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

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185445		R-C 09/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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	{F 000}		
	A second On-site Revisit Survey was conducted 09/10/15, to determine compliance with the deficiencies cited on the first Revisit Survey of 07/10/15. Based on the facility's acceptable Plan of Correction with an alleged compliance date of 08/06/15, it was determined the facility was in compliance on 08/06/15 as alleged.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

Acceptable

PRINTED: 07/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3875 TURKEYFOOT ROAD, ELSMERE, KY 41018

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{F 000}	INITIAL COMMENTS	{F 000}	Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.	
	An onsite Revisit Survey was conducted 07/08/15 through 07/10/15 to determine if the facility had corrected deficiencies cited from abbreviated surveys completed on 04/01/15 and 05/14/15, as alleged in their Plan of Correction, with a compliance date of 06/18/15. It was determined the facility had corrected deficiencies cited at 42 CFR 483.10 Resident Rights, F166 cited from the 05/14/15 survey and at 42 CFR 483.20 Resident Assessment, F280 cited from the 04/01/15 survey. However, continued non-compliance remained at 42 CFR 483.20 Resident Assessment, F282, 42 CFR 483.25 Quality of Care, F323, 42 CFR 483.65 Infection Control, F441, and at 42 CFR 483.75 Administration, F514. Additional deficiencies were cited at 42 CFR 483.15 Quality of Life, F246, 42 CFR 483.75 Administration, F490 and F520 with the highest scope and severity (S/S) of an "E".			
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246	1. Woodcrest Nursing and Rehabilitation assures that each Resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	8/06/2015
	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.		Resident # 4's call light string was replaced on 7/10/2015 by CNA #4 so that it could be placed within reach when he/she was in a laying down position and when sitting up in the wheelchair, at bedside. Resident #4 has been observed by members of nursing administration and he/she can in fact reach the call light cord. Nursing Administration includes the Director of Nursing/ Acting Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, Unit Managers, Evening Supervisor, and Weekend Supervisor.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Certified Nurse Aide's job		Resident C's call light string was attached to the chain pull on 7/10/2015 by CNA #4 making it accessible to him/her.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 8/18/2015

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 246 Continued From page 1

description it was determined the facility failed to ensure resident call light strings were within reach and the residents were able to use the stringed call light. This affected one (1) of eight (8) sampled residents, Resident #4 and three (3) of four (4) unsampled residents, Unsampled Residents B, C and D.

The findings include:

Review of the position description for Certified Nursing Aide (ACN) revealed essential functions of position was to answer signal lights, bells, or intercom system to determine residents' needs and to ensure call lights were within reach of the residents.

Interview with the Director of Nursing (DON) on 07/10/15 at 5:00 PM revealed the facility did not have a specific call light policy. She continued by stating the facility did not have an alternate call system to accommodate residents that were unable to pull the call light string. Further interview revealed the current call light system only supported the current string system.

Review of the Certified Nurse Aide (CNA) job description, no date, revealed they were to ensure the call lights were within resident reach and to ensure that residents unable to use the call light string, were checked on frequently.

1. Review of Resident #4's clinical record revealed the facility admitted him/her on 05/09/13 with diagnoses which included Parkinson's Disease, Vitamin Deficiency and Dysphagia. Review of Resident #4's annual Minimum Data Set (MDS) Assessment, dated 06/03/15, revealed Resident #4 was moderately impaired in cognition

F 246 Resident B's call light string was made accessible by CNA #9 immediately upon being questioned on 7/10/2015.

Resident D is cognitively unable to utilize any call light based on her BIM score of 3 (severely impaired) completed on 5/05/2015. Nursing staff and department head staff have been inserviced on 8/05/2015 by the Director of Nursing and/or Staff Development Coordinator to ensure they check on resident frequently and when making rounds to ensure needs are met. Resident D has not had any negative outcome based on this current practice.

2.
Residents unable to use a call light due to significant cognitive impairments will continue to be checked during routine rounds, cares and or observations by nursing staff and/or facility staff to ensure needs are being met. By 8/8/2015, all residents will be reviewed by a member of nursing administration (DON, unit managers, Staff Development Coordinator, supervisors), Social Services and or Administrator to ensure their call light needs are addressed and maintained to meet their needs.

3.
Education presented by the Staff Development Coordinator on Residents Rights including Accommodation of needs began on July 15, 2015 for staff including contracted therapy, contracted housekeeping and laundry, and department heads. Education concluded on 7/20/2015 with

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F 246 Continued From page 2

and was able to make his/her needs known.

Observations during initial tour, on 07/08/15 at 8:35 AM, revealed Resident #4's call light string was not accessible to him/her and his/her roommate (Unsampled Resident C) did not have a call light string at all.

Observation, on 07/09/15 at 9:30 AM, revealed Resident #4 was not able to reach the call light string that was installed in the middle of the wall. Resident #4's left side of bed was against the wall and the call light string was hanging above his/her bed approximately twelve (12) to eighteen (18) inches from the top of the mattress, at knee level. Resident #4 was not able to reach the call light string when in a supine (laying down) position in bed; the call light string was also not accessible if Resident #4 was sitting up in the wheelchair, at bedside.

The Surveyor was unable to interview Resident #4 as he/she was asleep during all observations. Interview with Resident #4's family member, on 07/08/15 at 5:10 PM, revealed the resident was fairly independent but needed assistance at times and would be able to use the call light if it was assessable and in reach.

Interview with CNA #4, on 07/10/15 at 7:45 PM, revealed Resident #4's call light string was not accessible because it was too short and he/she would have had to sit up, lean and reach to the left to use the call light system.

2. Record review revealed Unsampled Resident C was admitted by the facility on 02/18/11. Continued review of the Quarterly MDS Assessment, dated 05/23/15, revealed the

F 246

anyone missed ie PRN staff and newly hired will have the education before working in the building.

Staff will be educated during orientation regarding call light placement and checking those frequently that cannot use the call lights due to severe cognitive impairment and where the information is located on the CNA care plan by the Staff Development Coordinator. (SDC).

The Interdisciplinary Team (IDT) which includes unit managers, therapy director, MDS Coordinator(s), Social Services will be educated by the Director of Nursing and/or the SDC regarding call light interventions to be updated to reflect the needs of the resident(s) on Comprehensive care plans and CNA care plans on 8/05/2015. Moving forward, all residents will have call light interventions reviewed and updated to the Comprehensive care plan and CAN care plan per the RAI schedule and or changes in the residents condition by the IDT.

4.
Room rounds are being conducted starting on 7/13/2015 by department heads (including but not limited to Administrator, Business Office Manager, Human Resources Director, Admissions Director, Marketing Director, Minimum Data Set Coordinators and Social Service Director) to review presence of safety equipment to include call light strings and placement thereof to assure they are accessible by the Residents. Rounds are being done at least 3 times per week for four weeks, at least

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F 246 Continued From page 3

resident was cognitively impaired.

Observations during initial tour, on 07/08/15 at 8:35 AM, revealed Unsampled Resident C did not have a call light string at all.

Continued observations on 07/08/15, 07/09/15 and 07/10/15 revealed Resident #4 and Unsampled Resident C did not have accessible call light strings until 07/10/15 at 8:00 PM.

Interview with CNA #4, on 07/10/15 at 7:45 PM, revealed Unsampled Resident C's call light was inaccessible because he/she did not have a call light string at all.

Interview with the DON, on 07/10/15 at 8:55 AM, revealed there was an apparent system failure in regard to Resident #4 and Unsampled Resident C related to call light accessibility.

3. Record review revealed the facility admitted Unsampled Resident B to the facility on 05/28/15. Review of the Admission MDS Assessment, dated 06/04/15 revealed the facility assessed the resident having no cognitive impairment and able to make his/her needs known.

On 07/10/15 at 7:30 PM, a facility wide sweep was performed by the Surveyors to ensure call light strings were accessible to the residents. No concerns were noted on the second floor; however, on the first floor, at 7:40 PM, Unsampled Resident B's call light string was behind the headboard and, per observation, he/she was not able to reach the call light string.

Interview and observation, with Unsampled Resident B, on 07/10/15 at 7:30 PM, revealed the

F 246

2 times per week for four weeks and at least once per week for two months: if a concern is identified during rounds it will be brought to the charge nurse's attention and will be addressed by nursing immediately, the concern will also be identified to the DON and/or a member of nursing administration and the administrator who will follow up to ensure the concern has been corrected. Re-education will be given by charge nurse, nursing administration and/or administrator for compliance, by shift's end. Results are turned into the Administrator who is monitoring and presenting findings to the daily morning department head meeting M-F for necessary follow up and cumulatively will be presented to the month QA meeting. The Quality Assurance (QA) Committee include the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Dietary Manager, Social Worker, Activities Director, Minimum Data Set Coordinator, Admissions Director, Marketing Director, Business Office Manager, Human Resources Director, Maintenance Director, Housekeeping Director, Therapy Director. A quorum of the Committee consists of either the Medical Director, DON, or Administrator and one other of the included positions above.

The Administrator is responsible to ensure data is submitted and appropriate follow up taken.

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F 246	Continued From page 4 resident was unable to reach the call light string. Interview with CNA #9, on 07/10/15 at 7:35 PM, revealed Unsampled Resident B should have his/her call light within reach. 4. Record review revealed the facility re-admitted Unsampled Resident D on 02/08/14 with diagnoses which included Encephalopathy and Mental Disorder. Observation of Unsampled Resident D, on 07/10/15 at 7:32 PM, revealed the resident to have non-purposeful left arm/hand movements, which would make the pull type call bell string inaccessible to him/her. Interview with Unsampled Resident D's daughter, on 07/10/15 at 7:36 PM, revealed the resident was not able to use the pull type call system related to the non-purposeful arm movements. She further stated Unsampled Resident D needed a different type of call light, other than the pull string. However, there was no documented evidence the facility had identified the resident's need for an alternative call light device. Interview,with CNA #4 on 07/10/15 at 7:45 PM, revealed staff had had recent education on making sure the call light strings were accessible for the residents. Interview with Registered Nurse #4, on 07/10/15 at 7:50 PM revealed resident call lights were to be accessible to the residents at all times. Interview with the Marketing Director, on 07/10/15 at 5:45 PM, revealed it had been her responsibility to do daily room rounds that	F 246		

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F 246	Continued From page 5 included call light accessibility on the hall that Resident #4 and Unsampled Resident C lived. If a resident did not have a call light near, she was to put the call light where the resident could reach it, and indicate on the CNA care plan that the call light had not been near the resident. She did not ask residents if they could reach the call light string. Interview with the DON on 07/10/15 at 7:35 PM revealed she had conducted all the call light audits herself at the time of the audits, all residents had had their call lights within reach.	F 246		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Resident Assessment Instrument (RAI) User Manual Version 3.0 it was determined the facility failed to ensure the Comprehensive Care Plan was implemented for two (2) of eight (8) sampled residents (Residents #5 and #7). Resident #7's Comprehensive Care Plan on fall prevention included interventions of Lambs Wool to the bedside table, non-skid strips to the floor in front of the toilet, and a Dycem non-slip mat placed above and below the wheelchair cushion. However, observation revealed no Lambs Wool on the bedside table, only one-half of a non-skid	{F 282}	Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care. 1. Woodcrest Nursing and Rehabilitation provides and arranges services provided by qualified persons in accordance with each resident's written plan of care. Resident #7's bedside table had lamb's wool re installed, three non-skid strips were reapplied to the floor in front of the toilet, and a Dycem non-slip mat was re applied to the top of the wheelchair cushion by LPN #1 on 7/9/2015. Resident #5's care plan was changed to a more appropriate intervention of sensor alarms to the bed and wheelchair by the Staff Development Coordinator on 7/10/15	08/06/2015

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{F 282} Continued From page 6

strip on the floor in front of the toilet, and no Dycem non-slip mat placed on top of the wheelchair cushion.

