

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

PRINTED: 09/10/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2012 |
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| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 |
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| F 000 | <p>INITIAL COMMENTS</p> <p>A Standard Health/abbreviated/partial extended survey was initiated on 08/20/12 and concluded on 08/24/12 and the Life Safety Code survey was conducted on 08/22/12 with the highest scope and severity of a "J".</p> <p>KY18943 was substantiated and Immediate Jeopardy was identified on 08/23/12 and determined to exist 08/09/12 through 08/17/12 at 42 CFR 483.25 (F323) S/S of "J" and Substandard quality of care was identified in 42 CFR 483.25 (F323).</p> <p>On 08/09/12 at approximately 3:45 PM, Resident #18 who was assessed by the facility to be a high risk for elopement, left the facility unsupervised. The Delayed Egress Exit Alarm Controller sounded at the South Nurses Station side door. Interviews revealed staff on the South Unit visualized both the side and the front south doors from the nurses' station and did not witness anyone enter or exit the building. The door location indicator panel at the nurse's station showed the Dining Room indicator lamp was on. Staff proceeded to the Dining Room door; however, the door would not release and the delayed egress exit alarm was not alarming. Per interview staff returned to the South Unit, looked outside the side door, and reset the side door alarm; however, the grounds were not searched until staff realized Resident #18 was not in the building. Resident #18 ambulated a half a mile from the facility to a medical office, which called Resident #18 a cab. Resident #18 was transported by the cab to a family member's home approximately nine (9) miles out of the city limits. The resident was returned to the facility</p> | F 000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 10-04-12

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

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| F 000 | Continued From page 1 approximately 4:45 PM by the family. The Immediate Jeopardy was determined to exist on 08/09/12 through 08/17/12. The facility implemented corrective actions which were completed prior to the State Agency's investigation on 08/20/12, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be removed on 08/18/12. | F 000 | <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> | |
| F 253 SS=E | 183.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide a sanitary environment for residents. Two (2) of two (2) shower rooms, referred to as the North and South shower rooms, had used latex gloves on the floor, shower curtains with a dark brown/black substance on them, and wet washcloths hanging on grab bars. These shower rooms were used by all residents. In addition, the North shower room was used for the storage of wheelchairs. The findings include: Review of the facility's policy regarding Space | F 253 | F253 I. Corrective action taken. 1. On 08.23.12 Maintenance staff confirmed that the tub/whirlpool had not been in use in 2012; and, at the Administrator's request, Maintenance staff --beginning on 08.23.12 and finishing the following week--removed the tub/whirlpool from the South Shower room. 2. On 08.24.12, Maintenance and Housekeeping staff observed and confirmed that North and South Shower rooms, including the fixtures, curtains, and equipment in those rooms, were cleaned and sanitized; used gloves and other debris were discarded; wet wash cloths were removed and grooming items placed in the storage lockers. 3. On 08.24.12, and ongoing, the Maintenance Supervisor and Housekeeping Supervisor, have instructed housekeeping and nursing staff that shower rooms must be cleaned after each use and before the next use of the room; and that no non-personal care items will be stored on the direct care side of a shower curtain-- during direct care or before the shower room has been cleaned. | 10.07.12 |



