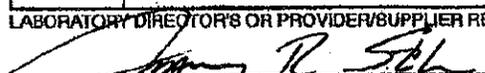


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/30/2011
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3578 PIMLICO PARKWAY LEXINGTON, KY 40517	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	F 312	
F 312 SS=D	<p>An Abbreviated Survey investigating #KY00016958 was initiated on 08/27/11 and concluded on 08/30/11. #KY00016958 was substantiated with deficiencies cited at 42 CFR 483.25 Quality of Care (F 312) with the scope and severity of a "D".</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide services to maintain personal/oral hygiene for one (1) of four (4) residents. The facility failed to ensure Resident #2 received assistance with oral care as assessed and per the facility policy.</p> <p>The findings include:</p> <p>1. Record review of the facility's "Clinical Oral Hygiene" policy, undated, states oral hygiene will be provided to residents to ensure cleanliness of mouth and teeth. Interview with Assistant Director of Nursing (ADON)/Unit Manager, on 08/27/11 at 9:30 AM, revealed oral care should be provided everyday. Oral care would include brushing/cleaning the oral cavity at least once a day, usually in the morning and soaking the</p>	F 312	<p>NOTE: Statement provided by unsampled SRNA (State Registered Nurse Aide) attests to providing oral care for Resident #2 at 5:30 a.m. on 08/26/11. Further OIG Inspector was informed that this was an issue that had remained as a continuing Quality Assurance (QA) item even though previous alleged deficiency was cleared. This said QA program was not provided opportunity to prove its effectiveness. In support thereto, as presented in the 09/22/11 QA Committee meeting, results of the oral care audits were presented. Those results revealed that 92 residents were reviewed relative to this alleged deficiency including Resident #1 with 100% compliance!</p> <p>Immediate Corrective Action For Residents Found To Be Affected</p> <ul style="list-style-type: none"> Resident #2 was provided oral care on 08/27/11 by SRNA as witnessed by the Assistant Director of Nursing (ADON). <p>Identification of Other Residents With The Potential to be Affected</p> <ul style="list-style-type: none"> DON (Director of Nursing), ADON, MDSN (Minimum Data Set Nurse), Restorative Nurse or SDC (Staff Development Coordinator) performed a 100% review of MDS assessments to identify residents dependent for ADL care. Those residents identified were reviewed to assure ADL care was provided. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: Administrator DATE: 09/23/11

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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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 312	<p>Continued From page 1</p> <p>dentures which is usually done in the evening or at night.</p> <p>Record review revealed the facility admitted Resident #2 on 03/15/11 with diagnoses which included Hip Replacement, Cerebral Vascular Accident and Left-sided Paralysis. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/02/11, revealed the facility assessed the resident's cognitive status as fourteen (14) out of fifteen (15) which indicated no cognitive impairment. Further review of the MDS revealed the facility assessed the resident to require extensive assistance with personal hygiene and one (1) person physical assist including brushing the resident's teeth. The facility also assessed the resident to have range of motion impairment on one (1) side of both the upper and lower extremities.</p> <p>Interview with Resident #2, on 08/27/11 at 8:45 AM, revealed he/she did not receive oral care daily and would like to have teeth and dentures cleaned more frequently. Further interview revealed the staff needed prompting to provide assistance for oral care. Resident #2 stated that he/she had not been provided assistance with oral care on 08/26/11 and therefore his/her mouth was not brushed nor were his/her dentures soaked.</p> <p>Interview, on 08/27/11 at 3:40 PM, with State Registered Nurse Aide (SRNA) #7, who was assigned to Resident #2 revealed when she asked the resident if he/she wanted his/her dentures soaked the resident requested the SRNA come back after he/she finished eating a snack. SRNA #7 further stated since it was close</p>	F 312	<ul style="list-style-type: none"> ◆ 100% of Comprehensive Care Plans were compared with SRNA Care Plans to assure uniformity for ADL care. No issues were noted. ◆ Oral care was provided to 100% of those residents identified as dependent for ADL care to assure compliance. <p>Measures Taken To Assure There Will Not Be a Recurrence</p> <ul style="list-style-type: none"> ◆ The SRNAs will document daily on the SRNA care plan to ensure ADL care is completed. ◆ Inservicing on ADL care was provided to licensed and certified nursing staff by the SDC, DON, ADON, MDSN or Restorative Nurse beginning on 08/27/11. ◆ A 10% oral hygiene audit of the total resident population via physical inspection and interview, if applicable, will be completed 3 days per week by Restorative Nurse, ADON, SDC, MDSN or DON to ensure dependent resident's oral hygiene is provided. Any concerns identified will be reported to the Administrator and DON immediately for appropriate intervention(s). <p>Monitoring Changes To Assure Continuing Compliance</p> <p>Findings of the 10% oral hygiene audit will be reviewed in the QA Committee meeting monthly for 3 months and then at the discretion of the QA Committee.</p>		

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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3678 PIMLICO PARKWAY LEXINGTON, KY 40517
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F 312	<p>Continued From page 2</p> <p>to change of shift, she failed to follow-up with the resident or to pass the information to the oncoming shift.</p> <p>Interview, on 08/30/11 at 11:00 AM, with SRNA #8 revealed Resident #2 had already been "gotten up and dressed" by the night shift on 08/26/11, therefore he assumed the resident's oral care had been completed.</p>	F 312	Date of Completion	09-05-11