Resident #5's Comprehensive Care Plan on fall prevention included interventions of tab alarming devices to the resident's bed and wheelchair. However, observations revealed the alarming devices in place on both the wheelchair and bed were sensor alarm devices, not tab alarms.

The findings include:

Interview, on 07/08/15 at approximately 4:10 PM, with the Director of Nursing (DON) revealed the facility did not have a written policy regarding care plans but followed the Resident Assessment Instrument (RAI) process for residents' Comprehensive Care Plans.

Review of the RAI User Manual Version 3.0, May 2011, revealed the Interdisciplinary Team (IDT) developed an individualized Comprehensive Care Plan based on the results of the comprehensive assessment. Further review revealed the care plan was supposed to be reviewed and revised periodically, and the services provided or arranged, by the facility, were consistent with each resident's written plan of care.

Interview, on 07/10/15 at 7:21 PM, with the Administrator revealed the facility had a system in place to ensure care plan interventions were followed.

1. Review of Resident #7's medical record revealed the facility initially admitted the resident 08/20/13 and re-admitted 03/20/14 with diagnoses which included Cirrhosis of the Liver

{F 282}

2.
In house residents are at risk to ensure that the comprehensive care plan regarding fall prevention interventions is implemented.

The Education Training Director, Director of Nursing, Minimum Data Set Coordinator and unit managers will review in house residents who are at risk for falls using the fall risk assessment by 8/5/2015 to ensure fall prevention interventions are implemented; thereafter per the Resident Assessment Instrument (RAI) process, quarterly, annually and at significant change by Minimum Data Set (MDS) Coordinator.

Rounds will be conducted by designated department heads (including but not limited to Administrator, Business Office Manager, Human Resource Director, Admissions and Marketing Directors, Minimum Data Set Coordinators and Social Service Director) to ensure devices are in place as directed by the care plan and updated as indicated for accuracy Nursing staff will receive updated communication daily with any changes made regarding fall interventions by the Director of Nursing, Education Training Director, unit managers, Minimum Data Set Coordination and or nursing supervisor(s), and or charge nurse.

Non-skid strips will be reviewed on resident indicated as having them, along with alarms and Dycem to wheelchair pads, and or lambs wool by the Interdisciplinary Team to determine if devices and intervention are still needed or a more appropriate intervention.

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{F 282} Continued From page 7

(Liver disease), Hypertension, Confusion, Dementia, Depressive Disorder, Debility, Diabetes, and History of Fractures: Right Wrist/Left Humerus. Review of the facility's Fall Risk Data Set, dated 05/13/15, revealed the facility assessed the resident as a high fall risk.

Record review of Resident #7's Comprehensive Care Plans, dated 06/11/15, revealed a potential for injury/fall care plan was created because the facility assessed the resident had a history of falls, impaired mobility, impulsive behaviors and decreased safety awareness. Review of associated care plan interventions revealed the placement of lambs wool to the bedside table and staff was to check placement each shift, non-skid strips to the floor in front of the toilet and placement was checked daily on the 11-7 shift, and a Dycem mat above and below the wheel chair cushion.

Observation of Resident #7's room, on 07/09/15 at 5:21 PM, revealed no lambs wool on the resident's overbed table, no Dycem mat above the wheelchair cushion, and one non-skid strip in front of the toilet with only 1/2 of the strip attached to the floor.

Interview and observation of Resident #7's room, on 07/09/15 at 5:36 PM, with Certified Nurse Assistant (CNA) #4 revealed the resident had care plan interventions which included: Dycem above the wheelchair cushion, lambs wool to the bedside table, and non-skid strips in front of the toilet. The CNA #4 revealed, after observation of the resident's room, there was no Dycem mat above the wheel chair cushion, no lambs wool to the overbed table, and there was only one non-skid strips in front of the toilet with only 1/2

{F 282}

Nursing staff will be educated by the Education Training Director, Director of Nursing and/or unit manager(s) regarding the following:

Following the resident plan of care for safety devices, how and to who to communicate if the device cannot be located.

Types of alarms used to assist with resident safety.

Communication between shifts updating plan of care for fall prevention and how will it be communicated with aides and nurses.

Licensed nurses responsible to ensure fall prevention interventions are in place during their shift.

Unit Manager (2) and Department Heads will be re-educated by The Education Training Director on how to review communication sheets to audit safety interventions and who to communicate non-compliance to.

These educations will be on going to include any current employee missed (prior to working) and new hires during orientation.

3.
Education was presented by the Staff Development Coordinator to existing staff starting on 8/3/15 with 66% compliance by

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{F 282} Continued From page 8

attached to the floor. Further interview revealed she had forgotten to check if Dycem was above the wheelchair cushion, had not seen lambs wool on the table for awhile, thought it was an old order, and was going to put in a work order to replace the non-skid strips in front of the toilet.

Interview, on 07/10/15 at 6:50 PM, with CNA #10 revealed she routinely took care of Resident #7 and the care plan had interventions no longer in place. The CNA reported she had not seen the lambs wool to the overbed table and was told by a nurse it was discontinued but it was still on the care plan. Further interview revealed she worked 07/08/15 and there were non-skid fall strips in front of the toilet, probably three (3) strips, and if only one half of a fall strip was observed in place it was not an effective intervention.

Interview with Licensed Practical Nurse (LPN) #1, on 07/09/15 at 5:35 PM, revealed she cared for Resident #7 and after review the resident's care plan she felt the care plans met Resident #7's care needs and, the interventions on the care plan were checked daily to ensure they were in place. LPN #1 revealed, after observation of Resident #7's room, the lambs wool was not in place, but thought it was there that morning and was aware there was no Dycem mat on top of the wheel chair cushion, she had meant to get it. She reported there was only one non-skid fall strip in front of the toilet in the bathroom and some of the strip was not stuck down to the floor, and there was supposed to be more than one strip.

Interview with LPN #9, on 07/10/15 at 6:40 PM, revealed she worked 11-7 shift and was responsible to ensure all residents' care plan

{F 282}

8/5/2015. Anyone missed ie PRN staff and newly hired will have the education before working in the building. The Education Training Director, Director of Nursing and/or unit manager(s) and shift supervisor(s) will educate new nursing staff during orientation, on an ongoing basis, as well as any new department head to ensure residents comprehensive care plans are followed as implemented regarding fall prevention interventions; How and who to communicate any changes in interventions or if a device cannot be located for the care plan.

Education was presented to existing staff starting on 8/3/15 with 66% compliance by 8/5/2015.

The Interdisciplinary Team, consisting of Activities Director, Dietary Manager, Social Service, Minimum Data Set Coordination, Director of Nursing and Unit Managers, will review daily Monday through Friday to ensure new interventions for fall prevention have been implemented and communicated to nursing staff and department heads and make adjustments if indicated.

Education will continue to be provided for any identified non-compliance by shift supervisor, Director of Nursing, Education Training Director, Unit Manager(s) and or charge nurse on an ongoing basis.

4.
Rounds are being conducted on first and second shifts, starting on 7/13/2015 by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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 282} Continued From page 9

interventions were in place. She stated last time she checked, the lambs wool was present and she was sure the non-skid strips were in place by the resident's bed, but wasn't sure if they were in front of the toilet or not. She said she probably needed to check closer.

Interview, on 07/09/15 at 5:41 PM, with Registered Nurse (RN) #2/Unit Manager (UM) revealed Department Head Managers checked to ensure care plan interventions listed on the CNA care plan were in place each day. However, RN #2/UM revealed Resident #7's room only had one non-skid fall strip that was half way off the floor in front of the toilet and was a fall risk. In addition, she reported there was no lambs wool on the overbed table and no Dycem on the wheel chair cushion. Continued interview revealed the missing interventions were not caught on staff rounds and the care plan was not followed.

Interview, on 07/10/15 at 2:43 PM, with the Marketing Director revealed as part of the facility's plan to ensure care plan interventions were in place she was assigned specific rooms, including Resident #7's room, and rounded daily with the CNAs. Care Plan sheets to inspect made sure interventions were in place and at days end they had a meeting and turned in the rounding sheets with any noted concerns. She revealed they were educated prior to beginning the rounding on what to look at, how to read the care plan, and understanding what was on the care plan. The Marketing Director reported the Dycem was on top of the resident's wheel chair cushion when she had rounded but had identified the lambs wool intervention was continually not in place and had discussed the intervention with a nurse who informed her there was potential the

{F 282} department heads (including but not limited to Administrator, Business Office Manager, Human Resource Director, Admissions and Marketing Directors, Minimum Data Set Coordinators and Social Service Director) to review presence of safety equipment to include appropriate assistance devices per the comprehensive care plan and CNA care plan and to ensure both are congruent as well by nursing administration, licensed nurses and department heads. Department Head rounds are being done at least 3 times per week Monday through Friday for four weeks, at least 2 times per week for four weeks and at least once per week for two months: if a concern is identified during rounds it will be brought to the charge nurse's attention and will be addressed by nursing immediately, the concern will also be identified to the DON and/or a member of nursing administration and the administrator who will follow up to ensure the concern has been corrected. Re-education will be given by charge nurse, nursing administration and/or administrator for compliance, by shift's end. Results are turned into the Administrator who is monitoring and presenting findings to the daily morning department head meeting M-F for necessary follow up and cumulatively will be presented to the month QA meeting. The Quality Assurance (QA) Committee include the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Dietary Manager, Social Worker, Activities Director, Minimum Data Set Coordinator, Admissions Director, Marketing Director, Business Office Manager, Human Resources

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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{F 282} Continued From page 10

intervention was to be discontinued, however, she had not followed up and should have. Continued interview revealed she noticed there was only a partial non-skid strip in front of the toilet and last week there was one full strip and a partial one, but she just went by the interventions on the care plan and was not aware how may strips were supposed to be in place because it was not specified.