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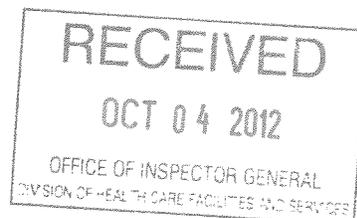
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| F 253 | <p>Continued From page 2</p> <p>and Equipment, revised 04/28/10, revealed sufficient space was to be made available for resident equipment. However, in the North shower room were stored wheelchairs, which were stored during the time residents were given their showers.</p> <p>Review of the housekeeping in-service on 7-Step Daily Washroom Cleaning, 01/01/2000, revealed all housekeeping staff had been trained on how to clean the shower rooms. The in-service included how to sanitize a washroom, trash removal, cleaning and sanitizing the tub and the use of a germicidal solution to disinfect the floor.</p> <p>Observation, on 08/20/12 during the tour of the facility which began at 1:45 PM, revealed a brown discolored substance on the toilet seat in the South shower room. The South shower room green tub/whirlpool was found to have dried white/gray streaks going down the entire front of the tub to the drain. There was black discoloration around the drain of the tub/whirlpool. The tub/whirlpool seat had cracks creating a rough surface, which were too numerous to count. The floor of the shower room had numerous hairs on it. The two (2) shower handle holders had a rust color on them where they were attached to the wall. Also observed was a brown discoloration to the back of the seat of the red/maroon shower chair.</p> <p>Observation, on 08/21/12 at 11:20 AM, of the South shower room revealed there was no change in the tub/whirlpool from the above observation.</p> <p>Observation, on 08/21/12 at 11:25 AM, of the</p> | F 253 | <p>II. Additional corrective actions.</p> <p>1. Any resident using the shower rooms has the potential to be affected. The shower rooms each have 3 compartments each separated by shower curtains. The first compartment--the one nearest the egress door-- will be used for storage only and no direct care will be performed in the storage compartment. During direct care or before the direct care compartments have been cleaned, no non-personal care items will be stored in the direct care compartments.</p> <p>2. After confirming that the shower rooms, fixtures, curtains and equipment had been cleaned and sanitized, Maintenance and Housekeeping Supervisors determined, confirmed, and advised Administrator and staff that (a) as of 08.24.12, any remaining discoloration on the shower curtains, shower-handle/soap-bottle holders, and shower chairs did not present a safety or sanitation concern; (b) any remaining discoloration on the shower chairs could be and was removed on 09.15.12 by scrubbing with Comet; (c) any remaining discoloration on the shower curtains could be and was removed on 10.02.12 by spraying and wiping with Val-U-4-U Citrus+ cleaner/degreaser; and (d) the discoloration on the shower-handle/soap-bottle holders could be and was removed on 10.02.12 by sanding and painting.</p> <p>3. New shower curtains were ordered on 09.10.12. New shower-handle/soap-bottle holders were ordered on 09.21.12. Upon receipt, the new items will be installed.</p> | |
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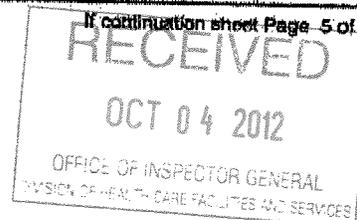
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| F 253 | <p>Continued From page 3</p> <p>North shower room revealed a latex glove on the floor, a white substance on the floor with the appearance of chipped paint, four (4) razor covers on the floor, two (2) wet washcloths on the grip bars, a piece of candy on the floor and two (2) shower handle holders had a rust color on them where they were attached to the wall.</p> <p>Observation, on 08/23/12 at 3:15 PM, of the North shower room revealed two (2) latex gloves on the floor, a wet Kleenex tissue on the floor, a wet washcloth on a shower chair not in use and a wet washcloth on a handrail. Stored in the shower room were six (6) wheelchairs: one (1) powered chair, one (1) upholstered chair, one (1) high back wheelchair and three (3) regular wheelchairs. A walker was stored against the back corner wall. There was a brown/black discoloration along the bottom of the shower curtain and cracks noted to the front part of the toilet seat. During the observation, Resident B was brought into the shower room and his/her shower started by Certified Nursing Assistant #1. All items observed remained in place. The shower room was not checked or cleaned prior to the shower for Resident B.</p> <p>Observation, on 08/23/12 at 3:20 PM, of the South Shower room revealed a black discoloration to the bottom of the shower curtain. In addition a long black streak was noted mid-level on the shower curtain. A hairbrush was stored in the shower room with hairs in it and no name on the hairbrush.</p> <p>Interview, on 08/21/12 at 10:30 AM, with Housekeeper #3 revealed the shower rooms were cleaned by Housekeeping. They were</p> | F 253 | <p>4. Pending the receipt of the new shower curtains and holders, the old curtains were replaced on 10.02.12 with temporary, newer, appropriate and compliant shower curtains; and the holders were removed, sanded, painted and reinstalled by 10.03.12.</p> <p>5. The Housekeeping Supervisor and Maintenance Supervisor will make daily (M-F) environmental rounds of resident rooms, shower rooms, and common areas to assure the facility is maintained in a sanitary and comfortable manner. The Housekeeping Supervisor and Maintenance Supervisor will review any findings with the Administrator and corrective action will be implemented immediately.</p> <p>III. Additional measures/systemic changes. On the days identified above and as a part of an all staff inservice on 09.28.12, the Maintenance Supervisor and Housekeeping Supervisor educated, and continuing on a monthly basis will educate, the housekeeping and nursing staff on housekeeping and storage procedures, including those identified in Sections I and II above. On and after 10.01.12 the Staff Development Coordinator will include housekeeping and storage procedures, including all corrective actions identified in Sections I and II above in the orientation of new hires as indicated. The Housekeeping Supervisor and Maintenance Supervisor will make daily (M-F) environmental rounds of resident rooms, shower rooms, and common areas to assure the facility is maintained in a sanitary and comfortable manner.</p> | | |



