review of the facility "Departmental Oxygen Therapy, Prevention of Infection Policy", undated, revealed the purpose of the procedure was to prevent infection associated with oxygen therapy tasks and equipment. Further review of the Policy, revealed the oxygen cannula and tubing was to be changed every seven (7) days or as needed, keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use.

Interview with the Director of Nursing (DON) 10/15/15 at 6:30 AM, revealed the facility did not have a policy related to labeling and storage of bed pans, bath pans, and urinals when not in use.

1. Observation on 10/14/15 at 5:00 AM, of Resident #13's shared bathroom revealed bed pans and a bath pans on the shower bench, unlabeled, and unbagged. In addition, observation of Resident #13's room revealed nasal cannula oxygen tubing, and a humidified water bottle which was dated 09/20/15. Also,

F 441 and humidification bottles began on October 14, 2015 and will be completed by November 12, 2015 or before. Education will be coordinated by the Staff Development Coordinator.

4. Rounds are being conducted by Admissions, Business Office, Unit Managers, Central Supply, Facility Driver, Activities and Social Service to review presence of safety equipment to include call light strings and placement thereof to assure they are accessible by the Residents, as well as to assure Nebulizer equipment, oxygen tubing and or humidified water bottles, bedpans or urinals are properly labeled and stored. Rounds are being completed a minimum of 3 times per week for one month, then 2 times per week for one month and then once per week for one month. Results are turned into the Administrator who is monitoring and presenting findings to the Daily morning department head meeting Monday through Friday meeting for necessary follow up and cumulatively will be presented to the monthly Quality Assurance meeting. The QA members include but is not limited to the Administrator, Director of Nursing, Medical Director and three staff members.

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F 441 Continued From page 11

Resident #13's nebulizer machine and tubing (hand held apparatus which delivers a moist agent or medication to the lungs upon inhalation) was at the bedside, and the tubing was unbagged and undated.

2. Observation on 10/14/15 at 5:05 AM, of Resident #14's shared bathroom revealed bed pans and bath pans which were on the shower bench unlabeled and unbagged. In addition, observation of Resident #14's room revealed nasal cannula oxygen tubing and a humidified water bottle which was dated 09/27/15. Also Resident #14's nebulizer machine and tubing was at the bedside, and the tubing was unbagged and undated.

3. Observation on 10/14/15 at 5:10 AM, of Resident #15's shared bathroom revealed bed pans and bath pans were on the shower bench, unlabeled and unbagged. In addition, observation of Resident #15's room revealed nasal cannula oxygen tubing, and a humidified water bottle which was undated. Also, the nebulizer machine and tubing was at the bedside and the tubing was unbagged and undated.

4. Observation on 10/13/15 at 11:12 AM, revealed an unlabeled urinal in Room #203.

5. Observation on 10/13/15 at 11:29 AM, revealed an unlabeled bed pan in the bathroom of Room #207

Interview on 10/15/15 at 2:40 PM, with Registered Nurse (RN) #4 revealed bed pans and bath pans should not be on the shower benches and should be bagged and labeled if residents shared a bathroom because this could be an infection

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F 441 Continued From page 12

control issue. Further interview revealed nasal cannula oxygen tubing, humidified water bottles, and nebulizer tubing should be changed weekly on Sunday's by the night shift nurse and should be bagged and dated.

Interview on 10/15/15 at 2:47 PM with Certified Nursing Assistant (CNA) #4 revealed bed pans and bath pans should not be on the shower benches and should be bagged and labeled if residents shared a bathroom. Further interview revealed the nurses changed out the oxygen equipment.

Further interview on 10/15/15 at 6:30 AM, with the DON, revealed bed pans and bath pans should not be left on the shower benches and should be bagged, labeled and stored if residents shared a bathroom because this could be an infection control risk. She further stated urinals should be labeled. Continued interview revealed nebulizer equipment, oxygen tubing, and humidified water bottles should be dated and changed weekly on Sunday's by the night shift nurse. She stated the oxygen tubing should be dated on the connector where it attached to the humidified water bottle.

