PRINTED: 08/18/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185118	A. BUILDING _____ B. WING _____	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE HEALTH CARE	1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted 08/02/11 through 08/04/11 and a Life Safety Code survey was conducted on 08/03/11. The Health survey cited deficiencies with the highest scope and severity of a "G" with the facility having no opportunity to correct before remedies would be recommended for imposition based on the facility's history.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policy, and review of the medical record, it was determined the facility failed to accommodate the need for improved mobility for one (1) of twenty-one (21) sampled residents, (#7). Resident #7 requested to use a personal motorized scooter and was denied. The findings include: Review of the facility's policy, revised 04/28/10, regarding motorized wheelchairs revealed residents use motorized wheelchairs to increase function to the highest possible level and indicated when physical limitations are not	F 246	F 246 I. **How corrective action will be accomplished for those affected.** Resident #7 was informed of the facility's policy of motorized wheelchairs. The family of resident #7 brought in a motorized wheelchair and a licensed therapist initiated an evaluation for safety in the device. The care plan for Resident #7 was updated by a licensed nurse to reflect use of the motorized wheelchair. II. **How corrective action will be accomplished for those residents having potential to be affected.** All current alert and oriented residents were interviewed to determine if any others had a desire to bring in a motorized wheelchair. No others expressed an interest. III. **What measures will be put in place/systemic changes made to ensure correction.** The facility staff were trained by the Staff Development Coordinator RN and the	8/31/11

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna McGill
TITLE: Executive Director
(X6) DATE: 8/26/11

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F 246	Continued From page 1 compatible with manual wheelchair mobility. Review of the medical record for Resident #7 revealed the facility admitted the resident on 07/15/11 with diagnoses of Multiple Sclerosis and Immobilization Syndrome. Review of the admission Minimum Data Set (MDS) Assessment completed on 07/25/11 revealed the facility assessed Resident #7 with cognition intact, total dependence with two (2) person physical assist for bed mobility, transfers, hygiene and bathing. The facility assessed the resident as impaired in range of motion on both sides of upper and lower extremities. Observation of Resident #7, on 08/02/11 at 11:30 AM, revealed the resident sitting in a wheelchair in the dining room eating lunch with adaptive utensils for eating, and sippy cups with straws for liquids. Observation and interview of Resident #7, on 08/02/11 at 3:15 PM, revealed the resident lying on a speciality mattress bed watching television. The resident stated "they won't let me bring my power chair, because they take up too much room". On 08/3/11 between 9:00 AM and 9:30 AM, Licensed Practical Nurse #5 completed a dressing change for Resident #7. The Staff Development Coordinator was assisting LPN #5 with the treatment. During this time Resident #7 stated he/she hoped they could bring their motorized scooter to the facility for use. At that time the Staff Development Coordinator said, "we don't have a lot of room, so we don't encourage they bring them in."	F 246	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Executive Director on the Policy and Procedure for motorized wheelchairs. The Admissions Coordinator will review the information on motorized wheelchairs with newly admitted residents and/or families at the time of admission. The Resident Council will be asked monthly by the Social Services Director at their monthly meeting of any concerns with accommodation of needs. Any concerns will be addressed. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Social Services Director and Admissions Coordinator will review their findings with newly admitted residents and Resident Council interviews with the Performance Improvement committee monthly with follow up actions or education as needed. **F 253** **I. How corrective action will be accomplished for those affected.**	8/31/11

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F 246	Continued From page 2 Interview with Resident #7, on 08/03/11 at 9:30 AM, revealed the resident was diagnosed with Multiple Sclerosis in 1994 and is unable to propel a wheelchair independently. Interview with the North Unit Manager, on 08/03/11 at 3:10 PM, revealed Resident #7 had asked about bringing the personal motorized scooter the week before last and she had told the resident that therapy would need to evaluate the resident first. The North Unit Manager stated at that time the former Assistant Director of Nursing overheard the conversation and told her and the resident they couldn't have those here, referring to the scooter. Interview with the Administrator, on 08/03/11 at 3:30 PM, revealed he was not aware Resident #7 had requested the use of the motorized scooter until just recently, and told the resident they would look into it. Interview with the Therapy Department Manager, on 08/03/11 at 3:35 PM, revealed she was not aware Resident #7 had asked about having a motorized scooter. She did state we basically took away the resident's independence.	F 246	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. The three brown stains in room 6 were painted on 8/4/11. 2. The black substance on the wall behind the commode in room 12 was cleaned on 8/4/11. 3. The bolt protruding from the door frame of room 22 was removed on 8/4/11. 4. The cabinet in the north shower room was found loose at the top from the wall and was repaired on 8/4/11. **II. How corrective action will be accomplished for those residents having potential to be affected.** All resident rooms were inspected by the Maintenance Director and any in need of ceiling paint or removal of black substances was completed. Shower rooms were inspected by the Maintenance Director to validate all cabinets secured to walls. All door frames were audited by the Maintenance Director to validate no other bolts protruding.	8/31/11
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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Northern Enforcement Branch

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F 253	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain an environment that was safe and homelike. There were brown stains on the ceiling, black substance on the wall, and sharp objects on a door frame. In addition, the wall cabinet in the shower room was detached from the wall. The findings include: Observations during the environmental tour of the facility, on 08/04/11 at 3:10 PM, revealed the following items were in need of repair: 1. The ceiling in Room 6 over Bed C had three circular brown stains. 2. There was a black substance on the wall behind the commode in Room 12. 3. The door frame to Room 22 had velcro attached to the frame with bolts that protruded from the door frame. 4. The wall cabinet in the North Shower Room had become detached from the wall and was supported by a stretcher. Interview with the Maintenance Director (MD), on 08/04/11 at 3:30 PM, revealed there was a maintenance log at each nurse's desk for staff to record maintenance needs. He checked those logs daily for identified needs. He was aware of the bolts protruding from Room 22's door frame and this could cause skin tears to residents. He identified the black substance in Room 12 to be	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **III. What measures will be put in place/systemic changes made to ensure correction.** All facility staff will be in-serviced on reporting both maintenance and housekeeping issues in the log books at each nursing station. The Maintenance Director and Housekeeping supervisor will bring the logs to the morning meeting each day (Monday-Friday) and report on the entries from the day before and the outcome. The Administrator will tour the center weekly and review these logs with the Maintenance Director and Housekeeping Supervisor to ensure competition of all issues. All staff will be in-serviced annually on the proper use of the Maintenance and Housekeeping log and will be covered in new hire orientation by the Maintenance Director. **IV. How the facility plans to monitor its performance to**	8/31/11

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F 253	Continued From page 4 mold.	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policy and review of the medical record, the facility failed to develop a comprehensive care plan for one (1) of twenty-one (21) sampled residents (#1). Resident #1 was on Hemodialysis three (3) times a week, using a shunt to the left upper arm. The facility failed to develop a comprehensive care plan that described the needs and services for the resident to maintain	F 279	**make sure that solutions are sustained.** The Administrator will review the maintenance and housekeeping logs weekly to insure that all issues are resolved. The Administrator will also make center rounds weekly with Maintenance Director and Housekeeping Supervisor to identify any potential issues and validate maintenance or housekeeping issues are properly attended too. Results of the rounds will be recorded and reported by the Administrator to the Performance Improvement committee monthly for the next 3 months to ensure proper action is being taken. **F 279** **I. How corrective action will be accomplished for those affected.** Resident #1 had the care plan updated on 8-9-11 by the Unit manager RN to include dialysis. **II. How corrective action will be accomplished for those residents having potential to be affected.** All residents receiving dialysis currently residing in the center had their care plans reviewed	8/31/11

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F 279	Continued From page 5 the highest practicable well-being. The findings include: Review of facility Care Plan policy revised 10/31/09 revealed a comprehensive care plan was developed that was consistent with the residents' specific conditions.....to meet the resident's needs as identified in the resident's assessment. Review of the medical record for Resident #1 revealed the facility admitted the resident on 05/05/11 with a diagnosis of End Stage Renal Disease (ESRD)(Dialysis Dependent). The resident went out to dialysis three (3) times a week utilizing a shunt to the left upper arm. Review of the admission Minimum Data Set (MDS) assessment, dated 05/25/11, revealed the facility assessed Resident #1 as non-interviewable and required total dependence with assist of two (2) for bed mobility, transfers, and dressing. Review of the Comprehensive Care Plan, dated 05/12/11, revealed the facility assessed Resident #1 as cognitively impaired, unresponsive at times and nonverbal. The staff were to anticipate all care needs as an intervention. Interview with the North Unit Manager, on 08/04/11 at 2:50 PM, revealed interim care plans were initiated by the nursing staff and care plan revisions were completed by the staff nurses. She stated they failed to develop a care plan for Resident #1 dialysis needs.	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* by the Unit manager RN on 8-18-11 with updates made to the care plan as needed. **III. What measures will be put in place/systemic changes made to ensure correction.** The facility has implemented a standardized care plan for any dialysis resident and the Staff Development Coordinator RN provided training on the use of this standardized care plan to all licensed staff beginning on 8-24-11. This training continued until 8-30-11 when all licensed staff had received it. New hire licensed staff will be trained on use of the standardized care plan as part of their orientation. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing will review the care plans of all dialysis residents monthly to validate dialysis services and interventions are properly addressed. Results of the review will be reported to the Performance Improvement committee monthly with follow up actions or education as needed.	8/31/11

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F 279	Continued From page 6 Observation, on 08/02/11 at 11:45 AM, revealed Resident #1 resting in bed, tilted to the right side, left arm propped up on a pillow and geri-sleeves in place to both arms.	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy regarding Indwelling Urinary Catheter Care, it was determined the facility failed to revise and update the plan of care related to monthly changing of an indwelling catheter for one (1) of the twenty-one	F 280	**F 280** **I. How corrective action will be accomplished for those affected.** Resident #15 care plan was reviewed by the Unit manager RN and updated to reflect foley catheter changes on 8-11-11. **II. How corrective action will be accomplished for those residents having potential to be affected.** All residents with foley catheters were reviewed by the Unit manager RNs to validate care plans reflective of foley catheter changes. This was completed on 8-17-11. **III. What measures will be put in place/systemic changes made to ensure correction.** The Unit manager RNs will bring all condition change	8/31/11