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| F 253 | <p>Continued From page 4</p> <p>cleaned every day and the housekeepers were to go in between residents and clean. She also revealed Housekeeping was to clean the tub/whirlpool and a previous housekeeper had instructed her on how to clean it. Continued interview revealed the reason to clean the shower room was to keep it sanitized. She revealed if the shower rooms were not sanitized there would be germs and people could get sick or catch something.</p> <p>Interview, on 08/21/12 at 12:05 PM, with Housekeeper #2 revealed Housekeeping was responsible to clean the shower rooms. She stated she tried to clean the shower room between resident showers. She revealed she did not know who cleaned the tub/whirlpool, as she only works North and the tub/whirlpool was South. She stated the housekeepers were responsible to monitor the shower rooms. The North shower room remained unchanged from the 11:25 AM observation when Housekeeper #2 saw the shower room. She revealed she would clean it after lunch.</p> <p>Interview, on 08/23/12 at 2:15 PM, with Housekeeper #1 revealed Housekeeping cleaned the shower room first thing in the morning, between residents, and at the end of the shift. She revealed the tub/whirlpool was wiped and sprayed down every day. She did not know who monitors the housekeepers. She revealed the reason to keep the shower rooms clean was because there were bacteria and everyone was in the shower room with their open bodies.</p> <p>Interview, on 08/23/12 at 2:20 PM, with Housekeeper #4 revealed the housekeepers</p> | F 253 | <p>The Housekeeping Supervisor and Maintenance Supervisor will review any findings with the Administrator and corrective action will be implemented immediately.</p> <p>IV. Facility plans to monitor its performance. The Maintenance Supervisor and Housekeeping Supervisor will monitor through environmental rounds on a daily basis to assure that the facility is maintained in a sanitary and comfortable manner. The Housekeeping Supervisor and Maintenance Supervisor will review any findings with the Administrator and corrective action will be implemented immediately. The data will be reviewed and analyzed monthly by the Safety Committee and then reported to the quarterly Performance Improvement Committee with a subsequent plan of action developed and/or education implemented as indicated. The Administrator is responsible for the overall compliance.</p> | | |



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| F 253 | Continued From page 5 were responsible for the shower rooms. She revealed she cleaned the shower rooms in the morning when she got to work and when residents came out of the shower or when she was told. She stated she checked the shower rooms at the end of the day before she left. She did not know who cleaned the tub/whirlpool or if it was still in use. She stated the reason to keep the showers clean was for safety and for the resident's health and cleanliness. So the resident would not get germs or sick, she revealed. Interview, on 08/23/12 at 2:55 PM, with the Housekeeping Manager revealed the shower rooms were cleaned to sanitize and for infection control purposes. She stated she would monitor the shower rooms and that the shower rooms should have been monitored by the Manager before her. The Housekeeping Manager started to work at the facility on Monday, 08/20/12, the day the survey began. In addition, she stated the District Manager over Housekeeping and Housekeeper #1 had tried to clean the tub/whirlpool and were unsuccessful. When asked about wheelchairs stored in the shower room, she stated she did not know if the shower room was to be used for storage. | F 253 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, | F 281 | F-281 1. Parameter mattress was provided to resident #3 on 08/23/12 as ordered by the physician 2. DNS-RN reviewed all residents on 08/23/2012 that were currently in the center with physician orders for any device and/or equipment that was ordered for decreased safety awareness, to validate the devices were in place. DNS-RN reviewed all residents Treatment Records on 8/23/2012 that were currently in the center with physician orders for any device and/or equipment that was ordered for decreased safety awareness to validate documentation was in place and accurate for placement of the devices. DNS-RN reviewed all residents comprehensive care plans on 08/23/2012 that were currently in the center with physician orders for any device and/or equipment that was ordered for decreased safety awareness to validate the device was listed as an intervention. | 10-7-12 |