Interview, 07/10/15 at 5:47 PM, with the Director of Nursing (DON) revealed it was a care plan issue if all the fall interventions were not in place. The DON revealed the lambs wool was probably not on the overbed table because the intervention was supposed to be discontinued and removed, but staff had not followed up on the issue to discontinue. She reported the care plan also included non-skid strips in front of the toilet, which were difficult to remove, and were supposed to be checked nightly by the nurse. She also reported half of a strip was not an effective to prevent falls and there were usually three (3) to four (4) strips in place. Continued interview revealed the Dycem was easily removed but they had focused on ensuring care plan interventions were in place and all staff was responsible.

Interview with the Administrator, on 07/10/15 at 7:21 PM revealed staff had previously identified lambs wool was not on the bedside table, but had not followed up with clarification if the intervention was supposed to be in place. He reported the Dycem to the wheel chair cushion was noted to be in place when the facility's Department Head rounded to ensure interventions were in place and was unsure why it was not present when observed by the surveyor. Continued interview revealed if only one (1) partial non-skid strip was

{F 282} Director, Maintenance Director, Housekeeping Director, Therapy Director. A quorum of the Committee consists of either the Medical Director, DON, or Administrator and one other of the included positions above.

The Administrator is responsible to ensure data is submitted and appropriate follow up taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015
NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	

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{F 282}	Continued From page 11 in front of the toilet, the care plan intervention was not met. 2. Review of Resident #5's medical record revealed the facility initially admitted the resident 03/25/15 and re-admitted 05/22/15 with diagnoses which included Diabetes, Alzheimer's Disease, Anxiety Disorder, Depression, Hypertension, Fall, Debility, and Aftercare Traumatic Hip Fracture. Record review of the resident's Initial Minimum Data Set (MDS), dated 05/30/15, revealed the facility's assessment triggered the Falls Care Area section related to Resident #5's impaired mobility, bowel/bladder incontinence, pain, use of Psychotropic medication, fall history, diagnoses of Dementia, Debility, Depression, and Anxiety. Continued record review revealed the facility developed a Potential for Fall and Related Injury Comprehensive Care Plan, dated 06/02/15, with interventions which included bed locked and in lowest position, environment free of clutter, and wheelchair sensor pressure alarm device. Further review of the care plan revealed, on 06/16/15, the interventions were updated which included discontinuation of the sensor pressure alarm and placement of a tab alarming device to Resident #5's wheelchair due to decreased safety awareness. In addition, the fall care plan interventions were updated, 06/23/15, to include a tab alarm device to the bed. Observations, on 07/08/15 at 1:00 PM and 5:56 PM, revealed Resident #5 had a sensor pressure alarm device to the wheelchair; however there was no observation of a tab alarm as per the care plan.	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

(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 282}	Continued From page 12	{F 282}		

Further observations and interview, on 07/09/15 at 2:00 PM, with Certified Nurse Assistant (CNA) #6 revealed the resident had a sensor pressure alarm device to his/her wheel chair and bed, but no tab alarm as per the care plan.

Interview, on 07/09/15 at 2:19 PM, with CNA # 7 revealed she routinely cared for Resident #5 and was familiar with the care plan which included a tab alarm to his/her wheelchair and bed; however the resident had sensor alarms to his/her bed and wheelchair instead of a tab alarm. The CNA revealed the tab alarm was connected to the resident to let you know if a resident attempted to get up and the pressure alarm was a weight sensor device. Continued interview revealed the care plan was not followed and staff checked alarms and should have noticed the sensor alarms.

Interview, on 07/09/15 at 2:51 PM, with Licensed Practical Nurse (LPN) #6 revealed the purpose of the care plan was to know the residents care needs and Resident#5's care plan included a tab alarm device to the bed and wheelchair. The LPN revealed the resident currently had sensor alarms to the bed and wheel chair and they had been in place for awhile, but should have had tab alarm as care planned.

Interview, on 07/09/15 at 6:45 PM, with LPN #3 revealed the main purpose of the care plan was for the aides and the nurse's monitor to ensure the interventions were in place. The LPN revealed she felt the sensor alarms were more appropriate, but the care plan intervention had tab alarms and the care plan was supposed to be followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

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STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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{F 282}	Continued From page 13	{F 282}		
	Interview, on 07/09/15 at 5:41 PM and 07/10/15 at 10:20 AM, with the Registered Nurse (RN) #2/Unit Manager (UM) revealed care plans were supposed to be up-to-date and updated by the Unit Managers and nurses. RN #2/UM revealed there was a difference between the sensor and tab alarms. The tab alarms alerted staff when a resident attempted to get up and the sensor pressure alarm alerted staff when there was no longer any pressure to the area. Further interview revealed the care plan was not followed regarding the alarm intervention. Further interview, on 07/10/15 at 5:47 PM, with the DON revealed Resident #5's care plan was individualized based on needs and was updated when the resident had falls. The DON revealed the resident was assessed to determine which alarm was more effective and was care planned for tab alarms to the bed and wheelchair. Continued interview revealed, staff monitored the alarm interventions and the care plan was not followed if sensor alarms were in place. Continued interview, on 07/10/15 at 7:21 PM, with the Administrator revealed there were audits done daily to ensure care plan interventions were in place and staff had not questioned why the alarms in place had not matched the care plan intervention.		Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323	1. Woodcrest Nursing and Rehabilitation assures that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.	8/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

(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 323	Continued From page 14 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy it was determined the facility failed to ensure planned assistive device interventions to prevent falls were in place for two (2) of eight (8) sampled residents (Residents #5 and #7). Observation, on 07/09/15, of Resident #7's room revealed fall prevention care plan interventions of a Dycem mat above the wheelchair cushion, lambs wool attached to the overbed table, and fall non-skid strips in front of the toilet were not in place. Record review revealed the resident had two (2) fall incidents on 07/08/15. In addition, observation revealed Resident #5 had a pressure alarm in place to the wheel chair and bed; however, the care plan indicated the resident was to have a tab alarm after experiencing falls on 06/16/15 from the wheel chair and 06/23/15 from the bed. The findings include: Review of the facility's "Fall Assessment/Intervention Process", undated revealed all residents were assessed for fall risk and appropriate interventions were initiated to reduce the risk of injuries with falls. Further review of the policy revealed per F323 the facility must ensure each resident received adequate supervision and assistance devices to prevent accidents.	F 323	Resident # 7's Lamb's wool was replaced on his/her bedside table, the 3 non-skid strips were replaced in front of the toilet and dycem replaced above the wheelchair cushion by LPN #1 on 7/10/2015. Resident # 5's Care Plans were changed from tab alarms to a more appropriate for him/her sensor alarms. The comprehensive care plan and CNA care plan were updated as indicated by the Staff Development Coordinator on 7/10/2015. 2. All residents are at risk for the alleged deficient practice. All residents will have fall prevention interventions reviewed by the Interdisciplinary Team (IDT) which includes unit managers, therapy director, Director of Nursing and social services with an audit to ensure interventions are in place and congruent with the comprehensive care plan and CNA care plan and completed by 8/5/2015. In addition, the IDT will review and update Comprehensive Care Plans as indicated to more appropriate interventions for fall prevention related to floor strips, tab or sensor alarms, dycem to wheelchair pads and/or lamb's wool and completed by 8/5/2015. 3. Education presented by the Staff Development Coordinator began on 07/15/2015 for nursing staff concerning following the Comprehensive care plans and/or CNA care plans to include having the appropriate assistance devices. Education	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323 Continued From page 15

1. Review of Resident #7's medical record revealed the facility initially admitted the resident 08/20/13 and re-admitted 03/20/14 with diagnoses which included Hypertension, Confusion, Dementia, Depressive Disorder, Debility, and Diabetes. Review of the facility's most recent Fall Risk Data Set, dated 05/13/15, revealed the facility assessed Resident #7 was a high fall risk. Review of the Annual Minimum Data Set (MDS) Assessment, completed on 05/13/15, revealed the facility assessed resident to be severely cognitively impaired with a Brief Interview of Mental Status (BIMS) score of a seven (7) out of fifteen (15).

Record review of Resident #7's Comprehensive Care Plans, dated 01/27/15, revealed a potential for injury/fall care plan was created because the facility assessed the resident had a history of falls, impaired mobility, impulsive behaviors and decreased safety awareness. Review of the associated care plan interventions revealed; placement of lambs wool to the bedside table, no date, non-skid strips to the floor in front of the toilet, no date, and Dycem mat above and below the wheel chair cushion, no date.

Record review of the facility's incident reports revealed Resident #7 had two non-witnessed fall in his/her room on 07/08/15. Review of the Resident Incident Report, 07/08/15 at 4:46 PM,revealed the resident was noted sitting on the floor next to his/her roommate's bed with no apparent injury. In addition, review of the Resident Incident Report, 07/08/15 at 10:10 PM, revealed a Certified Nurse Assistant reported the resident was sitting on the bathroom floor with no apparent injury.

F 323

continued until 7/20/2015. Anyone missed ie PRN staff and newly hired will have the education before working in the building.

Education will be given during orientation and as indicated for compliance ongoing by the SDC and/or nursing administration. Education was provided to the Department Heads by the SDC and Administrator on 7/20/2015 and 8/3/2015 concerning review of CNA care plans and what to look for on rounds.

The CNA care plan is an extension of the comprehensive care plan and will match it for a communication reference tool for each resident they care for on assignment. It includes safety devices, etc to provide care for the resident. The CNA care plan and the comprehensive care plan will be updated with changes as they occur by the nursing supervisor, charge nurse, nursing administration and/or the IDT while at work, what safety items need to be in place and better assure the appropriate assistance devices are in place ongoing.

4.
Room rounds are being conducted starting on 7/13/2015 by department heads, to review presence of safety equipment to include appropriate assistance devices per the comprehensive care plan and CNA care plan and to ensure both are congruent.