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F 280	Continued From page 7 (21) sampled residents (#15). The findings include: Review of the facility policy, dated 04/28/10, regarding "Indwelling Urinary Catheter Care" revealed the rationale would include the care of a catheter provided to prevent infection and/or reduce irritation ... 25. "Update the care plan as necessary." Review of Resident #15's clinical record revealed the resident had diagnoses of Chronic Wounds, Osteomyelitis, Immobilization Syndrome, and Urinary Tract Infection. Review of physician's orders, dated 04/30/11, revealed the resident's indwelling catheter was to be changed monthly. Observation of Resident #15, on 08/04/11 at 7:55 AM, revealed light brown sediment occluding the inside of the catheter tubing. The urine color was a dark amber. Observation during a skin assessment at 11:50 AM revealed the resident's bed was urine soaked around the catheter tubing with a foul urine odor. Review of Resident 15's plan of care, dated 04/16/08, revealed an approach, dated 4/22/09, to change the indwelling catheter as needed; however, there was no evidence the care plan had been revised or updated to reflect the physician's order to change the catheter monthly. Interview with the Unit Manager (UM) on the North Hall, on 08/04/11 at 11:55 AM, revealed the order had been obtained to change the catheter monthly in April 2011; however, was unaware it had not been transcribed onto the TAR (treatment	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* forms to the daily stand up meeting (Monday- Friday) and validate care plan updates reflective of new MD orders. The weekend supervisor RN will be responsible for validating the care plan updates from new MD orders on Saturday and Sunday. All licensed nurses will be trained on the use of the condition change form by the Director of Nursing Services or Staff Development Coordinator RN beginning on 8-24-11. This form includes a section on care plan updates and MD orders. The training will continue until 8-30-11 when all licensed nurses have received it. New hire licensed staff will be trained on use of the form in general orientation. The Director of Nursing Services will audit at least 5	8/31/11

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F 280	Continued From page 8 administration record) in May, or that the catheter had not been changed in May or June 2011. The UM also revealed there would be a potential for infection with not changing the indwelling catheter, especially with incontinence of the bowel. At 2:50 PM the UM stated the nursing staff completed the care plan updates, and quarterly care plan updates are completed by the Assessment Coordinator.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to follow the plan of care for three (3) of the twenty-one (21) sampled residents. Residents' #2 and #16's c-collar was not applied as ordered and Resident #15's chin hairs were not shaved. The findings include: 1. Review of Resident #15's clinical record revealed diagnoses of Immobilization Syndrome, Chronic Wounds, and Osteomyelitis. Review of the Annual Significant Change Assessment, dated 01/24/11, revealed the resident was total assist with bed mobility and transferring, and maximum assist with bathing and personal hygiene.	F 282	new orders every week and validate care plan updates made appropriately. Any concerns will be addressed immediately. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing Services will audit at least 5 new orders every week and validate care plan updates made appropriately. Any concerns will be addressed immediately. The Director of Nursing will review the findings from the care plan update audits monthly and track and trend the results with the findings reported to the monthly Performance Improvement committee for follow up or further education as needed. The Performance Improvement committee may increase or decrease frequency of the audits based on findings.	

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F 282	Continued From page 9 Chin hairs were observed on Resident #15 on 08/04/11 at 7:55 AM. Interview with Resident #15, on 08/04/11 at 2:10 PM, revealed the chin hairs bothered the resident and stated it had been a long time since the chin hairs had been removed. Review of the Self-Care Deficit Care Plan relating to decreased mobility, dated 04/16/2008, revealed the resident was to be shaved when needed. CNA #4 was interviewed, on 08/03/11 at 2:20 PM, and revealed the past month had been difficult at times to complete bathing; she also revealed problems occurred mainly on weekends, due to staff leaving or calling in. Interview with the Unit Manager, on 08/04/11 at 11:55 AM, revealed the Certified Nursing Assistant's (CNA) should monitor the chin hairs and could be taken care of even if the resident did not go to the shower. 2. Review of the medical record for Resident #16 revealed the facility admitted the resident most recently on 12/07/07 with diagnoses of Dementia with disturbances, Parkinson Disease and Rheumatoid Arthritis (RA). Review of the Annual Minimum Data Set Assessment dated 05/27/11 revealed the facility assessed Resident #16 as severe cognitively impaired, required extensive assistance of two (2) for bed mobility, transfers, dressing, eating, hygiene and bathing.	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 282** **I. How corrective action will be accomplished for those affected.** Residents #2 and #16 soft cervical collars had been sent to the laundry. New collars were placed on the residents on 8-5-11 so they will now have a back up to allow for laundering of their soft collars. Resident #15 had chin hairs removed on 8-5-11. **II. How corrective action will be accomplished for those residents having potential to be affected.** All residents currently in the center with physician orders for adaptive equipment were reviewed by a licensed nurse to validate devices were listed on the care plan and certified nursing assistant assignment sheets. Any	8/31/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185118	A. BUILDING _____ B. WING _____	08/04/2011

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F 282	Continued From page 10 Review of the Comprehensive Care Plan revealed Resident #16 was care planned for impaired physical mobility secondary to diagnosis of RA and Parkinson's Disease. A care plan intervention was initiated on 02/05/09 for a soft C-collar to be worn when up in wheelchair and for all meals for proper positioning. Observation, on 08/04/11 at 8:25 PM, revealed Resident #16 sitting in the dining room being fed by staff. The resident did not have the soft C-collar applied. Interview with Certified Nursing Assistant #12, on 08/04/11 at 2:10 PM, revealed Resident #16 did not have the cervical collar applied because it was soiled and needed replaced. CNA #12 went on to say the C-collar had not been available for about a week. 3. Record review revealed the facility admitted Resident #2 on 11/21/08 with the following diagnoses: Alzheimer's; Diabetes; Dementia; Chronic Obstructive Pulmonary Disease; Hypertension; and a Pacemaker. Resident #2 began Hosparus care on 05/11/11. Continued Review of Resident #2's clinical record revealed a occupational therapy discharge note, dated 09/24/09, revealed the resident had been treated for cervical Range of Motion and was to have a cervical collar in place when the resident was out of bed. Review of the current Physician orders for July of 2011 revealed the resident was to utilize bilateral shin guards, torso support, bilateral arm protectors and a soft	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* residents with devices in need of routine laundering were given a back up device. All female residents were checked by a licensed nurse to determine need of routine shaving of chin hairs. Any found to need shaving were provided with removal of chin hairs at that time. Those identified to be in need of routine shaving had their care plans and certified nursing assessment sheets updated to reflect removal of chin hair. **III. What measures will be put in place/systemic changes made to ensure correction.** The certified nursing assistant assignment sheets will be brought to the daily (Mon-Fri) clinical meeting by the Unit Managers. Updates will be made at that time based on new physician orders or care plan updates. The weekend RN supervisor	8/31/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 11 cervical collar when up in the chair. Review of the Resident's comprehensive plan of care revealed a cervical collar was to be applied when the resident was up in the chair. Review of the certified nursing assistant (CNA) flowsheet and the treatment administration record (TAR) revealed the resident was to have a soft cervical collar applied when up in the chair. Observation of Resident #2, on 08/02/11 at 3:15 PM, 08/02/11 at 3:45 PM, 08/02/11 at 4:30 PM, 08/03/11 at 9:30 AM, 08/03/11 at 10:00 AM, and 08/03/11 at 11:00 AM, revealed the resident sitting up in a Broda chair without the soft cervical collar in place. Interview with CNA #1, on 08/04/11 at 2:25 PM, revealed she was assigned to the resident on 08/02/11. When asked about the cervical collar not being in place, she stated the cervical collar had been sent out to be washed and there was not another collar available. She was able to say when the cervical collar should be applied.. However, she could not say what potential negative outcome or problems could occur with the resident by not wearing the cervical collar as ordered. Interview with Licensed Practical Nurse (LPN) #1, on 08/04/11 at 6:15 PM, revealed the cervical collar was ordered for proper alignment and stated it helped to prevent further contractures. The LPN stated not wearing the cervical collar could cause worsening of the neck contracture and the collar also helped to position the resident's head to allow the resident to see what he/she was near, therefore preventing potential accidents. She further revealed all staff was	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* will be responsible for updating the assignment sheets on Saturday and Sunday as needed. Licensed nurses will be trained beginning on 8-24-11 and continuing until 8-30-11 by the Staff Development Coordinator RN on using the assignment sheets to conduct rounds every shift to validate care provided according to the plan of care for each resident. These quality of care rounds will be turned in daily to the Director of Nursing. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing will review the daily charge nurse rounds and track and trend them. The results will be reported to the monthly Performance Improvement	8/31/11

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F 282	Continued From page 12 responsible to make sure the cervical collar was in place. She stated any staff member could have applied the collar. She also revealed she was not aware that the cervical collar had not been placed for two (2) consecutive days. Interview with the South Hall Unit Manager, on 08/04/11 at 6:20 PM, revealed the cervical collar assists with the position of the head. She stated the resident leans the head to the side without the cervical collar, which could lead to a contracture. She was not aware the cervical collar had not been in place for two (2) consecutive days. The South Hall Unit Manager stated the CNA's and the staff nurses are responsible to make sure the the collar was placed as ordered. She stated she was ultimately responsible for ensuring the nursing staff was following the care plan. Refer to F309 and F318	F 282	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Committee with follow up action or education as needed. The Performance Improvement Committee will determine the frequency of the rounds and may increase or decrease them based on the findings. **F 309** **I. How corrective action will be accomplished for those affected.** Resident #2 was evaluated by OT on 8-23-11 and a restorative passive range of motion plan was recommended. The resident is on the restorative nursing program at this time and the care plan has been updated. **II. How corrective action will be accomplished for those residents having potential to be affected.** All residents currently residing in the center were	8/31/11
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for	F 309		