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| F 281 | <p>Continued From page 6 and review of the facility's policy, it was determined the facility failed to follow physician orders for one (1) of twenty (20) sampled and two (2) unsampled residents. Resident #3 did not have a parameter mattress as ordered by the physician.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Physician Orders, dated 04/28/11, revealed physician orders were received upon admission to the facility. Readmission orders should not be resumed from a previous stay and State regulation should be followed in recording physician orders. Performance Improvement included printing a Selected Order Type Report and compare with the actual care delivery.</p> <p>Review of the clinical record for Resident #3 revealed the facility admitted the resident on 02/23/12 and re-admitted Resident #3 on 06/17/12 with a diagnosis of Dementia with Behaviors. Admission orders included a parameter mattress to define bed parameters related to decreased safety awareness due to dementia and to check placement every week.</p> <p>Review of the Treatment Record for August 2012 revealed the parameter mattress had not been checked for placement upon or since admission.</p> <p>Review of Resident #3's comprehensive care plan, dated 06/26/12, revealed a perimeter mattress to the bed and should be checked every week due to a risk for falls related to previous falls.</p> | F 281 | <p>3. Licensed nurses will be responsible for notifying the maintenance department via a Maintenance Request Form the need for any resident that receives a physician order for a parameter mattress. Licensed nurses will be responsible to document on the Treatment Record to validate placement for any device and/or equipment that is ordered for decreased safety awareness. Licensed nurses will be responsible for updating the comprehensive care plan for any resident that receives a physician order for any device and/or equipment that will be used for decreased safety awareness.</p> <p>All Licensed nurses and the Maintenance Department will be re-educated beginning 08/23/2012 by the DNS-RN, Staff Development Coordinator- RN, and Unit Managers-LPN/RN by the means of a presentation for the process for filling out a Maintenance Request Form for residents that receive a physician order for a parameter mattress to ensure services provided or arranged by the facility meet professional standards of quality.</p> <p>All Licensed nurses will be re-educated beginning 08/23/2012 by the DNS-RN, Staff Development Coordinator -RN, and Unit Managers-LPN/RN by means of presentation for the policy regarding Physician Orders, dated 04/28/11 to ensure services provided or arranged by the facility meet professional standards of quality.</p> | 10-7-12 |
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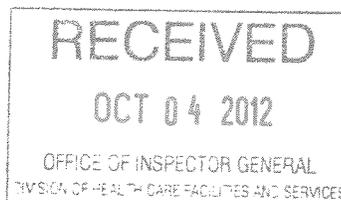
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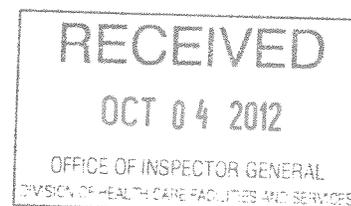
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| F 281 | <p>Continued From page 7</p> <p>Observation, on 08/20/12 at 1:45 PM, on 08/21/12 at 9:20 AM, 10:15 AM, 10:55 AM, 11:50 AM, 12:00 PM, 12:05 PM, 12:10 PM, 2:00 PM, on 08/22/12 at 9:45 AM, 9:55 AM, 10:55 AM, 11:20 AM, 2:00 PM, and on 08/23/12 at 9:45 AM and 2:00 PM, revealed the resident did not have a perimeter mattress on the bed.</p> <p>Interview, on 08/23/12 at 1:15 PM, with Licensed Practical Nurse (LPN) #6 revealed Resident #3 did not have a perimeter mattress on the bed. She stated the maintenance department was responsible to get a perimeter mattress when it was ordered by the physician. The LPN stated a maintenance log should be completed and submitted to the Maintenance Director. She stated Resident #3 was at risk for falls and should have a perimeter mattress due to a lack of safety awareness. The LPN stated the resident had a perimeter mattress before transfer to a hospital. She stated the resident had not fallen since returning to the facility, however, the resident was at an increased risk for falls.