Nursing administration, and licensed nurses are doing rounds as a part of their everyday activity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015
NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	

(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 323	Continued From page 16 Interview, on 07/10/15 at 5:06 PM, with RN #5 revealed she was called into the residents room at night, on 07/08/15, by an aide and when she went in the resident was sitting on the bathroom floor with her back in front of the sink and her legs straight out. The RN revealed, when asked the resident what happened the resident stated he/she had slipped. Continued interview revealed the RN was not sure if there were non-skid strips were in front of the toilet, but had observed the strips in front of the bed. Observation of Resident #7's room, on 07/09/15 at 5:21 PM, revealed the following interventions listed on the fall care plan were not observed: lambs wool on the resident's overbed table, no Dycem mat above the wheelchair cushion, and one non skid strip in front of the toilet with only half (1/2) of the strip attached to the floor. However, further observation of the bathroom revealed the resident had three (3) non-skid strips in front of the sink. Interview and observation of Resident #7's room, on 07/09/15 at 5:36 PM, with Certified Nurse Assistant (CNA) #4 revealed she had not observed the following care plan interventions: Dycem above the wheelchair cushion, lambs wool to the bedside table, and only one non skid strip in front of the toilet and only 1/2 attached of the strip attached to the floor. Further interview revealed she was going to put in a work order to replace the strips in the bathroom. Interview with Licensed Practical Nurse (LPN) #1, on 07/09/15 at 5:35 PM, revealed she cared for Resident #7 and after observation of Resident #7's room, the lambs wool was not in place, and	F 323	Department Head rounds are being done at least 3 times per week Monday through Friday for four weeks, at least 2 times per week for four weeks and at least once per week for two months: if a concern is identified during rounds it will be brought to the charge nurse's attention and will be addressed by nursing immediately, the concern will also be identified to the DON and/or a member of nursing administration and the administrator who will follow up to ensure the concern has been corrected. Re-education will be given by charge nurse, nursing administration and/or administrator for compliance by shift's end. Results are turned into the Administrator who is monitoring and presenting findings to the daily morning department head meeting M-F for necessary follow up and cumulatively data, tracking and trending will be presented to the monthly QA meeting. Any updates to plan will be made as deemed necessary by the QA Committee to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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F 323	Continued From page 17	F 323		

was aware there was no Dycem mat on top of the wheel chair cushion. She reported there was only one non skid fall strip in front of the toilet in the bathroom and some of the strip was sticking up from the floor, there was supposed to be more than one strip.

Interview, on 07/09/15 at 5:41 PM, with Registered Nurse (RN) #2/Unit Manager (UM) revealed Resident #7's room had only one non skid fall strip, that was half way off the floor, which should have been identified earlier and was a fall risk. In addition, she reported there was no lambs wool on the overbed table and no Dycem on the wheel chair cushion. Continued interview revealed the missing interventions were not caught on staff rounds and the care plan was not followed.

Interview, 07/10/15 at 5:47 PM, with the Director of Nursing (DON) revealed the non-skid strips in front of toilet was an intervention to prevent falls and half of a strip was not effective usually have three (3) to four (4) strips in place. The DON revealed the resident was non-compliant but was usually steady enough and potentially the non-skid strips not being in place may have been a factor in the fall but had not investigated to determine, but if she had fallen by the sink they had non-skid strips in front of the sink. The DON reported she or the usually go in after a fall and make sure interventions were in place as a double check; however, the DON was tied up with the surveyors and unable to follow the process as would typically.

Interview with the Administrator, on 07/10/15 at 7:21 PM revealed the non-skid strip intervention was not met if there was only one partial non-skid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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 323	Continued From page 18 fall strip in front of the toilet and it should have been caught and addressed. 2. Review of Resident #5's medical record revealed the facility initially admitted the resident 03/25/15 and re-admitted 05/22/15 with diagnoses which included Diabetes, Alzheimer's Disease, Anxiety Disorder, Depression, Hypertension, Fall, Debility, and Aftercare Traumatic Hip Fracture. Record review of the resident's Re-Admission Minimum Data Set (MDS), dated 05/30/15, revealed the facility's assessment triggered the Falls Care Area section related to Resident #5's impaired mobility, bowel/bladder incontinence, use of Psychotropic medication, fall history, diagnoses of Dementia, Debility, Depression, and Anxiety. Further review of the record revealed the facility developed a Potential for Fall and Related Injury Comprehensive Care Plan, dated 06/02/15, with interventions which included bed locked and in lowest position, environment free of clutter, and wheelchair sensor pressure alarm device. Review of the Incident Report dated 06/16/15 revealed Resident #5 was found on the floor out of the wheelchair. Further review of the care plan revealed, on 06/16/15, the interventions were updated which included discontinuation of the sensor pressure alarm and placement of a tab alarming device to Resident #5's wheelchair due to decreased safety awareness. Review of the Treatment Administration Record (TAR) for June 2015, revealed staff was documenting the resident had a tab alarm in place.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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F 323	Continued From page 19	F 323		

Review of the Incident Report dated 06/23/15, revealed at 10:30 PM the resident was non-compliant with the call bell, was repositioning in bed and fell from the bed. In addition, the fall care plan interventions were updated, 06/23/15, to include a tab alarm device to the bed.

Review of the Incident Report, dated 06/26/15 revealed Resident #5 was noted on floor beside the bed. It was noted the resident was attempting to reposition in bed and fell from the bed. Further review revealed the care plan was updated and a perimeter defined mattress was place. The care plan included a tab alarm to the bed at that time.

Review of the Incident Report dated 07/04/15 at 11:30 PM revealed Resident #5 was beside the bed and reported he/she slid out of the bed because he/she wanted the nurse. The note indicated the alarm was sounding at the time. Review of the care plan revealed a new intervention to move the resident closer to the nurses station and re-education was completed.

Observations, on 07/08/15 at 1:00 PM and 5:56 PM, revealed Resident #5 had a sensor pressure alarm device to the wheelchair; however, there was no observation of a tab alarm as per the care plan.

Further observations and interview, on 07/09/15 at 2:00 PM, with Certified Nurse Assistant (CNA) #6 revealed the resident had a sensor pressure alarm device to his/her wheel chair and bed, but no tab alarm to the wheel chair or the bed as per the care plan.

Interview, on 07/09/15 at 2:19 PM, with CNA #7 revealed she routinely cared for Resident #5 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 20	F 323		

was familiar with the care plan which included a tab alarm to his/her wheelchair and bed; however, the resident had sensor alarms to his/her bed and wheelchair instead of a tab alarm. CNA #7 stated the tab alarm was connected to the resident to let staff know if a resident attempted to get up and the pressure alarm was a weight sensor device. Continued interview revealed the care plan was not followed and staff checked alarms and should have noticed the sensor alarms were in place instead of the tab alarms.

Interview, on 07/09/15 at 2:51 PM, with Licensed Practical Nurse (LPN) #6 revealed Resident#5's care plan included a tab alarm device to the bed and wheelchair. LPN #6 revealed the resident currently had sensor alarms to the bed and wheel chair and they had been in place for awhile, but should have had tab alarm as care planned.

Interview, on 07/09/15 at 5:41 PM and 07/10/15 at 10:20 AM, with the Registered Nurse (RN) #2/Unit Manager (UM) revealed there was a difference between the sensor and tab alarms. The tab alarms alerted staff when a resident attempted to get up and the sensor pressure alarm alerted staff when there was no longer any pressure to the area. Further interview revealed Resident #5 was supposed to have tab alarms in place as per the care plan.

Interview, on 07/10/15 at 3:24 PM, with the Social Work Assistant revealed she was assigned to check rooms and was assigned Resident #5's room. She revealed they took the CNA care plan and checked the interventions, the alarms to the resident's wheel chair and bed were listed on the care plan. Continued interview revealed she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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F 323	Continued From page 21 knew there were alarms on the wheel chair and bed, but didn't realize the alarms were actually sensor alarms and she was checking that alarms were in place and didn't really know the difference in the two alarms. The Social Work Assistant reported the care plan said it was supposed to be tab alarms to wheel chair and bed, but they were sensor alarms and that was her error. Further interview, on 07/10/15 at 5:47 PM, with the DON revealed Resident #5's care plan was individualized based on needs and was updated when the resident had falls. The DON revealed the resident was assessed to determine which alarm was more effective and was care planned for tab alarms to the bed and wheelchair. Continued interview revealed, staff monitored the alarm interventions and the care plan was not followed if sensor alarms were in place. Continued interview, on 07/10/15 at 7:21 PM, with the Administrator revealed Department Heads were assigned to complete audits to ensure care plan interventions were in place related to falls. Per interview, they were educated about the audits but not all Department Heads had a nursing background.	F 323		
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	F 441	Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care. 1. Woodcrest Nursing and Rehabilitation established and maintains 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.	8/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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 441 Continued From page 22

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.

(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 and review of Lippincott's "Textbook for Nursing Assistants", it was determined the facility failed to have an effective system in place to monitor and/or control resident infections.

F 441

Resident #5's dentures were removed from his/her bathroom counter cleaned and placed in a denture cup by CNA #7 on 7/9/2015. The resident discharged to home on 7/28/2015.

Resident B's urinary catheter tubing and drainage bag was replaced immediately after it was discovered and drainage bag placed into a privacy bag by the charge nurse during survey. The comprehensive plan of care and CNA care plan was updated by nursing administration on 8/3/2015.

2.
Any resident with dentures or a urinary catheter is at risk for this alleged deficient practice. All residents have been reviewed for denture cups and these were placed if missing by the nursing staff on 7/13/2015. Urinary catheter drainage bags have been placed into privacy bags to ensure the spout does not become loose and touch the floor. Comprehensive Care plans and CNA care plans were updated as indicated for those residents stated above by nursing administration by 8/5/2015.

3.
Education presented by the Staff Development Coordinator on Residents Rights and infection control including catheter bags having no part touch the ground and dentures to be placed in the denture cups began on July 15, 2015 for nursing staff, also including contracted therapy, contracted housekeeping and laundry, and the department heads. Education concluded on 7/20/2015 with anyone missed ie PRN staff and newly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

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F 441 Continued From page 23

Observations revealed Resident #5's dentures laying on his/her bathroom counter and Unsampled Resident B's unsecured urinary catheter spout dragging the ground in the smoking area outside the facility.

The findings include:

Interview with the Director of Nursing (DON) on 07/09/15 at 3:35 PM revealed the facility did not have a written infection control policy. Request was made for the DON to provide the Surveyor with a copy of reference material determining how the facility monitored and/or controlled infection control but documentation was not forthcoming.

Review of the facility's resource material, "Lippincott's Textbook for Nursing Assistants", Copyright 2005, revealed the urinary catheter emptying spout needed to be secured when not in use. The rationale provided indicated bacteria could enter the closed drainage system if the spout was not closed and/or secured properly which could lead to a nosocomial urinary tract infection.

1. Review of Unsampled Resident B's medical record revealed the facility admitted him/her on 05/28/15 with diagnoses which included Neurogenic Bladder and Paraplegia.

Observation on 07/09/15 at 3:10 PM revealed Unsampled Resident B outside smoking with visitors. His/her urinary catheter emptying spout was not secured in the holder and was observed to be dragging the ground.

Interview with Certified Nurse Assistant (CNA) #9, on 07/09/15 at 3:20 PM, revealed she had not

F 441

hired will have the education before working in the building. In addition education will be provided on the privacy catheter bags to assist with infection and placement of dentures into denture cups when removed from resident's mouth ongoing by the SDC and/or nursing administration and charge nurses.

Urinary catheter cover bags were ordered all all catheter bags were placed inside of the cover bags on 7/31/2015 by nursing staff so that the catheter bag cannot touch the ground and all in house residents received denture cups if they did not have them. These will be placed as intervention on the aide care plan and comprehensive care plan by nursing staff and/or nursing administration ongoing.