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F 309	Continued From page 13 one (1) of the twenty-one (21) sampled residents (Resident #2) as evidenced by the facility's failure to follow the written physician orders for restorative therapy and passive range of motion. The findings include: The facility did not provide a policy on nursing restorative therapy as requested. Review of Resident #2's clinical record revealed the facility admitted the resident on 11/21/08 with the following diagnoses: Alzheimer's; Diabetes; Dementia; Chronic Obstructive Pulmonary Disease; Hypertension; and a Pacemaker. The Resident began Hosparus care on 05/11/11. Review of the annual Minimum Data Set (MDS) assessment completed on 08/31/10 revealed the facility assessed the resident to have limited range of motion to bilateral upper and lower extremities with partial loss of voluntary movement to the neck. A Physical Therapy (PT) discharge summary, dated 12/30/10, stated the resident's right cervical had neck flexion which measured negative 22 degrees from the neutral position. The PT discharge summary documented reason for discharge was the resident had met the maximal potential. PT recommended the resident receive restorative therapy for passive range of motion (PROM) and stretching to the right cervical area. A Physician order, dated 12/30/10, revealed to discontinue skilled therapy and begin restorative therapy for PROM and positioning. Review of the nurses notes revealed a condition of change form dated 12/30/10 that stated the resident was to	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* assessed by the Rehabilitation Department staff for any increases in muscle tone, decrease in range of motion, and possible contractures. Anyone found to have any increases in muscle tone, decrease in range of motion, and/or possible contractures was picked up by the therapists and MD/family notification occurred. This assessment was completed by 8-19-11. **III. What measures will be put in place/systemic changes made to ensure correction.** All nursing staff has been educated by the Director of Nursing Services or Staff Development RN beginning on 8-23-11 for identification of decrease range of motion, increase in muscle tone, or contractures and on the use of a change in condition form. Competencies for	8/31/11

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

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F 309	Continued From page 14 begin restorative therapy for PROM and positioning. However, review of the restorative nursing book (on 08/04/11) revealed no restorative plan had been initiated and there was no written documented evidence Resident #2 had received restorative nursing. Observations of Resident #2, on 08/02/11 at 3:15 PM, 08/02/11 at 3:45 PM, 08/02/11 at 4:30 PM, 08/03/11 at 9:30 AM, 08/03/11 at 10:00 AM, and 08/03/11 at 11:00 AM, revealed the Resident sitting up in the Broda chair without a soft cervical collar in place. Observation during a skin assessment performed by licensed practical nurse (LPN) #1, on 08/03/11 at 5:30 PM, revealed the resident lying in bed with neck flexed toward the right side and a cervical pillow around the neck. Interview with LPN #1 revealed the resident had a right sided neck flexion contracture. Interview with the North Unit Manager, on 08/04/11 at 8:30 AM, revealed she was responsible for the restorative program. She stated she was not aware Resident #2 was to receive restorative services. When she resumed responsibility for the program, she did not receive a restorative plan for the resident. After reviewing the restorative order, dated 12/30/10, the North Unit Manager stated it did not appear the order was transcribed and communicated to the nursing restorative department. Interview, on 08/04/11 at 3:25 PM, with Licensed Practical Nurse (LPN) #1 revealed she was not aware Resident #2 was to have restorative nursing for PROM and positioning. After	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* SRNAs on range of motion were initiated on this date as well. The education and competencies continued through 8-30-11 until all SRNAs received a competency and all nursing staff were educated. The restorative nurse RN, Unit managers, Director of Nursing, restorative SRNAs, Staff Development Coordinator RN, and facility rehab manager were educated on the policies and procedures of discontinuation from therapy and referrals to restorative nursing by the Multi-site Rehab Clinical Mentor on 8-22-11. A change of condition form has been generated for the nursing assistants use to help with change of condition of the residents. These forms will be placed at each nursing station for nursing	8/31/11

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F 309	Continued From page 15 reviewing the physician order, LPN #1 stated it did not appear the order was ever reviewed and transcribed by the nurse as evidenced by the lack of the nurse's signature, which notates completion. She further revealed the unit managers are responsible for ensuring orders are completed and transcribed. Interview, on 08/04/11 at 3:30 PM, with the South Unit Manager revealed orders should be signed and dated when completed. Failure to perform PROM as ordered could potentially cause contracture of the joints or worsen current contractures. She stated it was the responsibility of the nurse to ensure physician orders were completed, transcribed, and communicated to the appropriate department. Interview with the Director of Nursing (DON), on 08/04/11 at 4:00 PM, revealed she was normally notified when a resident would be discharged from therapy and started on the restorative program. The DON was unaware of the physician order for restorative therapy and further interview with the DON at 5:00 PM revealed she was unable to locate any documented evidence that restorative therapy had ever been initiated. Refer to F282 and F318	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* staff use. If the nursing assistant identifies a change in condition he/she is to fill out this form and give to the nurse to follow up on. Once the nurse assesses the resident he/she is to notify the MD and family of the change and complete a rehab referral as warranted. This form will then be forwarded to the Unit manager who will review at the daily stand up meeting (Monday-Friday) and validate timely rehab or restorative intervention. The rehab department will conduct a quarterly screen, in conjunction with the MDS/RAI schedule, on every resident to assess for change of condition by using the MDS assessment calendars, generated by the MDS department. This quarterly review will start 10-1-11 as every resident has been reviewed in August 2011.	8/31/11
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policy, and review of medical records the facility failed to assist dependent residents with bathing, grooming, and fingernail care for five (5) of twenty-one (21) sampled residents (#1, #7, #9, #15, #16). Resident #1 did not receive showers as scheduled and did not receive nail care per facility policy that resulted in a cut to the resident's right hand. Residents #7, #9, and #16 did not receive showers as scheduled, and Resident #15 did not receive facial grooming as needed. The findings include: Review of the facility's policy on care of nails, dated January 2000, revealed the purpose of nail care was to provide cleanliness, to prevent the spread of infection, for comfort, and to prevent skin problems. 1. Review of the medical record for Resident #1 revealed the facility admitted the resident on 05/05/11 with diagnoses including Cerebral Vascular Accident (CVA), Hypertension, End Stage Renal Disease (ESRD)(Dialysis Dependent), Percutaneous Endoscopic Gastrostomy (PEG) for tube feeding, and Diabetes. Review of the Comprehensive Admission Minimum Data Set (MDS) Assessment, dated 05/25/11, revealed the facility assessed Resident #1 as severely cognitively impaired, nonverbal, extensive assistance requiring two (2) assist for	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **IV. How the facility plans to monitor its performance tomake sure that solutions are sustained.** The Director of Nursing will review the condition change forms and referrals to restorative nursing and track and trend the results with the findings reported to the monthly Performance Improvement committee. The rehab department manager will report on progress of quarterly screens to the monthly Performance Improvement committee. **F 312** **I. How corrective action will be accomplished for those affected.** Resident #1 received nail care on 8-2-11, a bedbath on 8-4-11, and a shower on 8-8-11. The resident has received regular showers and nail care since then. Resident #7 received a shower on 8-3-11 and has	8/31/11

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

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F 312	Continued From page 17 bed mobility, transfers, dressing, hygiene and bathing. Review of the Comprehensive Care Plan, dated 05/25/11, revealed Resident #1 required total care with grooming and dressing. The resident was to be showered/bathed two (2) times a week. Fingernails and toenails were to be cleaned and checked. The resident's skin would be examined during bathing for irritation or breakdown and reported to the nurse. Review of the shower schedule for Resident #1 revealed the resident was scheduled for showers on Mondays and Thursdays on the evening shift. In addition, at the bottom of the shower schedule there was a statement that stated fingernails and toenails are to be trimmed. Review of the Nursing Assistants flow sheet record revealed Resident #1 received two (2) out of eight (8) scheduled showers for the month of July 2011. In addition, to the showers, fingernails and toenails were documented to have been cleaned and checked. Review of the shower skin check sheet for Resident #1 revealed only two (2) days out of eight (8) were documented with skin checks for the month of July 2011. Review of the August 2011 shower skin check sheet for Resident #1 revealed the resident had a shower on 08/01/11 and there were no new skin area's noted. Observation, on 08/02/11 at 1:05 PM, of a skin assessment for Resident #1 revealed the resident's right hand was gripped tightly and had a foul odor. LPN #5 opened the resident's right hand and found the palm to be red with a 0.9cm	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* continued to receive routine showers since then. Resident #9 received a shower on 8-4-11 and has continued to receive routine showers since then. Resident #16 received a shower on 8-2-11 and has continued to receive routine showers since then. Resident #15 received facial grooming on 8-5-11 and has continued to receive regular grooming since then. **II. How corrective action will be accomplished for those residents having potential to be affected.** All residents requiring assistance with ADLs have potential to be affected.	8/31/11

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F 312	Continued From page 18 by 0.2cm open cut. The resident's fingernails were long and required trimming. Interview with Certified Nursing Assistant (CNA) #7, on 08/02/11 at 2:45 PM, revealed he was the person who had showered Resident #1 on 08/01/11. He did not trim the resident's fingernails and stated he had observed the skin issue on the resident's right hand; however, he had not reported or documented correctly on the shower skin check sheet. He stated if skin issues are not reported like they should be they can become open sores. 2. Review of the medical record for Resident #7 revealed the facility admitted the resident on 07/15/11 with diagnoses of Multiple Sclerosis and Immobilization Syndrome. Review of the Admission Comprehensive MDS Assessment, dated 07/25/11, revealed Resident #7 was cognitively intact, required extensive assistance of two (2) for mobility, transfers, dressing, hygiene and bathing. Interview with Resident #7, on 08/03/11 at 9:30 AM, revealed the resident had not received a shower for about a week. Resident #7 stated staff told him/her that the shower got missed because the resident changed rooms. Review of the Nursing Assistants flow sheet for Resident #7 revealed documentation that the resident had received zero (0) of five (5) showers. Review of the resident's weekly skin check sheet for Resident #7 revealed documentation of skin checks on 07/16/11 and 07/27/11. Resident #7 was originally in room 15C and based on the facility shower schedule the resident's showers	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **III. What measures will be put in place/systemic changes made to ensure correction.** Licensed nurses will be responsible for completing quality of care rounds every shift and validating showers given as scheduled and ADL care provided as needed for all residents. The rounds will be turned in daily to the Director of Nursing Services (Monday-Friday) and the weekend supervisor RN (Saturday-Sunday). Any concerns identified on the Charge nurses' assigned shift will be corrected before the shift ends. The Staff Development Coordinator RN will train all nursing staff on the policies and procedures for ADL care, shower schedules, and documentation of ADLs. This training was initiated on 8-24-11 and continued until	8/31/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185118	A. BUILDING _____ B. WING _____	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE HEALTH CARE	1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701