</p> <p>On 08/23/12 at 1:30 PM and 3:20 PM, interview with the North Unit Manager revealed Resident #3 did not have a perimeter mattress on the bed. The Unit Manager stated when a perimeter mattress was ordered on admission, the admissions office was responsible to make sure the maintenance department was aware in order to get the mattress prior to the resident's admission to the facility. The Unit Manager stated she monitors the Treatment Record with spot checks to see if anything was missing. She stated there was no documentation of doing the spot checks. The Unit Manager also stated she had not checked Resident #3's record and was not</p> | F 281 | <p>All Licensed nurses will be re-educated of their responsibility for updating the comprehensive care plan to reflect the intervention of the device and/or equipment for decreased safety awareness and documenting on the Treatment Record to validate placement for the devices and/or equipment ordered for decreased safety awareness beginning 8/23/2012 by the DNS-RN, Staff Development Coordinator-RN, and Unit Managers-LPN/RN by means of a presentation.</p> <p>Education will be on going until all licensed nurses and all of maintenance staff has attended. No licensed nurses or staff of the maintenance department will be allowed to work without having been in serviced. The facility does not employ agency staff, however, if the facility should employ agency staff, the agency staff will receive the in-service prior to working. This education will be added to general orientation for all new maintenance staff and licensed nurses that should be hired.</p> <p>4. The Unit Managers-LPN/RN and/or Weekend Supervisor-RN will review all physician orders daily to identify any residents that receives an order for a device and/or equipment for decreased safety awareness and will at that time validate placement of the device and/or equipment, documentation was placed on the Treatment Record and that the comprehensive care plan was updated.</p> | 10-7-12 |
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| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 | | |
| (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 281 | Continued From page 8 sure how the perimeter mattress was missed. She stated the purpose of the perimeter mattress was to keep the resident from falling out of the bed. The Unit Manager stated Resident #3 had not fallen since the facility re-admitted the resident, but the resident could fall. Interview with the Maintenance Director, on 08/23/12 at 1:35 PM, revealed the maintenance department was responsible to get the perimeter mattress for Resident #3. He stated a maintenance request should be completed by staff; however, he had no record of a maintenance request for a perimeter mattress for Resident #3. This was verified during record review. On 08/23/12 at 1:55 PM, interview with the Director of Nursing Services (DNS) revealed the nurse receiving the physician's order was responsible to contact the maintenance department to get the perimeter mattress for a resident. The DNS stated she was unaware why Resident #3 had an order for a perimeter mattress and stated the order for the mattress related to safety awareness would depend on the need for it. The DNS stated she did not know if Resident #3 had fallen since readmission to the facility, however the resident had a decline related to the disease process. | F 281 | DNS-RN will review all physician orders daily (Monday-Friday) using a Selected Order Type Report to identify any residents that receive an order for a device and/or equipment secondary to decrease safety awareness. DNS-RN will conduct a weekly audit on any identified resident that receives an order for a device and/or equipment secondary to decreased safety awareness to validate placement of the device, documentation on the Treatment Record, and updating of the care plan. Results of this weekly audit will be reported by the DNS-RN (at least monthly for 3 months then at least quarterly there after) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at least monthly for three months and then at least quarterly there after. The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these weekly audits based on the finding. | 10-7-12 | |
| F 323 SS-J | 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 prevent accidents. | F 323 | | | |