4.
Nursing administration, and licensed nurses are doing rounds as a part of their everyday activity.

Department Head rounds are being done at least 3 times per week Monday through Friday for two weeks, at least 2 times per week for two weeks and at least once per week for two weeks: if a concern is identified during rounds it will be brought to the charge nurse's attention and will be addressed by nursing immediately, the concern will also be identified to the DON and/or a member of nursing administration and the administrator who will follow up to ensure the concern has been corrected. Re-education will be given by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 24	F 441	charge nurse, nursing administration and/or administrator for compliance by shift's end. Results are turned into the Administrator who is monitoring and presenting findings to the daily morning department head meeting M-F for necessary follow up and cumulatively data, tracking and trending will be presented to the monthly QA meeting. Any updates to plan will be made as deemed necessary by the QA Committee to ensure compliance.	

been aware the spout was not secured. She continued by stating it was an infection control issue if the spout was not secured properly because germs could cause an infection.

Interview with Licensed Practical Nurse (LPN) #7, on 07/09/15 at 3:30 PM, revealed it was her expectation the CNA should have ensured the spout was secured R/T infection control concerns.

Interview with the Director of Nursing DON on 07/09/15 at 3:35 PM revealed it was her expectation for staff to ensure residents did not encounter infection control concerns.

2. Review of Resident #5's medical record revealed the facility initially admitted the resident 03/25/15 and re-admitted 05/22/15 with diagnoses which included Diabetes, Alzheimer's Disease, Anxiety Disorder, Depression, Hypertension, Fall, Debility, and Aftercare Traumatic Hip Fracture. Review of the annual Minimum Data Set, 05/30/15, Care Area Trigger Worksheet: Dental Care the resident had no natural teeth and wore dentures.

Observation with and interview with Certified Nursing Assistant (CNA) #7, on 07/09/15 at 2:19 PM, revealed one of Resident #5's denture plates was on the bathroom sink counter and not in a denture cup. CNA #7 revealed the dentures on the bathroom counter were supposed to be in a denture cup when not in use and it was not sanitary to leave them on the counter.

Further interview, on 07/10/15 at 8:36 AM, with CNA #7 revealed there was not a denture cup in the bathroom yesterday and she forgot to get one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

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STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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F 441	Continued From page 25 but she was going to get one now. The CNA reported leaving the dentures on the sink counter was an infection control concern due to germs. Interview, on 07/09/15 at 6:45 PM, with CNA #8 revealed she cared for Resident #5 on evening shift and worked last night. The CNA revealed she had cleaned the resident's dentures at night and put them in a denture cup. However, observation revealed there was no denture cup in the resident's room or bathroom. Interview, on 07/09/15 at 2:51 PM, with Licensed Practical Nurse (LPN) #6 revealed dentures were supposed to be stored in a denture cup and it was an infection control issue if the dentures were on the bathroom sink counter. Interview, on 07/10/15 at 5:47 PM, with the DON/Infection Control Nurse (ICN) revealed bathrooms were not the cleanest place in a resident's room. She reported if Resident #5's dentures were not in his/her mouth they were supposed to be stored in a denture cup. The DON/ICN revealed if the dentures were on the sink counter there was a risk of cross contamination because the sink counter was not sanitary.	F 441		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care. 1. Woodcrest Nursing and Rehabilitation is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable	8/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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F 490 Continued From page 26

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's Plan of Correction (POC) for 04/01/15 and 05/14/15 surveys, it was determined the facility's Administration failed to ensure the facility achieved substantial compliance on 06/18/15, as alleged in the facility's POC.

Observation, interview and record review identified continued non-compliance at 42 CFR 483.20, Resident Assessment, F282; 42 CFR 483.25 Quality of Care, F323; and, 42 CFR 483.75, Administration, F514. This failure affected two (2) of eight (8) sampled residents (Residents #5 and #7).

(Refer to F282, F323, and F514).

The findings include:

Interview, on 07/09/15 at 10:15 AM, with the Director of Nursing (DON) revealed the POC was a collaborative effort involving her and the Administrator.

1. Review of the facility's POC, dated and signed by the Administrator on 06/17/15, with an alleged compliance date 06/18/15, revealed the Director of Nursing (DON) and Nursing Administrators provided re-education on care plan interventions being followed to all nursing staff. The POC also included the DON, Unit Manager, and/or Staff Development Coordinator monitoring care plan interventions by observation and use of the aide Care Plan. In addition, the POC noted any discrepancies in the daily room round

F 490 physical, mental and psychosocial well-being of each resident.

Resident # 7's Lamb's wool was replaced on his/her bedside table, the 3 non-skid strips were replaced in front of the toilet and dycem replaced above the wheelchair cushion by LPN #1 on 7/10/2015.

Resident # 5's Care Plans were changed from tab alarms to a more appropriate for him/her sensor alarms. The comprehensive care plan and CNA care plan were updated as indicated by the Staff Development Coordinator on 7/9/2015.

2.
All residents are at risk for the alleged deficient practice. All residents will have fall prevention interventions reviewed by the Interdisciplinary Team (IDT) which includes unit managers, therapy director, Director of Nursing and social services with an audit to ensure interventions are in place and congruent with the comprehensive care plan and CNA care plan and completed by 8/5/2015.

In addition, the IDT will review and update Comprehensive Care Plans as indicated to more appropriate interventions for fall prevention related to floor strips, tab or sensor alarms, dycem to wheelchair pads and/or lamb's wool and completed by 8/5/2015.

3.
The administrator re-educated those individuals doing rounds on 7/20/2015 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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 490 Continued From page 27

observations and Comprehensive Care Plan interventions were to be reviewed during the daily Interdisciplinary Team's (IDT) Morning Meeting: 5% of the Comprehensive Care Plans were to be spot checked at biweekly intervals for one (1) month and then checked monthly thereafter. Results of the monitoring would be presented to the Quality Assurance Committee, which includes the Administrator. (Refer to F282)

Interview, on 07/10/15 at 7:21 PM, with the Administrator revealed the facility had a system in place to ensure care plan interventions were followed. The Administrator revealed they did daily rounds, predominately by Department Heads, to ensure interventions were in place. The Administrator reported staff was trained to use the aide Care Plans to ensure the interventions listed were observed in place and if any concerns were identified they were given to DON to follow-up. Staff interviews confirmed they had received education related to monitoring duties as per the POC.

However, observation, interview and record review revealed care plan interventions were not being implemented. Review of Resident #7's Comprehensive Care Plan on fall prevention revealed interventions of Lambs Wool to the bedside table, non-skid strips to the floor in front of the toilet, and a Dycem non-slip mat placed above and below the wheelchair cushion. However, observation revealed no Lambs Wool on the bedside table, only one-half of a non-skid strip on the floor in front of the toilet, and no Dycem non-slip mat placed on top of the wheelchair cushion.

Interview, on 07/10/15 at 2:43 PM with the

F 490

added steps of memos to unit managers and Director of Nursing on a daily basis Monday through Friday consolidating the findings for follow up by the unit managers. The unit managers turn their memo back to the administrator indicating items that have been addressed.

Another re-education was presented on 8/3/2015 this was reinforced through education presented by the Director of Nursing in the Department Head meeting on 8/5/2015.

Education presented by the Staff Development Coordinator began on 07/15/2015 for nursing staff concerning following the Comprehensive care plans and/or CNA care plans to include having the appropriate assistance devices. Education continued until 7/20/2015. Anyone missed ie PRN staff and newly hired will have the education before working in the building.

In addition, education will be given during orientation and as indicated for compliance ongoing by the SDC and/or nursing administration. Education was provided to the Department Heads by the SDC and Administrator on 8/3/2015 to review CNA care plans and what to look for on rounds.

The CNA care plan is an extension of the comprehensive care plan and will match it for a communication reference tool for each resident they care for on assignment. It includes safety devices, etc to provide care for the resident. The CNA care plan and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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F 490	Continued From page 28 Marketing Director revealed, as part of the facility's POC she was assigned specific rooms, including Resident #7's room, to ensure care plan interventions were in place. She revealed she were educated on what to look at, how to read the care plan, and understanding what was on the care plan. The Marketing Director revealed she rounded daily using the aide care plan sheets to observe and make sure resident interventions were in place. She revealed they had a meeting at the end of the day and turned in the rounding sheets with any identified concerns noted and she had turned these in to the DON and Administrator. The Marketing Director reported she rounded and had identified the lambs wool intervention was continually not in place. Interview with the DON, on 07/10/15 at 5:47 PM, revealed she thought the lambs wool was supposed to be discontinued and should have followed up to ensure the intervention was removed from the care plan. Continued interview with the Marketing Director revealed she noticed there was only a partial non skid strip in front of the toilet, but she went by the the care plan when completing her monitoring and the number of strips was not listed on the care plan. Resident #5's Comprehensive Care Plan on fall prevention included interventions of tab alarming devices to the resident's bed and wheelchair. However, observations revealed the alarming devices in place on both the wheelchair and bed were sensor alarm devices, not tab alarms. Interview, on 07/10/15 at 3:24 PM, with the Social Work Assistant revealed as part of the POC she	F 490	comprehensive care plan will be updated with changes as they occur by the nursing supervisor, charge nurse, nursing administration and/or the IDT while at work, what safety items need to be in place and better assure the appropriate assistance devices are in place ongoing. Compliance concerns will be documented during rounds. They are evaluated during the Quality Assurance process as evaluation of compliance and need for further Training. Concerns will be documented during rounds and then presented to QA for evaluation of compliance and need for further training. 4. Room rounds are being conducted starting on 7/13/2015 by department heads, to review presence of safety equipment to include appropriate assistance devices per the comprehensive care plan and CNA care plan and to ensure both are congruent. Nursing administration, and licensed nurses are doing rounds as a part of their everyday activity. Department Head rounds are being done at least 3 times per week Monday through Friday for four weeks, at least 2 times per week for four weeks and at least once per week for two months; if a concern is identified during rounds it will be brought to the charge nurse's attention and will be addressed by nursing immediately, the concern will also be identified to the DON and/or a member of nursing administration and the administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

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F 490	Continued From page 29 was assigned to check rooms daily and was assigned Resident #5's room. She revealed they took the CNA care plan and checked to ensure the listed interventions were in place. She reported Resident #5 had alarms to the resident's wheel chair and bed listed on the care plan. Continued interview revealed she observed there were alarms on the wheel chair and bed, but failed to recognize the type of alarms. The Social Work Assistant reported the care plan said there was supposed to be tab alarms to wheel chair and bed, but they were sensor alarms, it was her error in not identifying the discrepancy. Interview, on 07/10/15 at 7:21 PM, with the Administrator revealed staff, who rounded, were trained to use the aide Care Plans to ensure interventions listed were in place and any concerns with interventions were given to DON to follow-up. However, the Administrator acknowledged not all Department Heads had nursing backgrounds, but they were educated on the different interventions. 2. Review of the facility's POC, with a compliance date 06/18/15, revealed education was provided to the Director of Nursing and Assistant Administrator by the Regional Quality Manager, Registered Nurse (RN) consultant and the Regional Director of Operations regarding staff following care plan as related to accidents and incidents. POC review revealed Nursing Administration continued to track incidents and investigated any indication the plan of care was not followed and implemented immediate action. POC review revealed the DON or Nursing Administration on-call, during the weekend, was to respond immediately to incidents/accidents and ensure the care plan was followed.	F 490	who will follow up to ensure the concern has been corrected. Re-education will be given by charge nurse, nursing administration and/or administrator for compliance by shift's end. Results are turned into the Administrator who is monitoring and presenting findings to the daily morning department head meeting M-F for necessary follow up and cumulatively data, tracking and trending will be presented to the monthly QA meeting. Any updates to plan will be made as deemed necessary by the QA Committee to ensure compliance.	