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F 312	Continued From page 19 were scheduled for Wednesday's and Saturday's on the evening shift. Resident #7 had changed rooms on 07/31/11 to room 17A. The new shower days for Resident #7 was Monday and Wednesday on the evening shifts. Resident #7 did not receive a shower on 08/01/11 which was the new shower day. 3. Review of the medical record for Resident #16 revealed the facility most recently admitted the resident on 12/07/07 with diagnoses of Dementia with Disturbances, Schizophrenia, Rheumatoid Arthritis, and Parkinson's Disease. Review of the Annual Comprehensive MDS Assessment, dated 05/27/11, revealed the resident was severely cognitively impaired, required extensive assistance of two (2) for transfers, dressing, and bathing. Review of the facility shower schedule revealed Resident #16's showers should have occurred on Tuesday's and Friday's on the evening shift. Review of the Nursing Assistant flow sheet for Resident #16 revealed the resident only received four (4) out of nine (9) scheduled showers. Interview with Certified Nursing Assistant #11, on 08/04/11 at 4:30 PM, revealed she had worked at the facility for about two (2) years on the evening shift. She stated the last couple of months the facility experienced trouble with staffing and if there were only three (3) aides assigned, bed baths were given instead of showers. CNA #3 did not know why some of the skin sheets were not filled out. Interview with the North Unit Manager, on 08/04/11 at 5:15 PM, revealed the Nursing	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 8-30-11 when all nursing staff had been trained. New hires will receive the training in general orientation. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing will review the shift rounds by the Licensed nurses and track and trend the results with the findings reported to the monthly Performance Improvement committee. The Performance Improvement committee may decrease the frequency of the rounds after determining sustained compliance.	8/31/11

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F 312	Continued From page 20 Assistant flow sheet and the shower skin check sheet completed by the CNAs was where staff document showers and baths. She stated if a shower did not get completed, staff was to pass it on to the next shift. Based on the documentation reviewed, the facility was not providing the residents their showers. The showers are not getting done because of "staffing challenges". 4. Review of the clinical record for Resident #9 revealed the facility admitted the resident on 03/22/11 with the following diagnoses: Diabetes, Metastatic Renal Cell Cancer, Morbid Obesity, and Pain. Review of the admission MDS assessment, completed on 03/30/11, revealed the facility assessed the resident to require assistance with bathing, grooming, and personal hygiene. Review of the self-care plan of care, dated 04/06/11, revealed the resident had a deficit in dressing/grooming related to decreased mobility and debility. The interventions were to assist the resident with dressing as needed. Under the bathing care plan, the facility was to provide shampoo, shower/bath two times a week. The staff was instructed to set up bathing supplies and assist as needed. "Remind to shave PRN." (As needed) Review of the Quarterly MDS assessment completed on 06/24/11 revealed the resident required extensive assistance with personal hygiene. Continued review of the clinical record revealed Resident #9 was admitted to an acute hospital on	F 312		8/31/11

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F 312	Continued From page 21 07/18/11 after a visit to the resident's oncologist. The facility forward the results of an X-ray report findings dated 07/08/11 that revealed a displaced fracture of the proximal left humerus that appeared to be a pathologic fracture. The report stated "this could represent a pathologic fracture from metastatic disease." The resident's primary physician was notified the day the X-ray results were obtained and he referred the resident to the oncologist for treatment. The primary physician ordered additional pain medication. The resident underwent surgery (intramedullary rodding with Polaris nails) to help the left humerus to move as a unit. The facility readmitted the resident to the nursing facility on 07/29/11 and is in the process of assessing for a significant change in status due to decreased mobility and increased assistance needed from staff. Review of the interim plan of care dated 07/29/11 revealed the staff was to shave, bathe, and groom the resident. Review of the nursing assistant flow sheet record revealed the resident was to receive bed baths on non-shower days. Observation of Resident #9 during the initial tour of the facility, on 08/02/11 at 9:25 AM, revealed the resident lying in bed, wearing a hospital gown with heavy growth of facial hair. A slight body odor was present. On 08/03/11 at 8:05 AM the resident was observed in bed wearing the same hospital gown. The resident was attempting to feed self with food debris noted on the hospital gown. The facial hair remained on the resident's face with yellowish scaly patches noted on the resident's scalp and ear. Interview with the resident, on 08/03/11 at 8:10 AM, revealed staff usually cleaned the peri area	F 312		8/31/11

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F 312	Continued From page 22 when providing care but did not give a full bed bath daily. The resident indicated showers were given 2 times a week. When asked if staff offered to shave, the resident stated, "No"." At 10:00 AM, observation of a wound treatment revealed the resident's gown had not been changed from breakfast and was now soiled with stool. The staff provided a clean hospital gown after incontinent care. On 08/04/11, at approximately 3:15 PM observation revealed the resident lying in bed visiting with family. The resident now had a very strong body odor and was wearing the same hospital gown from 08/03/11. Interview with the resident's mom at the time of the observation revealed the resident sometime had body odor upon some of her visits to the facility. On 08/04/11, additional review of the nursing assistant flow sheet revealed staff had documented the resident had received bed baths on 08/02/11 and 08/03/11; however, interview with the resident on 08/03/11 at 8:10 AM revealed full bed baths were not provided. The resident stated the staff would "wash" certain areas only. In addition, the resident's soiled gown was not changed during the above observations. Interview with the North Unit Manager, on 08/04/11 at 3:45 PM, revealed the resident had experienced a decline due to the left shoulder fracture and had increased care needs. She stated the resident required assistance with bathing, grooming, and now eating. She indicated the resident would refuse to be shaved or bathed at times; however, there was no documented evidenced the resident had refused those	F 312		8/31/11

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F 312	Continued From page 23 services. 5. Review of the facility policy regarding "Shaving the Resident" revealed the purpose was to remove facial hair and improve the resident's appearance and morale....All documentation should be driven by the resident's needs as identified in the care plan. Review of Resident #15's clinical record revealed diagnoses of Immobilization Syndrome, Chronic Wounds, and Osteomyelitis. Review of the Annual Significant Change Assessment dated 01/24/11 revealed the resident required total assist with bed mobility and transferring, and maximum assist with bathing and personal hygiene. Review of the resident's cognition revealed a score of eight (8) or moderate impairment. Observation of Resident #15, on 08/04/11 at 4:30 PM, revealed multiple chin hairs present, and remained throughout the survey. Interview with Resident #15, on 08/04/11 at 2:10 PM, revealed: "the chin hairs bother me, and make me think I'm in bed with a man!" The resident also stated it had been a long time since the facial hairs had been cut. Review of the Self-Care Deficit Care Plan relating to decreased mobility, dated 04/16/08, revealed the resident was to be shaved as needed. Review of the Nurse Aide Flow sheet record for June, July and August 2011, which listed "shave as needed" revealed no documentation.	F 312		8/19/11

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

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F 312	Continued From page 24 Interview with CNA #4, on 08/03/11 at 2:20 PM, revealed the past month had been difficult at times to complete bathing, and revealed it occurred mainly on weekends, due to staff leaving or calling in. Interview with the Unit Manager, on 08/04/11 at 11:55 AM, revealed the Certified Nursing Assistant's (CNA) should monitor the chin hairs and the task could have been taken care of even if the resident did not have a shower that day.	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to provide appropriate treatment and services to prevent Urinary Tract Infections and restore normal bladder function as possible for one (1) of the twenty-one (21) sampled residents. Resident #15's catheter was not replaced monthly as ordered by the physician; thus creating the potential for infection.	F 315	**F 315** **I. How corrective action will be accomplished for those affected.** Resident #15's foley catheter was changed on 7-30-11. The MD for resident was notified on 8-10-11 and clarified orders to change foley catheter as needed and the care plan was updated accordingly. **II. How corrective action will be accomplished for those residents having potential to be affected.** All residents currently in the center with orders for an indwelling foley catheter had their MD contacted on 8-18-11 by the Unit managers and orders clarified for changes	9/3/11

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F 315	Continued From page 25 The findings include: Review of the facility policy, dated 04/28/10, regarding "Indwelling Urinary Catheter Care" revealed the rationale would be the care of a catheter to prevent infection and/or reduce irritation ....20. Check and evaluate the catheter every 30 days or as needed for indicators that the indwelling catheter needs to be changed. Rationales that may indicate the need to change the catheter include, but are not limited to: c. Persistent leakage around the catheter; and f. Suspected UTI ... 25. Update the care plan as necessary. Review of Resident #15's clinical record revealed diagnoses of Chronic Wounds, Osteomyelitis, Immobilization Syndrome, Urinary Tract Infection and Diabetes Mellitus. The Annual Significant Change Assessment, dated 01/24/11, revealed Section HO100 was coded as having an indwelling catheter, with urinary incontinence coded as a 9, or Not Rated. Bowel incontinence under Section HO400 was also listed as a 9, or Not Rated. The resident's cognition score was 8 or moderate impairment. The Urinary Elimination plan of care related to indwelling catheter and potential for infection, dated 04/16/08, revealed: Change Foley Catheter PRN, with date initiated (04/22/09). Review of the physician's orders, dated 04/30/11, revealed the indwelling catheter was to be changed every month; however, review of the May 2011 Treatment Administration Record (TAR) revealed no evidence the catheter had been changed in May, nor had the order been transcribed onto the TAR. Review of the June	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* as needed as recommended by company policy instead of routine changes monthly. **III. What measures will be put in place/systemic changes made to ensure correction.** All licensed staff has been educated by the Director of Nursing Services or Staff Development RN beginning on 8-24-11 and continuing until 8-30-11 on the policies for foley catheters and documentation of foley catheter changes. The Unit mangers will review foley catheters every month and validate changes have occurred as ordered by the MD or as needed. This review will also include validating documentation of foley catheter changes are documented on the treatment records as needed.	8/31/11

