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: 185392	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/01/2011
NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101	

(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 recertification survey was initiated on 08/30/11 and concluded on 09/01/11 with regulatory violations cited at the highest scope and severity of a D. A Life Safety Code survey was initiated and concluded on 08/30/11 with deficiencies cited at the highest scope and severity of an F. Abbreviated surveys were initiated on 08/30/11 and concluded on 09/01/11 investigating KY #16330, KY #16536, and Ky #16537, and the Division of Health Care did not substantiate the allegations.	F 000	Woodland Oaks does not believe and does not admit that any deficiencies existed, either before, during, or after the survey. Woodland Oaks reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position. Woodland Oaks reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver or any potentially applicable peer review, quality assurance or self-critical examination privileges which Woodland Oaks does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Woodland Oaks offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to our residents.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Preparation and General Guidelines for Enteral Tube Medication Administration, it was determined the facility failed to ensure a medication error rate of less than five percent (5%) for one (1) of twelve (12) sampled residents observed during a medication pass. Resident #15. During the observation of a medication pass for Resident #15, seven (7) scheduled medications were not administered via gastrostomy tube due to inadequate preparation of the medication. The findings include: Review of the facility's policy from the Pharmacy	F332	F332 1) For Resident #15 – the physician was notified and the 9 a.m. medications were held and then continued as ordered. Resident #15 had no adverse effect by holding the medications. Nurse #6	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/22/11

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.

RECEIVED SEP 22 2011 OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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	185392		09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND OAKS	1820 OAKVIEW ROAD ASHLAND, KY 41101

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F 332	Continued From page 1 Manual, Preparation and General Guidelines for Enteral Tube Medication Administration, revealed medications to be administered by gastrostomy tube should be crushed to a fine powder to avoid clogging the gastrostomy tube. Observation, on 08/31/11 at 9:15 AM, of a medication pass via a gastrostomy tube for Resident #15 revealed LPN #6 crushed all medications into pieces and placed them in a medication cup with thirty milliliters (30 ml) of warm water. LPN #6 attempted to administer the crushed medications in water with a large syringe by means of gravity. LPN #6 was unable to administer the medications as large pieces of the medications clogged the tip of the syringe and prevented the flow by gravity. LPN #6 shook the solution in the syringe many times in an attempt to dissolve the pieces of the medication in the solution and some of the solution was observed to spill onto the bed and onto Resident #15. LPN #6 wasted the remaining liquid and medications in the syringe and placed a call to the physician. Interview with LPN #6, on 08/31/11 at 9:30 AM, revealed she thought the medications did not dissolve into solution because she did not add enough water. LPN #6 said there were large pieces of the medications in the tip of the syringe which impeded the flow of the medications by gravity. LPN #6 stated if the medications were crushed more finely, the medications would have dissolved in the warm water, and she would have been able to get the medications through the gastrostomy tube. She also stated she called the physician to report the medications as not given because she was uncertain how much of the medications had been received.	F 332	was in-serviced on Medication Administration administered via G-tube by the Consultant Pharmacist on 9/15/11. 2) Resident #15 is the only patient that receives medication via G-tube. All Nurses (RNs and LPNs) were in-serviced on 9/15/11 by the Consultant Pharmacist on Medication Administration administered via G-Tube. In addition, all nurses will be educated upon hire by watching the Medication Administration via G-Tube video. 3) First Crush Automatic Pill Crushers were purchased by the facility to be used for crushing medications. They automatically turn pills into powder. In addition, all nurses will be evaluated on Medication Administration via G-Tube during their annual Competencies. A copy of the Annual Competency will be placed the employees file. 4) An audit will be conducted monthly, for the next 6 months, on 10% of all nurses by the Consultant Pharmacist during a medication pass to ensure proper Medication Administration via G-Tube. All findings will be reported to the Continuous Quality Improvement Committee to ensure proper medication Administration via g-tube. 5) 9/15/11	9/16/11