6. Observation on 10/14/15 at 5:00 AM revealed the treatment cart on the One West Hall contained one (1) Patrol Enteral Pump Set expired June 2015, and one (1) Compat Enteral Feeding Tube expired March 2015.

Interview on 10/14/15 at 6:30 AM, with the DON, revealed the nursing staff should check the treatment carts routinely and remove expired items. She further stated, all expired supplies should be discarded according to manufacturer/supplier guidelines.

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F 514 483.75(l)(1) RES  
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

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 "Cardiopulmonary Resuscitation" Policy, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized to ensure appropriate resident code status for three (3) of twenty one (21) sampled residents (Resident #7, #11, and #19).

The findings include:

Review of the facility's "Cardiopulmonary Resuscitation" (CPR) Policy dated 02/17/2015, revealed the facility would adhere to the resident's rights to formulate advance directives and in

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Woodcrest Nursing and Rehabilitation ensures that each Resident's clinical record is maintained in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized to ensure appropriate resident code status.

11/14/2015

1. No resident was identified as having had a negative outcome due to the alleged deficient practice.

Resident #7's son came to the facility on October 19, 2015 and with two witnesses which were Social Service staff, signed a new Code Status form as a DNR. Resident Corrections for Resident #11 code status made prior to survey. Resident # 19 was discharged on August 24, 2015.

2. Any resident could be affected by this alleged deficient practice. A complete

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F 514 Continued From page 14  
accordance to these rights, the facility would implement guidelines regarding cardiopulmonary resuscitation (CPR).

1. Review of Resident # 7's medical record revealed the facility admitted the resident on 02/18/2011 with diagnoses including; Dementia with Behavioral Disturbance, Atherosclerosis, Osteoporosis, Anxiety, and Depression. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 09/09/2015, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) indicating the resident was severely cognitively impaired.

Review of Resident #7's Physician's orders revealed a "Do Not Resuscitate" (DNR) order was obtained on 11/20/2014. Review of the Monthly October 2015 Physician's Orders revealed orders stating "Do Not Resuscitate"

Review of Resident #7's "Kentucky Emergency Medical Services DNR Form" revealed Resident #7 had signed the form on 11/26/14; however, the form was not notarized nor witnessed by two (2) person's not related to the resident as the form required.

Interview on 10/16/15 at 4:10 PM, with Registered Nurse (RN) #4, revealed she was unaware the Kentucky Emergency Medical Services DNR Form dated 11/27/14, was not witnessed by two (2) persons not related to Resident #7 as per the directions on the form.

Interview on 10/16/15 at 4:20 PM, with RN #5 Unit Manager, revealed she was unaware the Kentucky Emergency Medical Services DNR

F 514 census audit in regards to code status documentation was completed by Social Service on October 16, 2015 which revealed no other discrepancies.

3. Social Service began on October 16, 2015 auditing all new admissions for Code status in the chart versus Code status in orders with additional checks done at 24, 48, and 72 hours or as close there to as possible during Monday through Friday, and will be continuing this process on-going for new admissions. A red dot system denoting Do Not Resuscitate is placed on name tag at the resident's room and on the resident's medical chart. Those residents without a red dot are full code status. The on-duty nursing supervisor will be in charge of moving/updating code identifications with a change of room or facility discharge. There is a designated nursing supervisor 24 hours/day and this assigned nurse is responsible for this process for new admissions and/or room changes.

A new "Change of Code Status" form was developed by the Director of Nursing and initiated on October 16, 2015. The process is for any change in code status paperwork received, the attending physician is contacted for an updated code status order. A new telephone order that correlates with code status paper work is generated, Updated code status paperwork is placed in the Advance Directive tab in the Medical Record. If the code status is DNR a red dot

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F 514: Continued From page 15

Form dated 11/27/14 was not witnessed by two (2) persons not related to Resident #7 and stated that this should have been done.