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F 315	Continued From page 26 2011 TAR revealed the indwelling catheter change had been transcribed to the TAR for monthly changing; however, there was no evidence the catheter had been changed. Review of the July 2011 TAR revealed the catheter was not changed until 07/30/11. Review of the 06/11/11 urinalysis and culture report revealed a urinary tract infection with escherica coli, citrobacter, and pseudomonas cultured organisms. Review of the physician's orders revealed the resident was placed on antibiotics for the infection. Observation of Resident #15, on 08/04/11 at 7:55 AM, revealed the resident's indwelling catheter tubing had a large amount of thick, light brown sediment inside the tubing. A foul odor was present. Observation of a skin assessment with LPN#5, on 08/04/11 at 11:50 AM, revealed Resident #15's bed was urine soaked with the indwelling catheter in place. Interview with the North Unit Manager, on 08/4/11 at 11:55 AM, revealed the order to change the catheter was implemented in April; however, she could find no documentation on the TAR for May and June 2011. She thought the catheter had been changed in May; however, was not sure of the date. In addition, the Unit Manger did not know when the urinary drainage bag had last been changed. The catheter had been changed on 07/30/11, according to the TAR, and she could not give a reason why it would be leaking. However, she stated there would be a increased potential for infection if the indwelling catheter	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing will review the Unit manager audits of all foley catheters monthly and track and trend the results with the findings reported to the monthly Performance Improvement committee for follow up or further education as needed. The Performance Improvement committee may increase or decrease frequency of the audits based on findings.	8/31/11

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

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F 315	Continued From page 27 was not changed, "especially when there is incontinence of bowel." Interview with the Acting Director of Nursing, on 08/04/11 at 12:00 PM, revealed she was aware there had been problems with urine odors in the room; however, was unaware the indwelling catheter had not been changed.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policy, and review of the medical record, it was determined the facility failed to provide passive range of motion and restorative services for two (2) of twenty-one (21) sampled residents (#1 and #2). The facility assessed and determined on 05/06/11 that Resident #1 would benefit from passive range of motion. The facility failed to develop a treatment plan, failed to care plan for passive range of motion, and failed to provide passive range of motion for Resident #1. On 08/04/11 the facility assessed Resident #1 as having developed contractures to the right wrist and right hand. In addition, the resident developed a cut to the right palm of the hand	F 318	**F 318** **I. How corrective action will be accomplished for those affected.** Resident #1's MD was notified on 8-3-11. OT assessed the resident's right hand on 8-3-11. OT is working with the resident at this time and the care plan has been updated. Resident #2 was evaluated by OT on 8-23-11 and a restorative passive range of motion plan was recommended. The resident is on the restorative nursing program at this time and the care plan has been updated. **II. How corrective action will be accomplished for those residents having potential to be affected.** All residents currently residing in the center were	8/31/11

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F 318	Continued From page 28 where the resident's fingernails had caused injury due to new onset of contractures. The facility failed to provide restorative services as recommend by the therapy department for Resident #2. The findings include: Review of the facility's policy Specialized Rehabilitative Services, dated 10/31/09, revealed Restorative nursing is provided by the nursing staff. In addition, documentation supports the referral to therapy services. Documentation was to include: Therapy referred to, change or decline observed, signs and symptoms of the change or decline observed and related diagnosis, if known. Interview with the North Unit Manager, on 08/04/11 at 10:10 AM, revealed she oversee's the Restorative Program. Residents are referred to Restorative if they are not picked up by therapy or discharged from therapy. They don't usually look at the therapy assessments and recommendation, only the new orders written by therapy. Review of the medical record for Resident #1 revealed the facility admitted the resident on 05/05/11 with the following diagnoses: Cerebral Vascular Accident (CVA), Hypertension, End Stage Renal Disease (ESRD) (Dialysis Dependent), Seizure Disorder, Percutaneous Endoscopic Gastrostomy (PEG) for tube feeding, and Diabetes. Review of the Physical Therapy Evaluation for	F 318	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* assessed by the Rehabilitation Department staff for any increases in muscle tone, decrease in range of motion, and possible contractures. Anyone found to have any increases in muscle tone, decrease in range of motion, and/or possible contractures was picked up by the therapists and MD/family notification occurred. This assessment was completed by 8-19-11. **III. What measures will be put in place/systemic changes made to ensure correction.** All nursing staff has been educated by the Director of Nursing Services or Staff Development RN beginning on 8-23-11 for identification of decrease range of motion, increase in muscle tone, or contractures and the use of a change in condition form. Competencies for SRNAs on	8/31/11

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

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F 318	Continued From page 29 Resident #1 completed on 05/06/11 revealed no voluntary movement observed except for right knee flexion. The clinical summary section of the evaluation stated the patient had the diagnoses of CVA and muscle weakness. The patient presents with minimal active movement of right knee only. Patient could benefit from positioning in Geri chair and passive range of motion. Review of the Occupational Therapy (OT) Evaluation for Resident #1 completed on 05/06/11 revealed the therapist assessed the resident's passive range of motion within normal limits, no contractures present, patient non responsive and does not respond to stimuli. The OT evaluation clinical summary stated evaluation only, no treatment recommended, patient would benefit from being put up in a Geri chair and Passive Range of Motion. Review of the condition change form, dated 05/06/11 and completed after the OT evaluation, revealed the therapist documented, OT evaluation complete, no further treatment recommendation at this time. Review of the medical record for Resident #1 revealed no new orders, treatment, or care plan updates regarding range of motion following the assessment completed by OT on 05/06/11. Interview with OT #1, on 08/04/11 at 11:00 AM, revealed she had completed the assessment for Resident #1 on 05/06/11. They could not pick the resident up for therapy because the resident was non responsive and there was no opportunity for improvement. OT #1 went on to say they had to have two (2) different areas for Restorative to	F 318	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* range of motion were initiated on this date as well. The education and competencies continued through 8-30-11 until all SRNAs received a competency and all nursing staff were educated. The restorative nurse RN, Unit managers, Director of Nursing, restorative SRNAs, Staff Development Coordinator RN, and facility rehab manager were educated on the policies and procedures of discontinuation from therapy and referrals to restorative nursing by the Multi-site Rehab Clinical Mentor on 8-22-11. A change of condition form has been generated for the nursing assistants use to help with change of condition of the residents. These forms will be placed at each nursing station for nursing	9/31/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185118	A. BUILDING _____ B. WING _____	08/04/2011

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F 318	Continued From page 30 pick them up and that's why she did not refer this resident to Restorative. She told nursing verbally Resident #1 did not meet the requirements for Therapy or Restorative and nursing said they would do passive range of motion during the residents bath. OT #1 could not recall who she told in nursing about her findings. She thought the resident had a potential to develop contractures when she completed her assessment on 05/06/11, because of the resident's condition. Interview with the North Unit Manager, on 08/04/11 at 2:10 PM, revealed she stated it was not true the residents must have a need in two or more area's to be on restorative. The restorative programs had residents with only one area and are receiving restorative. Nursing can recommend restorative, but they didn't put Resident #1 on, because the resident didn't have contractures. If the resident's are not on therapy or restorative they should be getting range of motion by the CNA's. Resident #1 was not care planned for any type of range of motion and it was not on the CNA's assignment sheet. The North Unit Manager acknowledged Resident #1 should have had some type of range of motion to prevent contractures. She stated she had recommended Resident #1 be evaluated many times in the morning stand up meeting, but Therapy did not agree. Review of the medical record for Resident #1 revealed no documentation of any communication regarding therapy evaluations or referrals from nursing. Review of the admission Minimum Data Set (MDS) assessment, dated 05/25/11 revealed the	F 318	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* staff use. If the nursing assistant identifies a change in condition he/she is to fill out this form and give to the nurse to follow up on. Once the nurse assesses the resident he/she is to notify the MD and family of the change and complete a rehab referral as warranted. This form will then be forwarded to the Unit manager who will review at the daily stand up meeting (Monday-Friday) and validate timely rehab or restorative intervention. The rehab department will conduct a quarterly screen, in conjunction with the MDS/RAI schedule, on every resident to assess for change of condition by using the MDS assessment calendars, generated by the MDS department. This quarterly review will start 10-1-11 as every resident has been reviewed in August 2011.	8/31/11

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F 318	Continued From page 31 facility assessed Resident #1 as non interviewable and required total dependence with assist of 2 for bed mobility, transfers, and dressing. Review of the Comprehensive Care Plan for Resident #1, initiated on 05/25/11, revealed the resident had impaired communication related to CVA, and impaired mobility. The care plan detailed staff was to reposition every two hours, provide total assistance for all grooming/hygiene care, and staff was to anticipate all needs. There was no documented interventions for any type of range of motion for Resident #1. Review of the Certified Nursing Assistant assignment sheet for Resident #1 revealed no documented evidence that staff was to provide range of motion for this resident. Observation of Resident #1, on 08/02/11 at 11:45 AM, revealed the resident resting in bed, sleeping, with eyes closed. The resident was non verbal but would open eyes. No staff was observed providing range of motion for this resident. Observation, on 08/02/11 at 1:05 PM, of the skin assessment for Resident #1, completed by Licensed Practical Nurse (LPN) #5, revealed the right hand was gripped tightly and had a fowl odor. LPN #5 opened the right hand and found the palm was red with a 0.9cm by 0.2cm open cut. The resident's fingernails were long. Interview with LPN #5, at the time of the skin assessment, revealed Resident #1 was to have gloves to both hands at all times to prevent injury,	F 318	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing will review the condition change forms and referrals to restorative nursing and track and trend the results with the findings reported to the monthly Performance Improvement committee. The rehab department manager will report on progress of quarterly screens to the monthly Performance Improvement committee.	8/30/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 318	Continued From page 32 but she didn't know where they were. Review of the Comprehensive Care Plan revealed Resident #1 had an intervention dated 06/23/11 to wear gloves at all times to prevent injury, remove only for bathing. Review of the OT Evaluation completed on 08/04/11 revealed the facility has assessed Resident #1 as having right wrist and hand contracture. Interview with OT #1 on 08/04/11 at 11:00 AM revealed she felt Resident #1 did not get passive range of motion because the resident now has contractures of the right wrist and hand. Interview with CNA #6, on 08/02/11 at 2:30 PM, revealed she had worked at the facility for one week. She had an assignment sheet she gets that tells her what the care needs are for each resident. She stated it would tell them who gets splints and who gets turned every two (2) hours. Interview with CNA #7, on 08/02/11 at 2:45 PM, revealed he had cared for Resident #1 frequently and was familiar with the needs of Resident #1. He receives the information on how to care for the residents from the CNA assignment sheets. Resident #1 is scheduled for showers on Mondays and Thursdays and receives bed baths on other days. He had no knowledge that Resident #1 was to wear gloves for protection, or to prevent injury. He stated he did not trim the nails for Resident #1. When asked about Range of Motion for Resident #1, CNA #7 stated if the resident received Range of Motion it was done by Restorative.	F 318		9/31/11

