

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

PRINTED: 12/19/2011  
FORM APPROVED  
OMB NO. 0938-0391

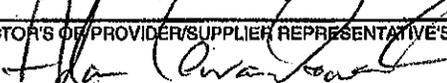
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/08/2011
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NAME OF PROVIDER OR SUPPLIER  WOODCREST MANOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  An Abbreviated Survey was initiated on 12/07/11 and concluded on 12/08/11 investigating ARO#KY00017477. ARO#KY00017477 was substantiated with related deficiencies cited. The highest scope and severity was a "D".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
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 interview and record review, it was determined the facility failed to provide the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the Comprehensive Assessment and Plan of Care, for one (1) of three (3) sampled residents, (Resident #1). The facility failed provide the every two (2) hour check and change for Resident #1 on 11/25/11 on three (3) separate occasions.  The findings include:  Record review revealed the facility admitted Resident #1 on 11/24/11 with diagnoses which included Right Hip Fracture, Urinary Tract Infection, Dementia, and Debility. The resident	F 309	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. Resident #1 no longer resides at the center. 2. All residents were evaluated by the DON/ADON/Unit Managers to identify their individual check and change needs. Based on the evaluations adjustments were made in the timeline for tasks to be completed and assigned meal times were made. 3. Re education of all licensed and certified Nursing staff will be completed by Education Training Director by 12/22/2011 regarding check and change needs and updated assignments. Monitoring for care needs, in addition to required routine monitoring, will be conducted by ADON/Unit Manager and Charge Nurses q two hours on all shifts for two weeks, then twice per shift for two weeks, then once a shift for two weeks. Additional monitoring will be completed by the DON or her designee twice a week for four weeks then monthly thereafter. 4. All monitoring audit results will be reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 12/22/11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	<p>Continued From page 1 was discharged on 11/26/11 at 12:30 AM.</p> <p>Review of the Nursing Assessment, dated 11/24/11 at 4:00 PM, revealed the facility had identified Resident #1 as being incontinent and needing to be checked and changed every two (2) hours. Review of the Elimination Tracking Chart, dated 11/25/11, revealed Resident #1 was checked and changed at 10:30 AM, 2:00 PM, 4:15 PM, 7:15 PM, and at 10:15 PM.</p> <p>Interview with the Director of Nursing (DON), on 12/07/11 at 12:25 PM, revealed the Certified Nursing Assistants (CNAs) are to check and change residents who are incontinent every two (2) hours and then document every time the resident was checked and if they had been incontinent or dry on the Elimination Tracking Chart. She further stated when the resident was a new admission and the CNA Care Plan had not been formulated, the unit nurse who did the admission would give the CNA a check sheet with the resident's specific care needs.</p> <p>Interview with the Physical Therapist (PT), on 12/08/11 at 11:15 AM, revealed she had evaluated Resident #1 on 11/25/11 at 10:30 AM. She further stated CNA #1 was in the room when she finished her evaluation and she told CNA #1 the resident could be transferred back to the bed when he/she was ready.</p> <p>Interview with CNA #1, on 12/07/11 at 5:50 PM, revealed when a resident was incontinent they were to be checked and changed every two (2) hours and then they were to document this on the Elimination Tracking Chart. She further stated she had changed Resident #1 before PT did the</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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></p> <p>QA members consist of Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Social Services, Dietary Service Manager, MDS nurse, Education/Training Director, Therapy Manager and Maintenance Director. 5. Date of Compliance: 1/20/2012</p>		

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F 309	<p>Continued From page 2</p> <p>evaluation at 10:30 AM and did not check the resident again until around 2:00 PM. Interview further revealed she should have checked the resident before 2:00 PM since he/she was an every two (2) hour check and change.</p> <p>Interview with CNA #1, on 12/07/11 at 6:00 PM, revealed she was covering for CNA #3 while he was in the dining room. She further stated when you cover for another CNA you are to answer the call lights, assist with the residents who need to be fed, and change a resident as needed. She further stated she assisted Resident #1 with his/her dinner but did not check or change him/her. She further stated at 7:15 PM, Resident #1's daughter came in and was very upset because the resident was in bed and needed to be changed, so she changed the resident's brief.</p> <p>Interview with CNA #3, on 12/07/11 at 5:40 PM, revealed he checked and changed Resident #1 at 4:15 PM but was not back on the unit until around 8:00 PM. He further stated he had to be in the dining room, then took the smokers out, and then it was time for his thirty (30) minute lunch break. He further stated the resident should have been checked before 7:15 PM.</p> <p>Interview with the DON, on 12/08/11 at 10:25 AM, revealed when a resident was assessed as being incontinent the CNA's were to check and change the resident every two (2) hours and as needed. She further stated if a CNA had the dining room, they were to check the resident before they left the floor to ensure the resident did not go beyond the two (2) hour time. Further interview revealed, when shown the times on the Elimination Tracking Chart with the times she stated, "What</p>	F 309			

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F 309	Continued From page 3 do you want me to say, I see the times". She further stated the resident should have been checked every two (2) hours.	F 309			