

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

PRINTED: 12/05/2011
FORM APPROVED
OMB NO. 0938-0391

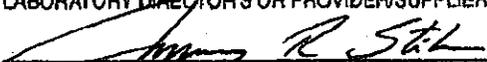
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/17/2011
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 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)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

RECEIVED
DEC 12 2011

F 000	INITIAL COMMENTS			
F 312 SS=D	<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 ensure good hygiene was maintained for two (2) of seven (7) sampled residents (Resident #1 and #2) and six (6) unsampled residents. Review of facility records and interviews with staff revealed the facility failed to provide showers for residents scheduled to receive showers on Monday 10/31/11 during the 7:00 AM to 3:00 PM shift.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Shower", dated December 2010, revealed residents would be provided a shower or bedbath, as appropriate. It continued to state additional showers may be given as necessary to keep a resident clean and odor free.</p>	F 312	<p>NOTE:</p> <p>As indicated within the Statements and evidence provided within this Statement of Deficiencies (SOD) there is no regulatory guideline nor were there any frequencies noted within the facility policies for frequency of providing bathing/shower accommodations. Further it should be noted that per facility policy the frequency should be "as appropriate" and that "additional showers may be given as necessary to keep the resident clean and odor free". There is no mention of any evidence of residents that were identified as being unclean or presenting odor. In fact the premise is based solely on failure to maintain a set schedule on a set day and providing a bed bath rather than a shower. Another fact that was not mentioned was that several residents in fact received as many as three bed baths or showers in a two day period.</p> <p>Immediate Corrective Action For Residents Found To Be Affected</p> <ul style="list-style-type: none"> Residents #1, 2, A, C, D, E, F, and G were provided showers or bathing per personal preference was completed on 11/15/11 through 11/17/11 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 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 12/2/2011
-------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------	------------------------

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.

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

PRINTED: 12/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLIÇO 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)	(X5) COMPLETION DATE
F 312	<p>Continued From page 1</p> <p>Review of the facility's shower schedule revealed Resident #1, Resident #2; Unsampled residents A, C, D, E, F and G were scheduled to receive showers on Monday and Thursday of each week.</p> <p>1. Review of Resident #1's medical record revealed the facility admitted the resident on 12/08/10 with diagnoses which included Gait disorder secondary to Asthenia and Osteoarthritis, Morbid Obesity, Sleep Apnea disorder, Diabetes Mellitus and Deep Vein Thrombosis.</p> <p>Review of the quarterly Resident Assessment Instrument (RAI), dated 09/19/11, revealed the resident was assessed to require extensive assist and required two (2) person assist with bathing.</p> <p>Review of the Comprehensive Care Plan for daily care needs, dated 10/11 revealed the resident was to be showered as scheduled.</p> <p>Review of the shower sheets for the date of 10/31/11 revealed no documented evidence Resident #1 received a shower that day.</p> <p>Review of the electronic documentation, on 11/16/11 at 8:05 PM, with the Administrator and Director of Nursing (DON) revealed no evidence the residents received a shower on 10/31/11.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on 09/16/08 with diagnoses which included Cerebrovascular Disease, Morbid Obesity, Cardiac Dysrhythmia, Neurogenic Bladder, Muscular Wasting, Contracture of Hand Joint, Hypertension and Paralytic Ileus.</p>	F 312	<p>dependent for ADL care. Those residents identified were reviewed to assure ADL care was provided.</p> <ul style="list-style-type: none"> ◆ 100% of Comprehensive Care Plans were compared with SRNA Care Plans to assure uniformity for ADL care per resident preference. Any issues were corrected accordingly. ◆ Bathing per personal preference was provided by 11/17/11 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 11/15/11. ◆ A 10% 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 hygiene is provided. Any concerns identified will be reported to the Administrator and DON immediately for appropriate intervention(s). 	

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

PRINTED: 12/05/2011
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 11/17/2011
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 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 312	Continued From page 2 Review of the Comprehensive Care Plan for daily care needs, dated 07/11, revealed the resident required total assist with bathing. Review of Resident #2's annual RAI dated 09/15/11 revealed the resident required total assist of two (2) or more persons for bathing. Review of the shower sheets for the date of 10/31/11 revealed no documented evidence Resident #1 received a shower that day. Review of the electronic documentation, on 11/16/11 at 8:05 PM, with the Administrator and Director of Nursing (DON) revealed no evidence the resident received a shower on 10/31/11. Review of the electronic documentation, on 11/16/11 at 8:05 PM, with the Administrator and Director of Nursing (DON) revealed no evidence Unsampled Residents A, C, D, E, F, and G received a shower on 10/31/11. Interview with Certified Nursing Assistant (CNA) #1, on 11/15/11 at 2:25 PM, revealed she may have completed one (1) shower on 10/31/11. Interview with CNA #2, on 11/15/11 at 2:35 PM, revealed day shift on 10/31/11 showers were not completed for residents scheduled to receive showers on Monday. Interview with CNA #3, on 11/15/11 at 2:45 PM, revealed on 10/31/11 day shift showers were not completed for residents scheduled to receive showers on Monday.	F 312	Monitoring Changes To Assure Continuing Compliance Findings of the 10% hygiene audit will be reviewed in the QA Committee meeting monthly for 3 months and then at the discretion of the QA Committee. Date of Completion 01-01-12		

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

 PRINTED: 12/05/2011
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 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)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 3</p> <p>Interview with CNA #4, on 11/15/11 at 3:10 PM, revealed showers were not done on 10/31/11 for the residents scheduled to receive showers during day shift on Mondays.</p> <p>Interview with CNA #10, on 11/16/11 at 1:35 PM, revealed showers were not completed for residents scheduled to receive showers on Monday during day shift on 10/31/11.</p> <p>Interview, on 11/16/11 at 6:15 PM, with the South Unit Assistant Director of Nursing (ADON), who was responsible for ensuring care was provided, revealed she knew there were only going to be three (3) aides on 10/31/11 and she did not schedule showers on the assignment sheet for the 7:00 AM through 3:00 PM shift. She further stated she did schedule the showers for Unsampled Residents E, F and G for the evening shift on 10/31/11; however, there was no documented evidence the residents had received or refused a shower. She further indicated the showers for Residents #1, #2, Unsampled Residents A, C and D were not rescheduled for the Monday shower.</p>	F 312			