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

PRINTED: 04/26/2012
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
	185187	A. BUILDING ____ B. WING ____	C 04/12/2012
NAME OF PROVIDER OR SUPPLIER: GREENWOOD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104	

RECEIVED MAY 2012 OFFICE OF INSPECTOR GENERAL

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F 000	INITIAL COMMENTS An abbreviated survey (KY #18182) was conducted on 04/11/12 through 04/12/12 to determine the facility's compliance with Federal requirements. KY #18182 was substantiated with deficiencies cited.	F 000	Greenwood acknowledges receipt of the Statement of the deficiencies and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance. Greenwoods response to this Statement of Deficiencies does not denote agreement with the Statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood reserves the right to refute any of the deficiencies through the Informal Dispute Resolution, formal appeal procedure, and/or legal proceeding.	
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, closed record review, and review of the facility's policy and procedure, it was determined the facility failed to provide necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being for one resident (#1), in the selected sample of four residents. On 04/09/12, a fire occurred at the foot of Resident #1's bed, which resulted in evacuation of Resident #1 and his/her roommate (Resident #4). The facility failed to conduct a thorough physical assessment of Resident #1 and Resident #4 following the incident. Findings include: A review of the facility's policy/procedure, "Reporting and Investigation of Resident Events	F 309	F309 Resident #1 is no longer a resident in our facility. Resident #4 was re-assessed by the Licensed Nurse on 4/12/12 to include a Physical assessment and vital signs with documentation in the medical record. All residents have the potential to be affected. To prevent the deficiency from occurring again the DON, Nursing Unit Coordinators, QI Nurse, Staff Facilitator and the MDS Nurses have audited the Incident / Event notes completed in the last 30 days to identify that a physical assessment and vital signs has been documented for any resident identified with an event or incident. Audits were completed on 5/14/12. Any concerns identified were corrected at the time of the audit as indicated. Residents will continue	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonathan McGain — TITLE: Administrator — (X6) DATE: 5/3/12

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	Continued From page 1 and Incidents," dated January 2009, revealed "The nurse or nursing supervisor that is informed of the event or incident will initiate the Resident QI Reporting form. Completion of the sections of the form by the nurse are to include a required resident assessment. A resident assessment should include a physical assessment, vital signs, and description of the injury." A closed record review revealed the facility admitted Resident #1 on 07/28/06 with diagnoses to include Functional Quadriplegia, Vascular Dementia with Delirium, and Acute Renal Failure. A review of the nurse's notes, dated 04/09/12 at 2:45 AM, revealed Licensed Practical Nurse (LPN) #1 was notified by Certified Nurse Aide (CNA) #1 about a fire to Resident #1's bed linens, which were at the foot of his/her bed. Resident #1 and Resident #4 were evacuated from the room and appropriate authorities were notified. "No injury," was documented regarding the incident. There was no documentation a full assessment was completed to include vital signs or a respiratory assessment. An interview with LPN #1, on 04/11/12 at 2:17 PM, revealed she arrived to Resident #1's room after being notified by CNA #1 that Resident #1's bed linens had caught on fire. She stated by the time she arrived, the fire had been extinguished. She stated Resident #1 and Resident #4 showed no acute signs of distress; therefore, a respiratory assessment was not completed. Additionally, she stated vital signs were not obtained. She stated vital signs should have been obtained and a complete assessment should have been completed on Resident #1 and Resident #4.	F 309	to receive the necessary care & services to attain or maintain the highest practicable physical, mental, & psychosocial well-being, in accordance with the comprehensive assessment & plan of care to include conduction of a thorough physical assessment following an incident or event. To prevent the deficiency from re-occurring the DON and Staff Facilitator have re-educated the Licensed Nursing Staff on 5/14/12 , stressing the importance of conducting a thorough physical assessment as indicated on any resident identified with an incident or event. This facility will monitor our performance for sustained solutions by conducting a QI audit review of daily incident / event notes Monday thru Friday to identify that a through physical assessment & vital signs has been obtained & documented in the medical record for any resident experiencing an event or incident. Any concerns identified during the audit will be addressed as indicated. The results of these audits will be reviewed with the Administrator & DON in the weekly QI Committee meeting. The first meeting will	