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F 323

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, review of the facility's policies, investigation, and the Delayed Egress Exit Alarm Controller, it was determined the facility failed to have an effective system to adequately supervise cognitively impaired residents with known elopement risk, for one (1) of twenty (20) residents sampled, Resident #18. The facility failed to respond promptly to an activated alarm on the South Unit and facility failed to ensure the emergency nursing panel located at the South Nurses Station was functioning properly. On 08/09/12 at approximately 3:45 PM, Resident #18 who was assessed by the facility to be a high risk for elopement, left the facility unsupervised. The Delayed Egress Exit Alarm Controller sounded at the South Nurses Station side door. Interviews revealed staff on the South Unit visualized both the side and the front south doors from the nurses' station and did not witness anyone enter or exit the building. The door location indicator panel at the nurse's station showed the Dining Room indicator lamp was on. Staff proceeded to the Dining Room door; however, the door would not release and the delayed egress exit alarm was not alarming. Per interview staff returned to the South Unit, looked outside the side door, and reset the side door alarm; however, the grounds were not searched until staff realized Resident #18 was not in the building. Resident #18 ambulated a half a mile from the facility to a

Past noncompliance: no plan of correction required.

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| F 323 | <p>Continued From page 10</p> <p>medical office, which called Resident #18 a cab. Resident #18 was transported by the cab to a family member's home approximately nine (9) miles out of the city limits. The resident was returned to the facility approximately 4:45 PM by the family.</p> <p>The facility's failure to ensure the emergency nursing panel was functioning properly and failure of the staff to respond to an activated alarm for cognitively impaired individuals with known elopement risk placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment or death. The Immediate Jeopardy was determined to exist on 08/09/12 through 08/17/12. The facility implemented corrective actions which were completed prior to the State Agency's investigation on 08/20/12, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be removed on 08/18/12.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Patient Elopement, revised 08/31/11, revealed an elopement was an event that required a prompt and organized response to promote patient safety. If an elopement occurred and the patient was missing, the staff should follow these guidelines: Phase 1 - provide procedures for the initial search of the Center and grounds and confirmation that the patient was missing. The search should last no longer than 30 minutes before entering Phase II. Phase I would be initiated as soon as the patient was noticed missing. Phase I of the Missing Resident Search Checklist included an initial search of the center</p> | F 323 | | |

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| F 323 | Continued From page 11 and immediate surroundings (every door, closet, office, department, shed, car dumpster, stairwell, elevator, resident room and bathroom etc.); confirmation that the resident was missing; an announcement using specific code phrase (Dr. Wander) over the PA system three (3) times to alert employees of the situation; and, investigate an alternative explanation for the resident's absence. Phase II - after thirty (30) minutes, conduct an intensive search of Center, grounds and the community to include neighborhoods and the resident's likely destinations. However, the Policy did not address how the staff was to respond to any alarm activated by the missing resident. Review of the facility's investigation, dated 08/17/12, revealed on 08/09/12 at 4:45 PM, upon return to the facility, Resident #18 stated he/she had a bad feeling about something at home and he/she had to find out what was going on. The resident stated he/she walked up the road to the doctor's office and had them call a cab to take him/her home. When questioned as to how he/she got out the door, the resident explained it just opened. Later, the resident told staff a nice man let him/her out of the door. The cab was called to the medical office (which is 0.3 miles/611 steps from the facility) and had the cab take the resident to a family member's home. The facility's investigation concluded the resident was assessed correctly and made no attempts at elopement from 04/06/12 through 08/09/12. It concluded the facility staff responded appropriately to the alarms that sounded. However, interview with the DON, on 08/23/12 at 5:00 PM, revealed staff was to respond to the door alarm immediately, find where the alarm was | F 323 | | |

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| F 323 | <p>Continued From page 12</p> <p>coming from, and physically open the door to check and make sure no one had exited. The DON stated it was not acceptable for staff to just look at the door and not physically check the door. In addition, the facility concluded a visitor must have entered the code to silence the alarm and the resident followed them out of the building. However, interviews with staff revealed the alarm was sounding on the South Unit.</p> <p>Interview with the Maintenance Director, on 08/22/12 at 4:58 PM, revealed there were eight (8) door stations with a keypad and two (2) staff alert panels located at each nurse's station. The Delayed Egress Exit Alarm controller system was purchased about 4 months ago. The Maintenance Director stated when the door alarms, the key pad will alarm and the sound of the alarm at the keypad was different from the alarm at the door. The Director stated when a patient was one (1) foot from the door, the door would not sound until pressure was applied to the door for fifteen (15) seconds. Further interview with the Maintenance Director revealed there was also a tail gate feature for when family members came into the building, so the door would alarm with the wandguard even when the code was entered into the keypad. The alarm panel on the South side nursing station had indicator lamps that only indicated the South lobby, dining room, South side door, the South break room and the South rear door. The alarm panel on the North side nursing station had indicator lamps that only indicated the North side door, the North back door and the North lobby.</p> <p>Interview with the Maintenance Director, on 08/23/12 at 5:20 PM, revealed the Maintenance</p> | F 323 | | |