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NAME OF PROVIDER OR SUPPLIER: WOODLAND OAKS

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F 332	Continued From page 2 Review of a faxed Physician Order dated 08/31/11 at 9:40 AM revealed an order to "hold" the 9:00 AM medications for Resident #15, and then continue medications as ordered. Interview, on 09/01/11 at 5:10 PM, with the Staff Development Nurse (SDN) revealed a skills checklist was utilized in orientation to validate the gastrostomy tube medication administration technique of each nurse. The SDN said a Pharmacy Representative observed a medication pass performed by each nurse, and provided a report to the Assistant Director of Nursing (ADON) or the Director of Nursing (DON). The SDN stated she did not receive a copy of the report from the Pharmacy and she was not aware of any current problems with regard to medication administration. Interview, on 09/01/11 at 5:35 PM, with the Assistant Director of Nursing revealed a Pharmacy Representative did a review of Pharmacy Policies and Procedures for each nurse and observed a medication pass performed by each nurse during orientation. All observed errors were reported to the DON or the ADON by the Pharmacy Representative. The ADON stated she observed all new staff perform a medication pass to validate technique and accuracy. The ADON stated medications in tablet form should be crushed into a powder, otherwise the gastrostomy tube could become clogged. The ADON stated Resident #15 was sent to the hospital earlier this year for a clogged gastrostomy tube. Interview, on 09/01/11 at 6:05 PM, with the DON	F 332		

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F 332	Continued From page 3 revealed she was not familiar with the facility policy regarding administration of medications by gastrostomy tube. The DON was not sure if medications which were not crushed to a powder could clog the gastrostomy tube.	F 332		
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 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.	F 441	F441 1) Resident #2 had proper catheter care performed immediately after initial catheter care after SRNA realized what she had done incorrectly. Resident #2 had no adverse reaction to improper Catheter Care. Resident #4 Catheter was not dislodged or pulled out and did not result in infection. 2) All residents with Catheters have been assessed for proper placement and all nursing staff (RNs and LPNs) were in-serviced by the Director of Nursing and the Nurse Aide Supervisor on proper peri-care, catheter care, and hand washing on September 1, 2011. The Quality Assurance Nurse will conduct random audits monthly on 10 percent of all patients with Catheters, for the next 6 months, to ensure proper catheter care is being provided. 3) Upon orientation, SRNA's will be educated on proper peri-care, catheter care, and hand washing and will in-service annually.	

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F 441	Continued From page 4 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Catheterizing and Managing Catheter Care, it was determined the facility failed to develop and implement an Infection Control Program to prevent the development and transmission of disease and infections, and failed to train staff to perform catheter care by anchoring the catheter to prevent injury for two (2) of twenty-two (22) sampled residents. Resident #2 and #4. The findings include: Review of the facility's policy Catheter Care revealed the catheter should be held near the meatus, then cleaned from the insertion site down the catheter about four (4) inches. The catheter should be cleaned with one (1) downward stroke without pulling on the catheter, then repeat as needed with a clean area of the washcloth, changing with a clean washcloth as needed. The catheter should then be rinsed with a clean washcloth in the same manner as it was cleaned. Review of the clinical record for Resident #2 revealed a diagnosis of Neurogenic Bladder (Loss of sensation), Benign Prostatic Hyperplasia	F 441	4) The Quality Assurance nurse will provide results to the CQI Committee monthly on the audits she performs during the month on 10 percent of all patients with Catheters. CQI committee will evaluate to ensure proper catheter care is provided. 5) September 1, 2011	9/2/2011

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F 441	Continued From page 5 (BPH) and frequent Urinary Tract Infections (UTI). Resident #2's diagnosis of Neurogenic Bladder was listed as the medical justification for the indwelling urinary catheter. Observation of catheter care for Resident #2, on 08/31/11 at 9:15 AM, performed by State Registered Nurse Aide (SRNA) #13, with LPN #3 present, revealed the shaft of the penis was cleaned first by use of a disposable wipe which was used to wash over the area without turning of the cloth to expose a clean area, or disposal of the wipe after one cleaning stroke. The catheter tubing was cleaned with the use of one (1) disposable wipe and was used to wipe from the insertion site of the catheter down the tubing to six (6) inches multiple times, without turning the wipe to expose a clean area, or use of a clean disposable wipe. Interview, on 09/01/11 at 9:30 AM, with SRNA #13, revealed she did not know if the facility had implemented any procedures in the catheter care policy to avoid cross-contamination which could lead to infections or urinary tract infections (UTI's). SRNA #13 said the facility trained staff to do one area of the catheter care at a time and said there was no need to fold the disposable wipe. Interview, on 09/01/11 at 9:45 AM, with LPN #3 revealed staff had been trained to perform catheter care with disposable wipes and she said each cleaning stroke of the catheter tubing should be performed from proximal to distal, folding the cloth to expose a clean side to avoid contamination and infection. LPN #3 said SRNA #13 was observed cleaning over the same area	F 441		