Interview on 10/16/15 at 4:30 PM, with the DON revealed she was unaware the Kentucky Emergency Medical Services DNR Form required a two (2) person signature in lieu of not being notarized and going forward it was her expectation the nursing facility staff complete the DNR form, having it either notarized or witnessed by two (2) persons as stated on the form. She further stated she was unsure if a resident with a BIMS of three (3) should sign a legal form, and she would need to further investigate.

2. Review of Resident #11's medical record revealed the facility admitted the resident on 08/28/08 with diagnoses including: Muscular Dystrophy, Charcot-Marie Tooth disease, Chronic Pain Syndrome, Hypothyroidism, Irritable Bowel Syndrome, Depression, Anxiety, Hypertension, and Peripheral Vascular Disease.

Review of the Quarterly MDS Assessment dated 08/13/15, revealed the facility assessed the resident as having a BIMS score of fifteen (15) indicating the resident had no cognitive impairment.

Review of the Care Plan Meeting Notes, dated January 2015, revealed Resident #11 had requested to change code status from "Do Not Resuscitate" to "Full Code".

However, review of the Monthly Physician's orders for the months of February 2015, March 2015, April 2015, May 2015, June 2015, July 2015, August 2015, September 2015, and

F 514: is placed on the name tag at the resident's room and on the resident's medical chart. Red Dot stickers are removed if the change is to Full Code. There are spaces for initials and date for each task and the completed form is forwarded to the Director of Nursing.

Re-education of the nursing staff concerning Code Status and the Red Dot Sticker process began on 10/14/15, and will be completed by November 12, 2015. This education included the need to check Physician's Orders and Advanced Directives in the event of a cardiac or respiratory failure, as to not rely strictly on the red dot system. After this date, any newly hired nursing staff or potential agency nurses shall receive this education during orientation, prior to assuming work duties. Education will be coordinated by the Staff Development Coordinator.

4. Social Services will monitor resident code status and ensure system implementation. Social Services will audit new admissions and re-admissions and will additionally complete full house audits once per month for the next three months. After this time, Social Services will continue to monitor via full house audit on a quarterly basis, in addition to the on-going review of new admissions and re-admissions. Any discrepancies will be immediately corrected and reported to the Monthly Quality Assurance Committee for any necessary follow up. The QA members

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F 514 Continued From page 16  
October 2015 all revealed orders for "Do Not Resuscitate".

Further review revealed there was no documented evidence of Physician's Orders for Full Code until 10/06/15, nine (9) months later. Review of the Physician's order dated 10/06/15 revealed orders for code clarification requesting a Full Code order for Resident # 11.

3. Review of Resident #19's closed medical record revealed the facility admitted the resident on 08/16/15. Review of Resident #19's Admission Physician's orders, dated 08/16/15, revealed an order for "Full Code" Status; however, review of the "Kentucky Emergency Medical Services Form" in the record, dated 08/17/15 revealed the resident signed as requesting "Do Not Resuscitate" (DNR). Continued review of the Physician's Orders revealed no documented evidence the facility obtained a signed Physician's Order for "DNR" status.

Further interview, on 10/16/15 at 4:30 PM, with the DON, revealed clinical records should be accurate and complete with no discrepancies related to Physician's orders for Code Status, Advanced Directives, and Kentucky Emergency Medical Services Forms. The DON revealed she was unaware of these concerns until questions were brought up during the survey.

F 514 include but is not limited to the Administrator, Director of Nursing, Medical Director and three staff members.

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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: 1998</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2)stories, Type II (111) Unprotected</p> <p>SMOKE COMPARTMENTS: Four (4)smoke compartments</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY and Wet SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator</p> <p>A Life Safety Code Survey was initiated and concluded on 10/15/15 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.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) 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.