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| F 323 | <p>Continued From page 13</p> <p>Director became aware the keypad in the dining room was not functioning when the facility Regional Properties staff came on 07/31/12. The dining room door would not open unless the fire alarm was alarming. The Maintenance Director initiated weekly door checks and during this time he never detected any problems with the emergency nursing panels not indicating the correct door.</p> <p>Record review of the Door Security System checks, completed on 08/06/12, revealed keypads, buttons, and bypass switches was documented "no" for not functional for the dining room door and a new keypad was ordered on 08/02/12. Interview with the Maintenance Director, on 08/23/12 at 5:20 PM, revealed the nursing panel did not display the correct door alarm due to the voltage was at 5 volts and the required voltage was 12-15 volts.</p> <p>Interview with the Certified Medication Technician (CMT), on 08/20/12 at 2:08 PM, revealed Resident #18 came up to the nurses' station and wanted to know what the time was. The CMT stated it was 3:15 PM and Resident #18 stated he/she was to get off of work at 3:00 and he/she was going to get in trouble for working into overtime. Resident #18 was then observed to leave the nurses' station and talk to two (2) residents in the north lobby. The CMT stated Resident #18 then went to the south unit and she assumed Resident #18 was going to an activity scheduled at 3:45 PM in the dining room. The CMT then stated she heard the alarm sound at the South door, she went to the South Unit and saw the alarm indicator for the dining room door. She saw LPN #3 returning from the South side</p> | F 323 | | |

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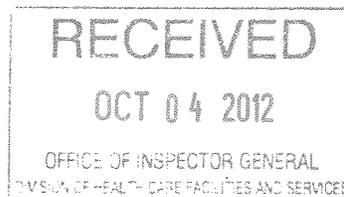
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| F 323 | <p>Continued From page 14</p> <p>door and she returned to the North Unit. The North Unit Manager questioned her about seeing Resident #18. She indicated no she had not seen the resident; however, she proceeded outside to the gazebo to check the area and found nothing. The CMT voiced knowledge of the missing resident protocol; however, stated she did not actually go and check the South side door herself.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 08/22/12 at 10:42 AM, revealed she was noting orders at the South Nurses Station and heard the South side door alarm sound at approximately 3:45 PM. LPN #3 stated she immediately looked at the front and side doors and did not see anyone. LPN #3 then stated she looked at the Nurses Panel behind her and noticed it was the dining room indicator lamp that was lighting up. LPN #3 walked to the dining room and pushed on the dining room door and the door would not open (she had held the door longer than the 15 seconds and noted it would not open). LPN #3 then went to the South nurses' station, realized the South door was still alarming, and checked the South front and side door by looking outside and saw the housekeeper walking around. The housekeeper stated she did not see anyone, so they proceeded back to the unit and completed a head count.</p> <p>Interview with Housekeeper #4, on 08/22/12 at 10:34 AM, revealed she was working on the South Unit when she heard the alarm sounding at the South side door. The South Nursing Panel Indicator light was showing the dining room door. LPN #3 then went to the dining room door and Housekeeper #4 went to the South doors. The</p> | F 323 | | |
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| F 323 | <p>Continued From page 15</p> <p>Housekeeper stated she pushed on the door for 15 seconds, when the door opened she looked toward the dining room and the road and did not see any residents, except for LPN #3 who was looking towards her from the dining room door. Housekeeper #4 then walked outside toward the porch area and did not see anyone.</p> <p>Interview with the Certified Nursing Assistant (CNA) # 5, on 08/22/12 at 6:18 PM, revealed he worked on the North Unit when the alarm sounded. CNA #5 stated he walked to the South Unit and went through the South side door, walked around the area, and saw no family or residents. The CNA stated he did not disarm any doors, but Housekeeper #4 had disarmed the door before he went outside. CNA #5 stated as he was coming back into the facility when someone verbalized Resident #18 was missing.</p> <p>Interview with LPN #2, on 08/21/12 at 2:43 PM, revealed when the door alarm sounded she knew it was the South Unit because none of the alarms were sounding on the North Unit. She did not go to check the South Unit because she knew there was a nurse at the South nurse's station and they would check it. LPN #2 stated it was the facility's practice for all staff to respond to an alarm by physically checking the door and the outside area. Per interview, even though she did not go the door as soon it sounded, she knew she was to physically check the alarming door and go out the door to ensure no residents had walked out of the building. LPN #2 stated she should of responded to the alarm, a resident could elope if no one responded to the doors.</p> <p>Further interview with LPN #2, on 08/21/12 at</p> | F 323 | | |