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	185445		R-C 07/10/2015

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F 490	Continued From page 30 Additional POC review revealed audit of incidents/accidents for following the Plan of Care were done daily in the Interdisciplinary Team Meeting (IDT). (Refer to F323) Interview with the DON on 07/09/15 at 10:15 AM, during the POC review, revealed the facility did not have documented evidence the education occurred. Review of the facility's "Fall Assessment/Intervention Process", undated revealed per F323 the facility must ensure each resident received adequate supervision and assistance devices to prevent accidents. Observation, on 07/09/15, of Resident #7's room revealed fall prevention care plan interventions of a Dycem mat above the wheelchair cushion, lambs wool attached to the overbed table, and fall non-skid strips in front of the toilet were not in place. Record review revealed the resident had two (2) fall incidents on 07/08/15. In addition, observation revealed Resident #5 had a pressure alarm in place to the wheel chair and bed; however, the care plan indicated the resident was to have a tab alarm to the wheel chair and the bed. Resident #5 experienced a fall on 06/16/15 from the wheel chair and on 06/23/15, 06/26/15 and 07/04/15 experienced falls from the bed. Interview, on 07/09/15 at 5:41 PM, with Registered Nurse (RN) #2/Unit Manager (UM) revealed the missing interventions were not caught on staff daily rounds, but were important intervention to help prevent accidents or injury for Resident #7. Continued interview, 07/10/15 at 5:47 PM, with	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

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F 490	Continued From page 31	F 490		

the DON revealed she or the Unit Managers usually made sure interventions were in place as a double check after a fall; however, the DON revealed she was tied up with the surveyors and unable to follow the process as would typically occur.

Continued interview, on 07/10/15 at 7:21 PM, with the Administrator revealed the facility had a system in place to ensure care plan interventions were followed for falls risk residents to reduce the risk for accidents or injuries related to falls. The Administrator revealed they did daily rounds, performed predominately by Department Heads, to ensure care plan interventions were in place. The Administrator reported staff was trained to use the CNA care plans and observed the interventions listed on the plan were in place and if there were any concerns with interventions they were given to DON to follow-up who would bring to the QA meeting for review.

3. Review of the POC, with a compliance date 05/14/15, revealed the Director of Nursing (DON) and Unit Managers (UM) reviewed all orders for accuracy. POC review revealed education was provided to licensed personnel by the DON and Staff Development Coordinator which included the posting of orders, the writing of Physician orders, and the monthly change over process to ensure complete and accurate medical records. Further POC review revealed any deviation was addressed by the Director of Nursing and brought to the Quality Assurance meeting. (Refer to F514)

Interview with the Administrator, 07/10/15 at 7:21 PM, revealed the accuracy of medical record documentation was always emphasized by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

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F 490	Continued From page 32 facility.	F 490		

Interview with the Director of Nursing (DON) revealed the facility process was to have Physician orders for alarms in order to ensure placement on the TAR and nurses were suppose to monitor that the alarms were in place and document on the TAR.

However, review of Resident #5's June 2015 TAR revealed documentation of a tab alarm to the bed initialed by staff, daily on the 11:00 PM - 7:00 AM shift; however, there was no Physician's order and observations revealed a pressure alarm instead of a tab alarm. Further record review revealed at monthly change over (June to July) staff again failed to obtain a Physician's order for the tab alarm and had not included the device on the July 2015 TAR. In addition, review of Physician orders revealed a tab alarm was to be placed on the resident when up in the wheelchair. Review of the June/July 2015 TAR revealed staff initialed they had checked placement and function of the tab alarm to Resident #5's wheel chair; however, Resident #5 had a pressure alarm to the wheel chair.

Interview, on 07/10/15 at 5:47 PM, with the DON revealed the issue should have been identified during the June 2015 to July 2015 change over process when staff noticed the hand written bed tab alarm intervention. Per interview, staff should have obtained the order and placed the intervention on the July 2015 TAR. Continued interview revealed there was another issue with documentation as staff continued to document on the TAR the wheelchair tab alarm placement but the resident had a pressure alarm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 490	Continued From page 33	F 490		

Continued interview, on 07/10/15 at 7:21 PM, with the Administrator revealed staff compared Physician orders and the MAR/TAR to ensure they were correct/accurate at the monthly change over and the bed alarm should have been identified and carried over onto July 2015 orders and TAR. He state this should have been discovered during our Quality Assurance monitoring.

Observation of Resident #7's room revealed no lambs wool to the resident's overbed table and only one partial non-skid strip to the bathroom floor in front of the toilet. Interview with staff revealed the lambs wool intervention had not been in place for awhile and when non-skid strips were ordered they usually placed three (3) to four (4) strips and were difficult to remove. Review of Resident #7's medical record revealed staff had initialed on the July 2015 TAR the lambs wool and non-skid strips were in place.

Interview, on 07/10/15 at 2:43 PM with the Marketing Director revealed as part of the facility's plan to ensure care plan interventions were in place she was assigned specific rooms, including Resident #7's room, and rounded daily to inspect. She revealed she had identified the lambs wool intervention was continually not in place and she notified the DON as instructed. She stated there was only a partial non-skid strip in front of the toilet currently and she was not aware how many strips were supposed to be in place per the care plan.

Interview, 07/10/15 at 5:47 PM, with the DON revealed nurses should have checked to make sure the lambs wool was in place prior to initialing on the TAR. She further stated the Marketing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015
NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	

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F 490	Continued From page 34 Director informed her the lambs wool was not in place and she thought the intervention had been discontinued. She stated she should have gone to the record to clarify the order with the care plan. She reported the non-skid strips in front of the toilet were checked nightly by the nurse and half a strip was not an effective to prevent falls, there were usually three (3)/four (4) strips. Further interview, on 07/10/15 at 7:21 PM, with the Administrator revealed staff should have ensured devices were in place at the time they documented on the intervention.	F 490	Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.	
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: Based on observation, interview, record review it was determined the facility failed to ensure staff accurately documented on clinical records for two	F 514	1. Woodcrest Nursing and Rehabilitation maintains 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 contains 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. Resident # 7's Lamb's wool was replaced on his/her bedside table, the 3 non-skid strips were replaced in front of the toilet and dycem replaced above the wheelchair cushion by LPN #1 on 7/10/2015. Resident # 5's Care Plans were changed from tab alarms to a more appropriate for him/her sensor alarms. The comprehensive care plan	8/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

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F 514 Continued From page 35

(2) of eight (8) sampled residents (Resident #5 and Resident #7).

Observation of Resident #5's bed and wheel chair revealed sensor alarm devices in place. Interview with staff revealed the resident had sensor alarm devices to the bed and wheelchair and not tab alarms. However, review of the resident's Treatment Administration Record (TAR) revealed initials by staff that the resident had tab alarms in place to the wheel chair.

Interview with the Director of Nursing (DON) revealed the facility process was to have Physician orders for alarms in order to ensure placement on the TAR and nurses were suppose to monitor that the alarms were in place and document on the TAR.

Review of Resident #5's June 2015 TAR revealed documentation of a tab alarm to the bed initialed by staff, daily on the 11:00 PM - 7:00 AM shift; however, there was no Physician's order. Further record review revealed at monthly change over (June to July) staff again failed to obtain a Physician's order for the tab alarm and had not included the device on the July 2015 TAR. In addition, review of Physician orders revealed a tab alarm was to be placed on the resident when up in the wheelchair. Review of the June/July 2015 TAR revealed staff initialed they had checked placement and function of the tab alarm to Resident #5's wheel chair; however, Resident #5 had a pressure alarm to the wheel chair.

Observation of Resident #7's room revealed no lambs wool to the resident's overbed table and only one partial non-skid strip to the bathroom floor in front of the toilet. Interview with staff

F 514 and CNA care plan were updated as indicated by the Staff Development Coordinator on 7/9/2015.

2.
All residents are at risk for the alleged deficient practice. All residents will have fall prevention interventions reviewed by the Interdisciplinary Team (IDT) which includes unit managers, therapy director, Director of Nursing and social services with an audit to ensure interventions are in place and congruent with the comprehensive care plan and CNA care plan and completed by 8/5/2015.

In addition, the IDT will review and update Comprehensive Care Plans as indicated to more appropriate interventions for fall prevention related to floor strips, tab or sensor alarms, dycem to wheelchair pads and/or lamb's wool and completed by 8/5/2015.

3.
Education presented by the Staff Development Coordinator began on 07/15/2015 for nursing staff concerning following their care plans and/or aide care plans to include having the appropriate assistance devices. Education continued until 7/20/2015. Anyone missed ie PRN staff and newly hired will have the education before working in the building.

Education will be given during orientation and as indicated for compliance ongoing by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

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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

F 514 Continued From page 36

revealed the lambs wool intervention had not been in place for awhile and when non-skid strips were ordered they usually placed three (3) to four (4) strips and were difficult to remove. Review of Resident #7's medical record revealed staff had initialed on the July 2015 TAR the lambs wool and non-skid strips were in place.

The findings include:

Interview with the Administrator, 07/10/15 at 7:21 PM, revealed accuracy of medical record documentation was always emphasized.

1. Review of Resident #5's medical record revealed the facility initially admitted the resident 03/25/15 and re-admitted 05/22/15 with diagnoses which included Diabetes, Alzheimer's Disease, Anxiety Disorder, Depression, Hypertension, Fall, Debility, and Aftercare Traumatic Hip Fracture. Review of the Physician Orders revealed an order, dated 06/23/15, to place a tab alarm to the resident when up in the wheelchair related to decreased safety awareness and check placement and function each shift. Further review of the Physician Orders revealed no order to place a tab alarm to the resident when in bed.