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F 441	Continued From page 6 with the cloth without turning the cloth to expose a clean side, which was not in accordance with the facility policy. Interview, on 09/01/11 at 10:15 AM, with SRNA #13 revealed she was advised the catheter care she performed for Resident #2 was incorrect, and that she had repeated the catheter care using the correct technique. SRNA #13 stated she used one (1) washcloth to clean each area, then disposed of each wipe before moving to the next area. Interview, on 09/01/11 at 5:10 PM, with the Staff Development Nurse (SDN) revealed no specific training was provided to SRNA's for catheter care during orientation, and was not sure if catheter care was included in video in-services for new SRNA hires. The SDN said staff are not trained to fold the wipe; they are trained to discard the wipe after each downward cleaning stroke. The SDN stated the catheter care procedure should be done by cleaning the catheter tubing in downward strokes with a disposable wipe, then disposing of each wipe after each downward stroke to avoid cross-contamination and infection. Interview, on 09/01/11 at 5:35 PM, with the Assistant Director of Nursing (ADON) revealed she was not sure of the facility policy for catheter care. The ADON stated the procedure should be done by cleaning from proximal to distal, with disposable wipes. Wipes should be used for one cleaning stroke, then discarded to prevent contamination and infections. Interview, on 09/01/11 at 6:06 PM, with the Director of Nursing (DON) revealed that she had	F 441		

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F 441	Continued From page 7 worked at the facility for four (4) months and was not familiar with the facility's policy for catheter care, or how the staff were trained to perform catheter care. Review of the clinical record, for Resident #4 revealed the facility admitted Resident #4 on 06/26/09 with the diagnoses of Pressure Ulcer on Buttock; Ulcer of Heel and Midfoot; Debility and Muscle Weakness. The resident had a foley catheter due to Urinary Retention. Observation, on 09/01/11 at 10:45 AM, of catheter care for Resident #4 performed by State Registered Nursing Assistant (SRNA) #9, revealed SRNA #9 failed to hold the catheter near the meatus prior to cleaning the foley catheter tubing. Interview with SRNA #9, on 09/01/11 at 11:00 AM, revealed she had never been taught to hold the catheter tubing when cleaning it. Interview with SRNA Supervisor, on 09/01/11 at 3:05 PM, revealed she conducted random audits on pericare with SRNAs. She stated the consequences of not holding the foley catheter tubing near the meatus as you clean down the catheter tubing would be pain for the resident and possible dislodging of the foley catheter tubing. She stated there would be an increased risk of infection if an indwelling foley catheter tubing was pulled out and had to be reinserted.	F 441		

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F 441	Continued From page 8 Interview with Assistant Director of Nursing (ADON), on 09/01/11 at 5:25 PM, revealed SRNAs were taught to hold the indwelling foley catheter tubing before cleaning to avoid pulling the catheter out.	F 441		

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	185392	A. BUILDING 01 - WOODLAND OAKS B. WING	08/30/2011

NAME OF PROVIDER OR SUPPLIER: WOODLAND OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE: 1820 OAKVIEW ROAD, ASHLAND, KY 41101

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1992 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V Unprotected SMOKE COMPARTMENTS: Four (4) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator installed in 1992. Fuel source is Natural Gas. A standard Life Safety Code survey was conducted on 08/30/11. Woodland Oaks Health Care Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred ten (110) beds and the census was one hundred 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	Woodland Oaks does not believe and does not admit that any deficiencies existed, either before, during, or after the survey. Woodland Oaks reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position. Woodland Oaks reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver or any potentially applicable peer review, quality assurance or self-critical examination privileges which Woodland Oaks does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Woodland Oaks offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to our residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Timothy B Hall

TITLE: X Administrator X

(X6) DATE: 9/22/11

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.