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

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F 318	Continued From page 33 Interview with CNA #12, on 08/04/11 at 9:50 AM, revealed she reviews the CNA assignment sheet and that tells her what is required for eating, turning the resident, how the resident is to be transferred, and any splints that are applied. Interview with CNA #3, on 08/04/11 at 9:55 AM, revealed she reviews the CNA assignment sheet and that's how she knows what the care needs are for residents. Review of the CNA assignment sheets revealed no instruction to perform Passive Range of Motion for Resident #1. 2. Clinical record review revealed the facility admitted Resident #2 on 11/21/08 with the following diagnoses: Alzheimer's; Diabetes; Dementia; Chronic Obstructive Pulmonary Disease; Hypertension; and a Pacemaker. The Resident began Hosparus care on 05/11/11. Review of the annual MDS assessment completed on 08/31/10 revealed the resident had limited range of motion with partial loss of voluntary movement to the neck. A Physical Therapy (PT) discharge summary, dated 12/30/10, stated the resident's right cervical had neck flexion which measured negative 22 degrees from the neutral position after heat and stretching. A restorative program had been initiated for passive range of motion (PROM) and stretching to the right cervical area. Continued review of the PT notes revealed the resident was only able to tolerate 5 minutes with a towel roll	F 318		9/30/11

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F 318	Continued From page 34 and was resistant to therapy. The documented reason for discharge was the resident had met the maximal potential of therapy. Physician orders for Resident #2, dated 12/30/10, revealed orders to discontinue skilled physical therapy and begin restorative therapy for PROM and positioning. Review of a condition change form (within the nurses notes) dated 12/30/10 revealed the resident was to begin restorative therapy for PROM and positioning. Review of the most current MDS assessment completed on 05/20/11 revealed the resident had a range of motion impairment to bilateral upper and lower extremities and required one to two person assist with activities of daily living. Review of the resident's comprehensive care plan, dated 06/03/11, revealed a problem of impaired physical mobility related to Alzheimer's, falls, physical restraints, decreased vision, and a pelvic belt when up in the chair. The facility set a goal for impaired physical mobility with the intent the resident would not develop further complications of immobility such as pressure sores, contractures and pneumonitis. Interventions included; turn and reposition; monitor for evidence of complications: contractures, venous stasis, blood clot, pneumonia, urinary tract infection and report. Additional interventions included: bed mobility with 1-2 assist; transfer with gait belt and 1-2 assist; tab alarm; Broda pedal chair for mobility with pelvic belt; Broda chair with bilateral shin guards, torso support, arm protectors when up in Broda chair; cervical collar while up and in bed; and bolster pillows to bed. The resident's comprehensive plan of care did not reflect PROM or restorative therapy. Review of current physician orders for July 2011	F 318		8/31/11

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F 318	Continued From page 35 revealed the order for restorative nursing program to provide PROM and positioning was still current. Review of the current certified nursing assistant (CNA) flowsheet revealed no evidence the staff was to provide PROM. The restorative nursing book revealed there was no restorative plan developed and no written evidence that restorative nursing had been provided. Observations of Resident #2, on 08/02/11 at 3:15 PM, 08/03/11 at 10:00 AM and 11:00 AM, revealed the resident up in a Broda chair without the cervical collar applied. Observation during a skin assessment performed by licensed practical nurse (LPN) #1, on 08/03/11 at 5:30 PM, revealed the resident lying in bed with the neck flexed toward the right side and a cervical pillow around the neck. Interview with LPN #1 revealed the resident had a right sided flexion contracture. Interview, on 08/04/11 at 8:30 AM, with the North Unit Manager revealed she was responsible for the restorative program. She was not aware of Resident #2's need to receive restorative services. Interview with CNA #1, on 08/04/11 at 2:25 PM, revealed she was assigned to the resident on 08/02/11. When asked about the cervical collar not being in place, she stated the cervical collar had been sent out to be washed and there was not another cervical collar available. She was able to say when the cervical collar should be applied, however, she could not say what potential negative outcome or problems could	F 318		8/31/11

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Northern Enforcement Branch

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F 318	Continued From page 36 occur with the resident by not wearing the cervical collar as ordered. Interview, on 08/04/11 at 3:30 PM, with the South Unit Manager revealed failure to perform PROM as ordered could potentially cause contracture of the joints or worsen current contractures. Interview, on 08/04/11 at 3:40 PM, with the North Unit Manager revealed she was not in charge of the restorative program at the time the order was received. When she resumed responsibility for the program, she did not receive a plan of care for the resident. After reviewing the restorative order, dated 12/30/10, the North Unit Manager stated it did not appear the order was transcribed and communicated to the nursing restorative department. Interview, on 08/04/11 at 3:45 PM, with the Therapy Manager revealed recommendations are given to the nursing department upon discharge from skilled therapy. To ensure communication, the restorative department signs the recommendations and a copy is filed with the therapy department. However, the therapy department does not keep the signed copy after three months if the resident is no longer active with the physical therapy department. Interview with the Director of Nursing (DON), on 08/04/11 at 4:00 PM revealed she was normally notified when a resident was discharged from skilled therapy and recommended to the restorative program. The DON stated she was not aware Resident #2 was to be on the restorative program. Further interview with the DON at 5:00 PM revealed she was unable to	F 318		8/31/11

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Northern Enforcement Branch

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 318	Continued From page 37 locate any evidence that restorative therapy had ever been initiated. Refer to F282 and F309	F 318	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and review of facility staffing schedule, the facility failed to provide sufficient staff to meet the residents' needs including bathing, and grooming for five (5) of twenty-one (21) sampled residents. Residents #1, #7, #9,	F 353	**F 353** **I. How corrective action will be accomplished for those affected.** Resident #1 received nail care on 8-2-11, a bedbath on 8-4-11, and a shower on 8-8-11. The resident has received regular showers and nail care since then. Resident #7 received a shower on 8-3-11 and has continued to receive routine showers since then. Resident #9 received a shower on 8-4-11 and has continued to receive routine showers since then. Resident #16 received a shower on 8-2-11 and has continued to receive routine showers since then. Resident #15 received facial grooming on 8-5-11 and has continued to receive regular	8/31/11

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F 353	Continued From page 38 and #16 did not recieve showers as scheduled and Resident #15 did not recieve grooming as needed. (Refer to F312) The findings include: Review of the census revealed the facility had one hundred twelve (112) beds and on 08/02/11 the facility census was one hundred eight (108). Interview with the Ombudsman, on 08/02/11 at 3:00 PM, revealed she had received a complaint this morning that second shift only had two (2) aides for each unit. Interview during the Group resident council meeting, on 08/02/11 at 3:00 PM, revealed several unsampled residents stated there was not enough staff to care for the residents. The residents stated food trays were late, showers were not given as scheduled, and call lights were not answered promptly. The residents stated staffing was short on evenings and weekends. The Ombudsman was present during the meeting and stated she had received several concerns regarding staffing. Interview with Certified Nursing Assistant #4, on 08/03/11 at 2:20 PM, revealed the facility had been short staffed on the weekends and in the past month, it had gotten worse. Interview with Certified Nursing Assistant (CNA) #3, on 08/04/11 at 10:00 AM, revealed that only about fifty (50) percent of the time they have adequate staffing. Interview with CNA #10, on 08/04/11 at 2:45 AM,	F 353	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* grooming since then. **II. How corrective action will be accomplished for those residents having potential to be affected.** The Director of Nursing, or her designee, will identify through direct observation those residents affected by insufficient staffing. Adequate staff will be provided to meet the needs of the resident identified through this process. **III. What measures will be put in place/systemic changes made to ensure correction.** The facility has been aggressively recruiting for CNAs since before 8/4/11, and hired a new staffing scheduler. The corporate recruiting department has put a priority on staffing for this center, 3 CNA's will be in	8/26/11

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Northern Enforcement Branch

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F 353	Continued From page 39 revealed the last three (3) months they had been "staffing challenged" and that only four (4) out of seven (7) days did the facility have adequate staffing. Interview with CNA #11, on 08/04/11 at 4:30 PM, revealed that sometimes they only had three (3) CNA's and they could only give bed baths on those days. She added that in the last couple of months the facility had trouble with staffing. Interview with the North Unit Manager, on 08/04/11 at 5:15 PM, revealed the showers were not getting done because of "staffing challenges". Interview with the Staffing Coordinator, on 08/04/11 at 5:25 PM, revealed the facility did not have adequate staffing since she had been in this position, and that just made it really hard for staff that had to work extra. Interview with the Administrator, on 08/04/11 at 2:45 PM, revealed he acknowledged the facility was having staffing issues from turn-over of staff to new employees quitting. He stated the facility tried to replace call ins and give a two (2) dollar bonus to work second shift. He stated they hired a new staffing coordinator and they needed a Director of Nursing who would be starting on September 12th.	F 353	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* orientation on 8/22/11. Other Kindred centers in close proximity to this center will be notified of open positions until full time staffing can be hired for this center. An on call system has been implemented and a licensed nurse is on call 24 hours a day and is responsible to assist with staffing concerns. A weekend supervisor RN is in place and is responsible on the weekends to validate adequate staff to meet resident needs. The Social Services Director or Social Services Assistant will conduct at least 5 interviews of residents monthly to validate adequate staffing to meet residents' needs and determine any concerns with assistance with ADLs.	8/31/11
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

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

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F 431	Continued From page 40 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy titled Storage of Medications it was determined the facility failed to ensure proper storage of medications on one (1) of four (4) medication carts, and monitor the drugs used in the facility for expiration dates on one (1) of two (2) treatment carts. Medications	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing or designee will monitor staffing and scheduling of nursing personnel on a daily basis to assure that staffing levels are sufficient to meet the residents' needs. The Administrator is responsible for overall compliance. The Administrator will review staff assignments on a daily basis to insure adequate staffing is available. The staffing levels will be reported to the Performance Improvement committee for three months. Results of the resident interviews will also be reported to the monthly Performance Improvement committee for tracking and trending and follow up actions will occur as needed. **F 431** **I. How corrective action will be accomplished for those affected.** LPN observed in medication pass received on the spot	8/31/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185118	A. BUILDING _____ B. WING _____	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 40 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy titled Storage of Medications it was determined the facility failed to ensure proper storage of medications on one (1) of four (4) medication carts, and monitor the drugs used in the facility for expiration dates on one (1) of two (2) treatment carts. Medications	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** **V.** The Director of Nursing or Ashley Lang, RN unit manager and or Executive Director will meet each afternoon with the staffing coordinator to review the schedule. Each morning the staff coordinator will attend the Stand Up meeting and identify any call offs, so action can be taken to replace staff. **I How corrective action will Be accomplished for those affected.** LPN observed in mediations pass received on the spot	