Continued record review of the June 2015 and July 2015 TARs revealed the staff initialed, each shift, placement and function of the wheel chair tab alarm were checked. In addition, the June TAR had documentation a tab alarm was placed to the bed related to decreased safety awareness with placement checked on the 11:00 PM to 7:00 AM shift, and initialed by staff indicating the alarm was checked. Further record review revealed the Tab alarm monitor intervention for the bed was

F 514 SDC and/or nursing administration. Education was provided to the Department Heads by the SDC and Administrator on 7/20/2015 and 8/3/2015 concerning review of CNA care plans and what to look for on rounds.

The CNA care plan is an extension of the comprehensive care plan and will match it for a communication reference tool for each resident they care for on assignment. It includes safety devices, etc to provide care for the resident. The CNA care plan and the comprehensive care plan will be updated with changes as they occur by the nursing supervisor, charge nurse, nursing administration and/or the IDT while at work, what safety items need to be in place and better assure the appropriate assistance devices are in place ongoing.

The treatment Administration Record is no longer being used as a sign off tool for care plan interventions.

4.
Room rounds are being conducted starting on 7/13/2015 by department heads, to review presence of safety equipment to include appropriate assistance devices per the comprehensive care plan and CNA care plan and to ensure both are congruent.

Nursing administration, and licensed nurses are doing rounds as a part of their everyday activity.

Department Head rounds are being done at least 3 times per week Monday through Friday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015
NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	

(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 514	Continued From page 37 not placed on the July TAR. Observations, on 07/08/15 at 1:00 PM and 5:56 PM, revealed Resident #5 had a sensor pressure alarm device to the wheelchair. Further observations and interview, on 07/09/15 at 2:00 PM, with Certified Nurse Assistant (CNA) #6 revealed the resident had a sensor pressure alarm device to his/her wheel chair and bed, not a tab alarm. Interview, on 07/09/15 at 2:19 PM, with CNA # 7, who routinely cared for for Resident #5, revealed the resident had sensor alarms to his/her bed and wheelchair not tab alarms. Continued interview revealed staff checked alarms and should have noticed they were sensor alarms. Interview, on 07/09/15 at 6:56 PM, with CNA #8 revealed the resident had sensor alarms to the wheelchair and bed and the devices were in place for awhile. Interview, on 07/09/15 at 2:51 PM, with Licensed Practical Nurse (LPN) #6 revealed alarms were Physician ordered and were on the TAR to be checked by nurses and initialed. Further interview revealed the July 2015 TAR had a tab alarm to the wheelchair and staff initialed they had checked this tab alarm on the TAR; however, the resident had a pressure alarm in place. Interview, on 07/09/15 at 6:45 PM, with LPN #3 revealed Resident #5's July 2015 TAR had a tab alarm to the wheel chair and there should have been a tab alarm and not sensor alarm. Interview, on 07/09/15 at 3:35 PM and on 07/10/15 at 5:47 PM, with the DON revealed	F 514	for four weeks, at least 2 times per week for four weeks and at least once per week for two months: if a concern is identified during rounds it will be brought to the charge nurse's attention and will be addressed by nursing immediately, the concern will also be identified to the DON and/or a member of nursing administration and the administrator who will follow up to ensure the concern has been corrected. Re-education will be given by charge nurse, nursing administration and/or administrator for compliance by shift's end. Results are turned into the Administrator who is monitoring and presenting findings to the daily morning department head meeting M-F for necessary follow up and cumulatively data, tracking and trending will be presented to the monthly QA meeting. Any updates to plan will be made as deemed necessary by the QA Committee to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 38 alarms were Physician ordered to ensure placement on the TAR and nurses were suppose to monitor that the alarms were in place and document. The DON revealed the nurse put a tab alarm on the TAR and failed to get an order or place the tab alarm on the resident's bed and staff were documenting that the tab alarm was being checked and in place on the June 2015 TAR. She reported during monthly change over they checked the current monthly Physician orders to the prior MAR /TAR and verified orders were captured. The DON further reported staff should have caught at change over the bed tab alarm was on the June 2015 TAR and obtained a Physician's order. Continued interview revealed there was another issue with documentation as staff documented on the TAR Resident #5 had a tag alarm in place to the wheelchair, but the resident had a pressure alarm. Interview, on 07/10/15 at 7:21 PM, with the Administrator revealed staff compared MAR/TAR entries to the Physician orders to ensure they were correct/accurate at the monthly change over. Per interview, the bed alarm should have been identified and carried over onto July 2015 orders and TAR and if they were accurately comparing, they would have caught that there was no order. 2. Review of Resident #7's medical record revealed the facility initially admitted the resident 08/20/13 and re-admitted 03/20/14 with diagnoses which included Cirrhosis of the Liver (Liver disease), Hypertension, Confusion, Dementia, Depressive Disorder, Debility, Diabetes, and History of Fractures: Right Wrist/Left Humerus.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3676 TURKEYFOOT ROAD, ELSMERE, KY 41018

(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 514	Continued From page 39	F 514		

Review of the July 2015 monthly Physician's orders revealed an order to place lambs wool to the bedside table with placement checked by staff each shift and an order to place non-skid strips to the floor in front of the toilet with staff checking place daily 11:00 PM to 7:00 AM.

Record review of the July 2015 TAR revealed staff had monitored/initialed the lambs wool intervention was in place on each shift and the night shift nursing staff had monitored/initialed non-skid strips were in front of the toilet.

However, observation of Resident #7's room, on 07/09/15 at 5:21 PM, revealed no lambs wool on the resident's overbed table, and one non-skid strip in front of the toilet with only 1/2 of the strip attached to the floor.

Interview and observation of Resident #7's room, on 07/09/15 at 5:36 PM, with CNA #4 revealed there was no lambs wool to the overbed table, and there was only one non skid strips in front of the toilet with only 1/2 attached to the floor. Further interview revealed she had not seen lambs wool to the table in awhile and thought it was an old order, and the non-skid strip in front of the toilet needed to be replaced.

Interview, on 07/10/15 at 6:50 PM, with CNA #10 revealed she routinely took care of Resident #7 and had not seen the lambs wool to the overbed table and was told by a nurse it was discontinued. Further interview revealed she worked 07/08/15 and there were non-skid fall strips in front of the toilet, probably three (3) strips, and if only one half of a fall strip was observed in place it was not an effective intervention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

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F 514	Continued From page 40 Interview with Licensed Practical Nurse (LPN) #1, on 07/09/15 at 5:35 PM, revealed interventions were checked daily. However, after observation of Resident #7's room, the lambs wool was not in place and there was only one non-skid fall strip in front of the toilet in the bathroom. Per interview, there was supposed to be more than one non-skid strip. Telephone interview, on 07/10/15 at 6:40 PM, with LPN #9 revealed she worked night shift and checked to ensure interventions were in place. She reported she had been taking care of Resident #7 and the lambs wool was in place last time she checked, but was not sure if the resident had non-skid strips in front of the toilet. Interview, on 07/10/15 at 2:43 PM with the Marketing Director revealed she was assigned specific rooms, including Resident #7's room, and rounded daily to inspect. She revealed she had identified the lambs wool intervention was continually not in place and she notified the DON as instructed. She stated there was only a partial non-skid strip in front of the toilet currently. Continued interview revealed, last week there was one full strip and a partial strip in place in front of the toilet and she was not aware how many strips were supposed to be in place per the care plan. Interview, 07/10/15 at 5:47 PM, with the DON revealed the lambs wool was probably not on the overbed table because the intervention was supposed to be discontinued. However, review of the Physician's orders revealed there was an order for the lambs wool. She stated nurses should have checked to make sure the lambs wool was in place prior to initialing on the TAR.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

(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 514 Continued From page 41

She reported the non-skid strips in front of the toilet were difficult to remove, and were supposed to be checked nightly by the nurse. She also reported half of a strip was not an effective to prevent falls and there were usually three (3) to four (4) strips in place.

Further interview, on 07/10/15 at 7:21 PM, with the Administrator revealed staff should have ensured devices were in place at the time they documented on the intervention.

F 520 483.75(o)(1) QAA
SS=D COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

F 514

Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.

F 520 1.

Woodcrest Nursing and Rehabilitation maintains a quality assessment and assurance committee consisting of the Director of Nursing; a physician and at least 3 other members of the facility staff. 8/6/2015

Resident # 7's Lamb's wool was replaced on his/her bedside table, the 3 non-skid strips were replaced in front of the toilet and dycem replaced above the wheelchair cushion by LPN #1 on 7/10/2015.

Resident # 5's Care Plans were changed from tab alarms to a more appropriate for him/her sensor alarms. The comprehensive care plan and CNA care plan were updated as indicated by the Staff Development Coordinator on 7/9/2015.

2.
All residents are at risk for the alleged deficient practice. All residents will have fall prevention interventions reviewed by the Interdisciplinary Team (IDT) which includes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015
NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	

(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 520 Continued From page 42

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's Plan of Correction (POC) for 04/01/15 and 05/14/15 surveys, it was determined the facility's Quality Assurance committee failed to ensure implementation of appropriate action plan to correct identified quality deficiencies to achieve and maintain compliance on 06/18/15, as alleged in the facility's POC.

Observation, interview and record review identified continued non-compliance at 42 CFR 483.20, Resident Assessment, F282; 42 CFR 483.25 Quality of Care, F323; and, 42 CFR 483.75, Administration, F514. This failure affected two (2) of eight (8) sampled residents (Residents #5 and #7).

(Refer to F282, F323, and F514).

The findings include:

Interview, on 07/09/15 at 10:15 AM, with the Director of Nursing (DON) revealed the POC was a collaborative effort involving her and the Administrator.

1. Review of the facility's POC, compliance date 06/18/15, revealed the DON, Unit Manager, and/or Staff Development Coordinator monitored care plan interventions by observation and use of the aide Care Plan. In addition, the POC noted any discrepancies in the daily room round observations and Comprehensive Care Plan interventions were to be reviewed during the daily

F 520 unit managers, therapy director, Director of Nursing and social services with an audit to ensure interventions are in place and congruent with the comprehensive care plan and CNA care plan and completed by 8/5/2015.

In addition, the IDT will review and update Comprehensive Care Plans as indicated to more appropriate interventions for fall prevention related to floor strips, tab or sensor alarms, dycem to wheelchair pads and/or lamb's wool and completed by 8/5/2015.

3.
The administrator re-educated those individuals doing rounds on 7/20/2015 and added steps of memos to unit managers and Director of Nursing on a daily basis Monday through Friday consolidating the findings for follow up by the unit managers. The unit managers turn their memo back to the administrator indicating items that have been addressed.

Education presented by the Staff Development Coordinator began on 07/15/2015 for nursing staff concerning following their care plans and/or aide care plans to include having the appropriate assistance devices. Education continued until 7/20/2015. Anyone missed ie PRN staff and newly hired will have the education before working in the building.