RECEIVED SEP 27 2011 OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES

RECEIVED SEP 20 2011 OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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K 000	Continued From page 1	K 000		
	Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)			
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130	K 130 1.) 9/24/11 2.) The corrosion on the battery, the size of a dime, was immediately cleaned and removed by the Director of Maintenance on 8/30/11. An audit of all doors in the facility was completed on 8/30/11 by the Director of Maintenance, any doors with illegal hold open devices were removed and remained closed on 8/30/11. Hold open closers were installed on doors that originally had illegal hold open devices. 3.) The Maintenance staff was in-serviced by the Director of Maintenance on 8/31/11 on the proper cleaning and weekly audit of the generator to ensure there is no corrosion on the battery terminals. The door closers will be monitored on a monthly basis by the Director of Maintenance. These audits will be given to the CQI team for review on a monthly basis.	
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the generator sets by NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds with a census of one hundred eight (108) on the day of the survey. The findings include: Observation on 08/30/11 at 3:20 PM, with the Director of Maintenance revealed corrosion on the battery terminals located inside the generator. Interview, on 08/30/11 at 3:20 PM, with the Director of Maintenance revealed he was unaware of the generator batteries having excessive corrosion on the terminals. Reference: NFPA 110 (1999 Edition).			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185392	A. BUILDING 01 - WOODLAND OAKS B. WING	08/30/2011

NAME OF PROVIDER OR SUPPLIER: WOODLAND OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE: 1820 OAKVIEW ROAD, ASHLAND, KY 41101

(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
K 130	Continued From page 2 Based on observation and interview, the facility failed to maintain doors within a required means of egress. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds, with a census of one hundred eight (108) on the day of the survey. The findings include: Observation, on 08/30/11 at 3:30 PM, with the Director of Maintenance revealed an unapproved hold open device located on the Kitchen and Laundry Room doors. Interview, on 08/30/11 at 3:30 PM, with the Director of Maintenance revealed he was aware of the hold open devices, but unaware they could not be used. NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egrees side.	K 130		
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	K 147	K147 1.) 9/2/11 2.) Maintenance staff was in serviced on the proper use of surge protectors and extensions cords were not to be in use. A Full audit of the facility was completed to ensure proper use of surge protectors and no extension cords were in use	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185392	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WOODLAND OAKS B. WING	(X3) DATE SURVEY COMPLETED 08/30/2011
NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101	

(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
K 147	Continued From page 3 determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred ten (110) beds with a census of one hundred eight (108) on the day of the survey. The findings include: Observation, on 08/30/11 between 12:45 PM and 4:30 PM, with the Director of Maintenance revealed: 1) Piggy backed power strips located in the Business Office. 2) An extension cord in the Admissions Office. 3) A refrigerator plugged into a power strip located in room 504. 4) An extension cord plugged into a power strip located in room 502. 5) Piggy backed power strips located in the Director of Nursing Office. 6) An extension cord in use in the North, and South Nurses Station. 7) Piggy backed power strips located in the SRNA Supervisors Office. 8) A refrigerator plugged into a power strip located in room 441. 9) An air pump plugged into a power strip located in room 401. 10) An extension cord on the microwave located in the employee break room. 11) An extension cord located in the Activities/ Housekeeping Office. 12) An air pump and a wheel chair charger plugged into power strips located in room 303.	K 147	3.) A letter was sent to all residents/family members regarding extension cords and power strips. We have also incorporated information on extension cords and power strips into the admission packet for residents and families so they will be aware upon admission to the facility. Maintenance will conduct a quality assurance audit monthly on all areas to ensure there are no extension cords and power strips in use.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185392	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WOODLAND OAKS B. WING	(X3) DATE SURVEY COMPLETED 08/30/2011
NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101	

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K 147	Continued From page 4 13) An extension cord running television sets in rooms 102, and 209. Interview, on 08/30/11 between 12:45 PM and 4:30 PM, with the director of Maintenance revealed they were unaware of the extension cords and power strips being misused. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

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