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F 309	Continued From page 2 An interview with CNA #1, on 04/12/12 at 10:16 AM, revealed she was asked by LPN #1 to obtain Resident #1's vital signs. She stated she did not chart the results nor did the nurse request the vital signs, so she discarded the results. An interview with the Director of Nursing (DON), on 04/12/12 at 3:05 PM, revealed she would have expected a full respiratory assessment to be completed following an incident of this nature. She stated she was able to retrieve a record of vital signs for 04/08/12, but the time was not recorded; therefore, she could not determine when the vital signs were obtained. She stated vital signs should have been obtained and documented appropriately for both Resident #1 and Resident #4.	F 309	be held on 5/15/12 and each week thereafter until compliance is maintained via the Executive Q/I team. The members of the Executive team are: Medical Director, Administrator, Director of Nurses, Quality Improvement Coordinator, Staff Development Coordinator, Director of Maintenance, Dietary Manager, Nursing Unit Coordinators, Director of Social Services and Housekeeping/Laundry Supervisor. Completion Date: 5/15/12	5/15/12
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 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:	F 514	F514 Resident #1 is no longer a resident in our facility. LPN #1 was assisted to obtain a different secured password by the System Administrator. All residents have the potential to be affected. To prevent the deficiency from occurring again the DON, Nursing Unit Coordinators, QI Nurse, Staff Facilitator and the MDS Nurses have audited progress notes completed within the last 30 days to identify that any progress notes corrected with a strike entry were corrected by the original author of the note. The audit was completed on 5/14/12 No other concerns were identified. The focus of this audit was to identify that Licensed and Non-licensed Staff are accurately documenting progress notes under the correct author. The facility will continue to maintain clinical records in accordance with acceptable professional standards and practices related to documenting in the medical record.	

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F 514	Continued From page 3 Based on interview, closed record review, and review of the facility's policy and procedure, it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were accurately documented for one resident (#1), in the selected sample of four residents, related to the failure to accurately document a nurse's note under the correct author. Findings include: A review of the facility's "Medical Records Policy," dated October 2007, revealed, "Errors will occur and can be corrected in a manner that will not compromise the legal integrity of the medical record. Errors are corrected by drawing a single line through the mistake and recording the correct information. The information corrected will be initialed and dated by the person making the correction." A closed record review revealed the facility admitted Resident #1 on 07/28/06 with diagnoses to include Functional Quadriplegia, Vascular Dementia with Delirium, and Acute Renal Failure. A review of the nurse's notes, dated 04/09/12 at 2:45 AM, revealed Licensed Practical Nurse (LPN) #1 documented an incident in which she was notified by a Certified Nurse Aide that Resident #1's bed linens had caught fire, causing an evacuation of the residents in the room and surrounding rooms. Further review of the nurse's notes, dated 04/09/12 at 2:45 AM, revealed a "strike" was added, on 04/10/12 at 11:12 AM, and a new note	F 514	Re-education was conducted on 5/14/12 by the Staff Facilitator for all staff who document in the medical record. Written handouts were distributed to all staff and each staff member signed a copy of the Facility Electronic Signature For Medical Records policy acknowledging understanding and that they have received the written information. This written information addresses the secured verification identifying that only the person whose name is typed on the clinical document has the security to cause that name to appear. That passwords must be kept confidential and must not be compromised for any reason, and that staff will be held accountable for any security violation or misuse of the user ID and/or password which includes allowing another individual to use the personally assigned user ID or password and inappropriate use of a user code or password assigned to someone else. Newly hired employees will receive this education during the Orientation process. This facility will monitor our performance for sustained solutions by conducting a QI audit review of daily progress notes Monday thru Friday to identify that any strike out entry in the medical record was corrected by the original author of the note. These audits will be completed by the DON, QI Nurse, Staff Facilitator, MDS Nurses, Unit Directors and Social Service staff. Any concerns identified during the audit will be addressed as indicated. The results of these audits will	

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F 514	Continued From page 4 was created regarding the same incident with LPN #1 as the author. An interview with LPN #1, on 04/11/12 at 4:28 PM, revealed she documented the nurse's note, dated 04/09/12 at 2:45 AM; however, she stated she did not come back and edit her nurse's note, on 04/10/12, as the nurse's note indicated. An interview with the Director of Nursing (DON), on 04/12/12 at 3:05 PM, revealed she spoke with LPN #1 over the phone, on 04/10/12, for further clarification regarding the nurse's note created by LPN #1 on 04/09/12 at 2:45 AM. The DON stated she documented the new nurse's note on the computer and a strike was added to the old nurse's note created by LPN #1. She stated she should have documented the new nurse's note in her name, since she edited LPN #1's nurse's note.	F 514	be reviewed with the Administrator & DON in the weekly QI Committee meeting. The first meeting will be held on 5/15/12 and each week there after until compliance is maintained via the Executive Q/I team. The members of the Executive team are: Medical Director, Administrator, Director of Nurses, Quality Improvement Coordinator, Staff Development Coordinator, Director of Maintenance, Dietary Manager, Nursing Unit Coordinators, Director of Social Services and Housekeeping/Laundry Supervisor. Completion Date: 5/15/12	5/15/12