Education will be given during orientation and as indicated for compliance ongoing by the SDC and/or nursing administration. Education

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

(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 520 Continued From page 43

Interdisciplinary Team's (IDT) Morning Meeting: 5% of the Comprehensive Care Plans were to be spot checked at biweekly intervals for one (1) month and then checked monthly thereafter. (Refer to F282)

Interview, on 07/10/15 at 7:21 PM, with the Administrator revealed the facility had a system in place to ensure care plan interventions were followed. The Administrator revealed they did daily rounds, predominately by Department Heads, to ensure interventions on the care plans were in place.

Record review revealed Resident #7's fall prevention Care Plan included interventions of Lambs Wool to the bedside table, non-skid strips to the floor in front of the toilet, and a Dycem non-slip mat placed above and below the wheelchair cushion. Observation of Resident #7's room, on 07/09/15 at 5:21 PM, revealed no lambs wool on the resident's overbed table, no Dycem mat above the wheelchair cushion, and one (1) partially attached non skid strip in front.

Interview, on 07/10/15 at 2:43 PM with the Marketing Director revealed, as part of the facility's POC, she was assigned specific rooms, to ensure care plan interventions were in place. The Marketing Director revealed she rounded daily with the aide care plan sheets to make sure resident interventions were in place and at days end, they met and turned in the rounding sheets with noted concerns. The Marketing Director reported the Dycem was on top of the resident's wheel chair cushion when she had rounded but had identified the lambs wool intervention was continually not in place. She stated she made the DON aware.

F 520 was provided to the Department Heads by the SDC and Administrator on 7/20/2015 and 8/3/2015 concerning review of CNA care plans and what to look for on rounds.

4.
Room rounds are being conducted starting on 7/13/2015 by department directors to review presence of safety equipment to include appropriate assistance devices per the comprehensive care plan and aide care plan and to ensure both are congruent as well by nursing administration, licensed nurses and department heads. Department Head rounds are being done at least 3 times per week Monday through Friday for four weeks, at least 2 times per week for four weeks and at least once per week for two months.

The Quality Assurance Committee offered a change in the Department head Rounds which began on 8/3/2015.

Results are turned into the Administrator, up to that time, the Administrator had given results to the DON for review, tracking, presenting to QA and making the necessary changes to the Care plans so that the Comprehensive care plan and the CNA care plan matched. The Administrator is now sending a memo to the unit managers with copy to the DON, consolidating noted issues found during the rounds. This memo is to be returned to the administrator signed by the unit manager and checked off on the memo, items they have addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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 520 Continued From page 44

Interview, 07/10/15 at 5:47 PM, with the DON revealed she thought the lambs wool had been discontinued and she should have gone to the record and clarified the order and corrected the care plan.

Continued interview, on 07/10/15 at 2:43 PM with the Marketing Director, who was a member of the Quality Assurance (QA) Committee, revealed she noticed there was only one (1) partially attached non-skid strip in front of the toilet and last week there was one full strip and the partial one, but she just went by the the care plan and was not aware how many strips were supposed to be in place per the care plan so she did not report this or note it on the monitoring sheet.

Record review of Resident #5's medical record revealed a fall care plan which included updated interventions of a tab alarm to the resident's wheelchair and bed instead of the observed sensor/pressure alarm.

Interview, on 07/10/15 at 3:24 PM, with the Social Work Assistant revealed she was assigned to check rooms, daily, as part of the POC and was assigned Resident #5's room. She revealed the aide care plan was used to check the interventions. Continued interview revealed she observed alarms on the wheel chair and bed. The Social Work Assistant reported the care plan said there was supposed to be tab alarms to wheel chair and bed, but she observed sensor alarms. She stated it was her error not to note the discrepancy in the observed alarms.

Interview, on 07/10/15 at 7:21 PM, with the Administrator, who was the Director of the QA

F 520 Call lights are included in the rounds.

Treatment Administration Records (TARs) are no longer used as a care plan tool by licensed nurses to document care plan interventions. The Administrator will monitor compliance of documented rounds by department heads and present findings to the daily morning department head meeting M-F for necessary follow up and cumulatively data, tracking and trending will be presented to the monthly QA meeting.to ensure substantial compliance. Any updates to plan will be made as deemed necessary by the QA Committee to ensure compliance specifically with call lights, safety equipment in the room or on the resident,.

The administrator will monitor and present to the Monthly QA to include substantial compliance of the noted deficiencies from the 7/10/2015 completed survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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 520	Continued From page 45 Committee, revealed they did daily rounds, predominately by Department Heads, to ensure interventions on the comprehensive care plans were in place. The Administrator reported staff were trained to use the aide care plans to ensure listed interventions were in place and any concerns were given to the DON to follow-up. However, the Administrator acknowledged not all Department Heads had nursing backgrounds, but were educated on the care plan interventions. He stated the monitoring staff was reporting to the DON and the DON brought the information to the Quality Assurance Meeting. However, the identified issues with care plan intervention implementation was not identified through the QA process. 2. Review of the facility's POC, with a compliance date of 06/18/15, revealed education was provided to the DON and Assistant Administrator by the Regional Quality Manager (RQM), Registered Nurse (RN) consultant and the Regional Director of Operations regarding staff following the plan of care as related to interventions to prevent falls or accidents. POC review revealed Nursing Administration continued to track incidents and investigated any indication the plan of care was not followed and implemented with immediate action after falls or accidents. POC review revealed the DON or Nursing Administration on-call during the weekend was to respond immediately to incidents/accidents to ensure the plan of care was followed. Additional POC review revealed audits of incidents/accidents for following the Plan of Care were done daily in the IDT. (Refer to F323) Record review of Resident #7's medical record	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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 520	Continued From page 46 revealed a fall care plan with interventions that included placement of lambs wool to the bedside table, non-skid strips to the floor in front of the toilet, and Dycem mat above and below the wheel chair cushion. However, observation of Resident #7's room, on 07/09/15 at 5:21 PM, revealed the following interventions listed on the fall care plan were not observed: no lambs wool on the resident's overbed table, no Dycem mat above the wheelchair cushion, and there was one partially attached non skid strip in front of the toilet. Record review of the facility's incident reports revealed Resident #7 had two non-witnessed fall in his/her room on 07/08/15 at 4:46 PM and at 10:10 PM. Interview, 07/10/15 at 5:47 PM, with the DON revealed she or the Unit Managers usually go in the resident's room after a fall and make sure interventions were in place as a double check; however, she stated did not follow the process after Resident #7's falls. Interview, on 07/10/15 at 7:21 PM, with the Administrator revealed the facility had a system in place to ensure care plan interventions were followed related to fall interventions. The Administrator revealed they did daily rounds, predominately by Department Heads, to ensure interventions on the care plans were in place. The Administrator reported staff was trained to use the CNA care plans to ensure listed interventions were in place and any concerns were given to the DON to follow-up. 3. Review of the POC, with a compliance date 05/14/15, revealed the DON and UM reviewed all orders for accuracy. POC review revealed education was provided to licensed personnel by	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER: WOODCREST NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3876 TURKEYFOOT ROAD, ELSMERE, KY 41018

(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 520	Continued From page 47	F 520		

the DON and Staff Development Coordinator which included the posting of orders, the writing of Physician orders, and the monthly change over process to ensure accuracy of the medical records. Further POC review revealed any deviation was addressed by the DON and brought to the Quality Assurance (QA) meeting. Further review revealed QA would review monthly to ensure compliance with revisions and would make updates to the plan of correction as indicated. (Refer to F514)

Interview with the Administrator, 07/10/15 at 7:21 PM, revealed accuracy of medical record documentation was always emphasized by the facility and per the POC.

Interview with the DON revealed the facility process was to have Physician orders for alarms in order to ensure placement on the TAR and nurses were suppose to monitor that the alarms were in place and document on the TAR.

Review of Resident #5's June 2015 TAR revealed documentation of a tab alarm to the bed initialed by staff, daily on the 11:00 PM - 7:00 AM shift; however, there was no Physician's order and observations revealed a pressure alarm instead of a tab alarm. Further record review revealed at monthly change over (June to July) staff again failed to obtain a Physician's order for the tab alarm and had not included the device on the July 2015 TAR. In addition, review of Physician orders revealed a tab alarm was to be placed on the resident when up in the wheelchair. Review of the June/July 2015 TAR revealed staff initialed they had checked placement and function of the tab alarm to Resident #5's wheel chair; however, Resident #5 had a pressure alarm to the wheel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING & REHABILITATION CENTER	3876 TURKEYFOOT ROAD ELSMERE, KY 41018

(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 520	Continued From page 48 chair. Interview, on 07/10/15 at 5:47 PM, with the DON revealed the issue should have been identified during the June 2015 to July 2015 change over process when staff noticed the hand written bed tab alarm intervention. Per interview, staff should have obtained the order and placed the intervention on the July 2015 TAR. Continued interview revealed there was another issue with documentation as staff continued to document on the TAR the wheelchair tab alarm placement but the resident had a pressure alarm. Record review revealed there was no documented evidence the facility attempted to obtain wheelchair/bed alarm status clarification. Continued interview, on 07/10/15 at 7:21 PM, with the Administrator revealed staff compared Physician orders and the MAR/TAR to ensure they were correct/accurate at the monthly change over and the bed alarm should have been identified and carried over onto July 2015 orders and TAR. He state this should have been discovered during our Quality Assurance monitoring. In addition, observation of Resident #7's room revealed no lambs wool to the resident's overbed table and only one partial non-skid strip to the bathroom floor in front of the toilet. Interview with staff revealed the lambs wool intervention had not been in place for awhile and when non-skid strips were ordered they usually placed three (3) to four (4) strips and were difficult to remove. Review of Resident #7's medical record revealed staff had initialed on the July 2015 TAR the lambs wool and non-skid strips were in place.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185445		R-C 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 520	Continued From page 49	F 520		

Interview, on 07/10/15 at 2:43 PM with the Marketing Director revealed as part of the facility's plan to ensure care plan interventions were in place she was assigned specific rooms, including Resident #7's room, and rounded daily to inspect. She revealed she had identified the lambs wool intervention was continually not in place and she notified the DON as instructed. She stated there was only a partial non skid strip in front of the toilet currently. Continued interview revealed, last week there was one full strip and a partial strip in place in front of the toilet and was not aware how may strips were supposed to be in place per the care plan.

Interview, 07/10/15 at 5:47 PM, with the DON revealed nurses should have checked to make sure the lambs wool was in place prior to initialing on the TAR. She further stated the Marketing Director informed her the lambs wool was not in place and she thought the intervention had been discontinued. She stated she should have gone to the record to clarify the order with the care plan. She reported the non-skid strips in front of the toilet were checked nightly by the nurse and half a strip was not an effective to prevent falls, there were usually three (3)/four (4) strips.

Further interview, on 07/10/15 at 7:21 PM, with the Administrator revealed staff should have ensured devices were in place at the time they documented on the intervention. He stated if issues were identified during the monitoring, they should have been brought to the QA meeting.