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F 431	Continued From page 41 were found stored crushed in a medication cup labeled only with the last name of a resident, a transdermal patch was lying loose in a drawer, and loose unlabeled pills were stored in the medication cart. The findings include: Review of the facility's policy titled Storage of Medication, dated 02/23/11, revealed medications should be kept in containers dispensed by the provider pharmacy. For medications removed from storage or dispensed by the pharmacy, but not yet administered to a patient, are returned to the pharmacy for credit or dispose of the medication according to procedure. Remove and dispose of according to procedures for medication disposal that are outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures from stock. Observation of the South Hall treatment cart, on 08/03/11 at 11:20 AM, revealed Proctozone 2.5% cream which had expired on 06/2011. Interview with the South Unit Manager, on 08/03/11 at 11:30 AM, revealed expired medication would be less effective. She further stated night shift should be checking the medications for expiration dates using the checklist available for night shift audits. She was responsible to ensure all medications were being checked to ensure they had not expired. Review of the night shift audit form revealed the form did not include the medication room or the treatment cart as part of the system to ensure	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* education by the Unit manager related to proper medication disposal for resident refusal of meds. The medications found in the medication cart were removed by the Licensed nurse on 8-3-11. The expired cream was disposed of on 8-3-11. **II. How corrective action will be accomplished for those residents having potential to be affected.** All medication carts and treatment carts were inspected by Licensed nurses and any concerns with storage of medications or expired medications were immediately addressed. **III. What measures will be put in place/systemic changes made to ensure correction.**	8/31/11

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F 431	Continued From page 42 medications were not expired. Observation of the South Front Hall medication cart, on 08/03/11 at 11:40 AM, revealed crushed medication in-between two (2) medication cups labeled only with a last name in the top drawer. An Excelon transdermal patch was found lying next to the cup, the patch was not in the protective wrapper and had only a last name written on the patch. The second drawer contained six (6) loose, unlabeled medications lying on the bottom of the drawer. Interview, on 08/03/11 at 11:50 AM, with Licensed Practical Nurse (LPN) #2 revealed she was aware she was not supposed to set up medications prior to administration. A resident had refused the medication and she was going to try and give the medication at a later time. She further revealed the medication should have been discarded. LPN #2 stated every nurse is responsible for checking the carts to ensure there are no loose pills and all medications are stored properly Interview, on 08/03/11 at 11:55 AM, with the South Unit Manager revealed she was responsible to ensure all nurses were checking the carts and that all medication were being stored safely and properly according to the facility's policy and nursing practice. Interview, on 08/04/11 at 3:30 PM, with the Interim Director of Nursing (DON) revealed all nurses were observed during medication pass annually by staff development. If there were any concerns during the medication pass, a one on one education was provided to that nurse. She	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Staff Development Coordinator RN will train all licensed nursing staff on the policies and procedures for storage of medications and cleaning medication carts every shift. This training was initiated on 8-24-11 and continued until all licensed nurses received the training on 8-30-11. New hires nurses will receive the training in general orientation. The Director of Nursing Services or Unit manager will inspect all medication carts and treatment carts weekly to validate proper storage of medications. Any concerns will be corrected at that time. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing will	8/31/11

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F 431	Continued From page 43 further revealed the nurses were expected to discard medications that were not given at the time they were ordered, or refused by the residents. The DON stated medications sometimes fell out of the bubble packs provided by the pharmacy due to over crowding in the medication carts. Loose pills in the drawers was not the proper storage of medications and the medication carts should be monitored by the unit managers. The DON stated the nurses perform audits on the medication carts during day shift; however, she was not aware if there was an auditing tool that included storage of medications and expiration dates of medications. She was ultimately responsible to ensure the proper storage of medication and monitoring for expiration dates of medications.	F 431	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* track and trend the findings from the medication and treatment cart audits and report findings to the monthly Performance Improvement committee. The Performance Improvement committee may decrease the frequency of the medication cart audits after determining sustained compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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	F 441	**F 441** **I. How corrective action will be accomplished for those affected.** LPN #1 received on the spot education by the Unit Manager on aseptic dressing change and handwashing technique on 8-3-11. LPN #2 received on the spot education by the Unit Manager on proper hand hygiene with body audits on 8-3-11.	

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F 441	Continued From page 44 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 and policy review it was determined the facility failed to follow the Infection Control policy and procedures on hand hygiene and dressing changes on three (3) of twenty-one (21) sampled residents (Residents #6, #9 and #13). The findings include: Review of the Clean Dressing Change policy PRO 66103 revealed when a nurse is performing a clean dressing they are to perform hand hygiene, put on a pair of gloves, remove old dressing and dispose in a plastic bag, remove gloves and dispose in the plastic bag, perform hand hygiene and put on a second pair of gloves.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **II. How corrective action will be accomplished for those residents having potential to be affected.** All nursing staff will be trained and demonstrate competency with a check off completed by the Staff Development Coordinator RN, Director of Nursing, Unit manager, Weekend supervisor RN, or another administrative RN on the procedure for proper handwashing and the technique. This training was initiated on 8-24-11 and continued until 8-30-11 when all nursing staff had received the education. All licensed staff will demonstrate competency with a check off completed by the Staff Development Coordinator RN, Director of Nursing, Unit manager, Weekend supervisor RN, or	9/30/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 45 Review of the Hand Hygiene/Handwashing policy PRO 68009 revealed hand hygiene is to be performed before donning gloves, after removal of medical/surgical gloves or utility gloves, intermittently after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. Interview with South Unit Manager (SUM), on 08/04/11 at 4:15 PM, revealed the purpose of good hand hygiene was to cleanse the hands of germs and prevent the spread of infection. 1. Observation, on 08/03/11 at 8:50 AM, revealed LPN #2 did not follow hand hygiene per facility policy. During a skin assessment for Resident #13, LPN #2 washed her hands prior to the beginning of the procedure, put on gloves and began a head to toe skin assessment. During the skin assessment LPN #2 discovered Resident #13's brief was wet. LPN #2 removed the wet brief, removed her gloves, and without performing hand hygiene, LPN #2 donned clean gloves. She then cleansed the perineal area using aseptic technique, removed gloves and again donned clean gloves without performing hand hygiene. 2. Observation, on 08/03/11 at 9:10 PM, revealed LPN #2 went into Room 4 to perform a skin assessment and a dressing change for Resident #6. LPN #2 entered the room, washed her hands, put on gloves and started the assessment. During the skin assessment, LPN #2 discovered Resident #6 had soiled his/her brief. LPN #2 removed the soiled brief, used skin wipes to clean the resident, placed the soiled	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* another administrative RN on aseptic technique with clean dressing change and the policy and procedure on clean dressing change. This training was initiated on 8-24-11 and continued until 8-30-11 when all licensed nursing staff had received the education. **III. What measures will be put in place/systemic changes made to ensure correction.** The Staff Development Coordinator RN or Director of Nursing will validate competency by observing 2 clean dressing changes and 2 body audits a week with different licensed staff. Any concerns will be addressed immediately with further staff education. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.**	8/31/11

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F 441	Continued From page 46 brief into the trash, removed her gloves and donned clean gloves without performing hand hygiene. LPN #2 then applied cream to Resident #6's buttocks and removed the dressing to the coccyx area. Interview, on 08/04/11 at 3:45 PM, with LPN #4 revealed the purpose of hand washing was to prevent cross contamination. If you don't use good hand hygiene it could create issues and infections for nurses, the residents they are working on as well as the next resident they may have contact. 3. Observation of a dressing change, on 08/03/11 at 10:00 AM, for Resident #9 revealed LPN#1 did not wash her hands after removing soiled gloves and donning clean gloves during the treatment to the resident's feet and left shoulder. When the nurse went to complete a skin assessment of the resident's coccyx, the resident was found to be incontinent of bowel. The nurse cleaned the stool from the resident's buttocks and coccyx with gloved hands, then applied barrier cream with the same soiled gloves to the resident's skin. The nurse removed the soiled gloves and applied clean gloves without washing her hands to complete the dressing change. Interview with LPN #1, on 08/03/11 at 10:30 AM, revealed she had forgotten to wash her hands between each glove change, because she had to change her gloves so many times during this treatment and the resident being incontinent of bowel.	F 441	***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** The Director of Nursing will track and trend the findings from the clean dressing change and body audit observations and report findings to the monthly Performance Improvement committee. The Performance Improvement committee may decrease the frequency of the clean dressing change audits after determining sustained compliance. **F 502** **I. How corrective action will be accomplished for those affected.** The lab vials found expired 7-31-11 were removed and discarded on 8-3-11.	8/31/11
F 502	483.75(j)(1) ADMINISTRATION	F 502		

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F 502 SS=E	Continued From page 47 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the laboratory supplies were not expired in two (2) of the two (2) medication rooms. Observation of the medication rooms revealed a total of forty-nine (49) expired laboratory vials and one (1) expired blood culture set. The findings include: 1. Observation of the South Hall medication room, on 08/03/11 at 11:00 AM, revealed two (2) blue top laboratory tubes which had expired 07/2011. Interview, on 08/04/11 at 11:30 AM, with the South Hall Unit Manager revealed expired laboratory vials could cause inaccurate results which could lead to other potential side effects. The South Hall Unit Manager stated night shift was responsible to monitor the medication rooms and check supplies for expiration dates on supplies. She provided a checklist which was utilized by the night shift for monitoring the medication carts and medication room. She stated she was responsible to ensure nurses had checked the medication rooms for expired laboratory supplies.	F 502	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **II. How corrective action will be accomplished for those residents having potential to be affected.** All lab vials were audited on 8-3-11 to verify no others found to have expired. **III. What measures will be put in place/systemic changes made to ensure correction.** All licensed nursing staff has been educated by the Director of Nursing Services or Staff Development RN beginning on 8-24-11 on the system for checking lab vial dates on a weekly basis and removing any that will expire in the next week. The training continued until all licensed nurses had received the training on 8-30-11. New hire licensed staff will receive the training with general orientation.	8/31/11

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F 502	Continued From page 48 Review of the checklist provided by the South Hall Unit Manager revealed monitoring for expiration dates and the medication room was not included on the monitoring tool. Interview, on 08/04/11 at 3:30 PM, with the Director of Nursing (DON) revealed she had been DON at the facility for one week. She stated all nurses should check the medication rooms for expired items. The Unit Managers should be checking as well to make sure all supplies are within date. The DON stated expired laboratory supplies could cause incorrect lab values. She stated she was not aware if there was even a monitoring tool which was utilized by the nursing staff. 2. Observation on 08/03/11 at 2:00 PM of the North Medication room revealed forty-nine (49) tiger top lab tubes with an expiration date of 03/2011. One (1) blood culture bottle had an expiration date of 03/2011. Interview with the North Unit Manager on 08/03/11 at 2:05 PM, revealed she just came to the facility in April of this year. She stated a new check list and an assignment sheet for staff was just started to do quality checks to ensure expired supplies were removed.	F 502	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The Unit mangers will review the lab vials weekly and validate none expired. Any that will expire in the next week will be removed from the medication rooms at that time. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Director of Nursing will review the Unit manager weekly audits of all lab vials monthly and track and trend the results with the findings reported to the monthly Performance Improvement committee for follow up or further education as needed. The Performance Improvement committee may increase or decrease frequency of the audits based on findings.	
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	F 514		

8/31/11

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F 514	Continued From page 49 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 record review, policy review and interview it was determined the facility failed to maintain complete and accurate records on two (2) of twenty-one (21) residents. The facility failed to document in the clinical record pertinent information regarding Resident #6's fall. In addition, the facility failed to transcribe physician orders to the Treatment Administration Record (TAR) in regards to changing Resident #15's indwelling catheter every month. The findings include: 1. Review of the facility's policy Resident Event Response PRO 52001 revealed documentation guidelines include: 1. Document emergency care and first aid administered and the resident's status in the medical record. 2. Record events leading up to the occurrence in the resident's medical record. 3. Record interventions used during the event and their effectiveness in the resident's medical record. 4. Update resident's care plan. 5. Record notification of MD and family member/responsible party.	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F 514** **I. How corrective action will be accomplished for those affected.** Resident #6 post fall evaluation was recreated by the interdisciplinary team on 8-25-11 and marked as a replacement for lost information as directed by company policy. Resident #15's foley catheter was changed on 7-30-11 and this was documented on the treatment administration record. The MD for resident #15 was contacted on 8-10-11 and orders for foley catheter changes was clarified. **II. How corrective action will be accomplished for those residents having potential to be affected.** All residents with foley catheters were reviewed by the Unit managers and Director of Nursing Services to validate foley catheter changes documented as ordered on 8-18-11.	8/31/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185118	A. BUILDING _____ B. WING _____	08/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 50 Record review for Resident #6 revealed a Resident Fall Event Report Worksheet, dated 02/27/11, indicated Resident #6 had sustained a fall and was transported to a local hospital for the treatment of a fractured tibia and fibula. The facility was unable to produce any documentation in the nurses's notes regarding the fall or subsequent transfer to a local hospital. There was no documentation in the nurse's notes until 03/01/11, two days after the fall. Interview with the Acting Director of Nursing on 08/04/11 at 4:30 PM revealed per policy nurses should document falls and follow-up in the nurse's notes. She stated Resident #6's medical record had been thinned and sent to Medical Record Department for filing. The nurse's notes for the end of February 2011 were unable to be located. 2. Review of the facility policy/procedure regarding Indwelling Urinary Catheter Care under Documentation Guidelines revealed: 1).Document on designated form, resident's output, if indicated; 2). Complications noted, as well as b. physician orders, and nursing interventions. 3). Date, time, and rationale of changing a catheter; 4). Update care plan as needed. Review of Resident #15's clinical record revealed the facility admitted the resident with diagnoses of Chronic Wounds, and utilized an indwelling catheter. A physician's order, dated 04/30/11, indicated the indwelling catheter was to be changed every month and as needed; however, review of the May 2011 Treatment Administration	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* All residents with falls in the past 30 days were reviewed by a licensed nurse on 8-18-11 to validate documentation of the event noted in the chart. **III. What measures will be put in place/systemic changes made to ensure correction.** All licensed nurses will be trained on the policies and procedures for documentation in the medical record by the Director of Nursing Services or Staff Development Coordinator RN. This training was initiated on 8-24-11 and continued until all licensed nurses received the training on 8-30-11. The Medical Records LPN will audit at least 5 medical records including progress notes and treatment administration records every week and validate documentation reflective of any fall or treatment provided. Any concerns will be addressed with staff members	8/31/11

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F 514	Continued From page 51 Record (TAR) revealed no evidence the order had been transcribed. Review of the June 2011 TAR revealed the order had been transcribed to the (TAR); however, there was no evidence the catheter change had been documented. Interview with the North Unit Manager, on 08/4/11 at 11:55 AM, revealed she could find no documentation on the TAR for May and June 2011 and stated she thought the catheter had been changed in May; however, was unsure of the date. There would be potential for infection with not changing the indwelling catheter, especially when there is incontinence of bowel. Interview with the Acting Director of Nursing, on 08/04/11 at 12:00 PM, revealed she was not aware there had been problems with the TAR documentation; however, stated it should be documented as indicated.	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* immediately according to policy and procedure. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Medical Records LPN will audit at least 5 medical records including progress notes and treatment administration records every week and validate documentation reflective of any fall or treatment provided. Any concerns will be addressed with staff members immediately according to policy and procedure The Medical Records LPN will review the findings from the medical records audits monthly and track and trend the results with the findings reported to the monthly Performance Improvement committee for follow up or further education as needed. The Performance Improvement committee may increase or decrease frequency of the audits based on findings.	8/31/11

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1964 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF TYPE OF STRUCTURE: One (1) story, Type III Unprotected SMOKE COMPARTMENTS: Five (5) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system. GENERATOR: Type II (installed in 2009) A standard Life Safety Code survey was conducted on 08/03/2011. Woodland Terrace 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 and eighteen (118) beds and the census was one-hundred and eight (108) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 8/26/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at E level. CFR: 42 CFR 483.70(a)	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately thirty-six (36) residents, staff and	K 018	*This plan of correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **K 018** **I. How corrective action will be accomplished for those affected.** Resident room doors # 21 and #23 were repaired on 8/3/11 **II. How corrective action will be accomplished for those residents having potential to be affected.** The Maintenance Director and Assistant will monitor all resident room doors on weekly rounds and make adjustments as needed.	

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K 018	Continued From page 2 visitors. The facility is licensed for one-hundred and eighteen (118) beds with a census of one-hundred and eight (108) on the day of the survey. The findings include: Observation, on 08/03/11 at 11:35 AM, with the Maintenance Supervisor, revealed the corridor door to resident rooms 21 and 23 would not latch when tested. Interview, on 08/03/11 at 11:35 AM, with the Maintenance Supervisor confirmed the observations, and acknowledged the requirement that corridor doors are to latch when closed and resist the passage of smoke. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and	K 018	**III. What measures will be put in place/systemic changes made to ensure correction.** The Maintenance Director or his assistant will bring the Maintenance log book to Morning meeting and report findings from the day before. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Director and Executive Director will meet weekly to review the Maintenance log book. The results will be presented to the PI committee meeting monthly for three months.	8/31

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K 018	Continued From page 3 similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3. Doors should not be blocked open by furniture,	K 018		

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K 018	Continued From page 4 door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical panels were maintained according to NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately twenty-five (25)residents, staff and visitors. The facility is licensed for one-hundred and eighteen (118) beds and the census was one-hundred and eight (108) on the day of the survey. The findings include: Observations, on 08/03/11 at 11:25 AM, with the Maintenance Supervisor revealed the electrical panels located in the resident's North hall were unlocked. Interview, on 08/03/11 at 11:25 AM, with the Maintenance Supervisor revealed he was unaware that the electrical panels located in resident corridors were required to be locked to	K 147	*This plan of correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **I. How corrective action will be accomplished for those affected.** The electrical panels on the North hall were fitted with locks on 8/3/11. **II. How corrective action will be accomplished for those residents having potential to be affected.** 25 residents had the potential of being affected. The Maintenance Director placed	

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K 147	Continued From page 5 prohibit unauthorized access. Reference: NFPA 70 (1999 edition 110-26, Space About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	locks on the North hall electrical panel and the Maintenance Director or his assistant will monitor to ensure locks are secure during weekly rounds. **III. What measures will be put in place/systemic changes made to ensure correction.** The Maintenance Director or his assistant will monitor to ensure locks are secure during weekly rounds. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Director and Executive Director will tour the center and will report findings to the PI committee monthly for three months.	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211		9/31
	This STANDARD is not met as evidenced by:			

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K 211	Continued From page 6 Based on observation and Interview, the facility failed to ensure Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source, per NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately twenty-five (25) residents, staff and visitors. The facility is licensed for one-hundred and eighteen (118) beds and the census was one-hundred and eight (108) on the day of the survey . The findings include: Observation, on 08/03/11 at 11:00 AM, with the Maintenance Supervisor revealed Alcohol Based Hand Rub dispensers were installed over or adjacent to the light switch in the North and South shower rooms. Interview, on 08/03/11 at 11:00 AM, with the Maintenance Supervisor revealed he was unaware that Alcohol Based Hand Rub dispensers were installed over or adjacent to an electrical ignition source. Reference: NFPA 101 (2000 Edition) Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other	K 211	*This plan of correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **I. How corrective action will be accomplished for those affected.** The alcohol based hand rub dispensers were moved on 8/3/11 from above the electrical switch. **II. How corrective action will be accomplished for those residents having potential to be affected.** 25 residents had the potential of being affected. The Maintenance Director moved the alcohol based hand rub in the North and South hall shower rooms and the Maintenance Director or his	

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K 211	Continued From page 7 o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	assistant will monitor during weekly rounds proper placement of alchohol based hand rub dispensers. **III. What measures will be put in place/systemic changes made to ensure correction.** The Maintenance Director or his assistant will monitor to ensure locks are secure during weekly rounds. **IV. How the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Director and Executive Director will tour the center and will report findings to the PI committee monthly for three months.	8/31