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| F 323 | <p>Continued From page 16</p> <p>2:43 PM, revealed a family member of a resident stated he had observed an older gentleman/lady with a plaid shirt and maroon pants walking toward the movie theater. LPN #2 then stated she went out of the side door and started running toward the movie theater. The movie palace was open, where she ran into the Speech Therapist who stated she had checked the inside of the theater and talked with the ticket person. The ticket person stated he did not see anyone who fit that description. LPN #2 and Social Services drove around the area and Speech Therapy continued to walk around the neighborhood. They received a call from the facility that the resident had been found and returned to the facility at approximately 4:45 PM.</p> <p>Interview with the DON, on 08/22/12 at 9:45 AM, revealed at approximately 4:00 PM, she was notified that Resident #18 was missing. The DON stated she then reported to the Administrator and they both got into their cars. The DON headed to the left of the building and the Administrator to the right of the building. The DON stated she came back to the facility around 4:30 PM to make phone calls. Per interview, she received a call from a family member of Resident #18 who told her he was on his way back to the facility with the resident. The resident was returned to the facility at approximately 4:45 PM.</p> <p>Interview with the Family Member of Resident #18, on 08/20/12 at 2:49 PM, revealed he had received a call from his wife that the resident had come to the house in a cab. He called the facility and asked about Resident #18 and a staff member replied Resident #18 decided to take a trip. He then asked where did Resident #18</p> | F 323 | | |

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| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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F 323 Continued From page 17

decided to take a trip to and the staff member stated he had no idea and that the local police had been called. The family member informed the facility they could stop looking because Resident #18 had been picked up a half a mile from the facility and delivered home in a cab. The facility offered to send the police to pick up Resident #18, but the family member refused and decided to deliver Resident #18 personally.

Interview with the City Cab, on 08/22/12 at 4:15 PM, revealed they had received a call from the medical office at about 4:15 PM and picked up Resident #18 at 4:30 PM. The City Cab stated he dropped Resident #18 off to his/her home at about 4:40 PM.

Interview with the Administrator, on 08/22/12 at 10:56 AM, revealed he came back to the facility to call the police. Once on the phone with the Police Department, the Administrator had learned Resident #18 had been located and was coming back to the facility. However, interview with the local Police Department, on 08/22/12 at 4:00 PM, revealed no record a phone call was taken in regards to Resident #18.

Interview with the DON, on 08/23/12 at 5:00 PM, revealed she was not aware the dining room door was not working properly until the day of the elopement. Per interview, the problem was the dining room door showed on the panel instead of the South side door, causing the staff to go to the wrong door. She also revealed the nurse heard the alarm on the south side door and visualized the door from the desk instead of going to that door.

F 323

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195118 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2012 |
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| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 |
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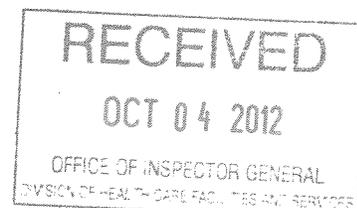
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| F 323 | <p>Continued From page 18</p> <p>Review of the clinical record for Resident #18 revealed the resident was transferred to the facility from a local hospital after suffering from complications with Chronic Obstructive Pulmonary Disease (COPD) and Iron Deficiency. The facility admitted the resident to the North side of the building on 04/06/12 with multiple diagnoses which included Alzheimer's Disease.</p> <p>Review of the Quarterly MDS, dated 07/06/12, revealed the facility assessed Resident #18 with a moderately impaired cognitive deficit. Review of the Wander/Elopement Risk evaluation revealed the last assessment was dated 04/12/12 with an indication of a wanderguard in place to the right ankle. The assessment dated 07/09/12 revealed the resident expressed a desire to leave the center, walked about the facility per self without assistance, and asked to go home, placing the resident at risk for elopement. Review of the resident's plan of care, dated 04/09/12, revealed a focus care plan titled resident was an elopement risk/wander. It directed staff to distract the resident by offering pleasant diversions and structured activities, monitor location every 30 minutes and document on the behavior log, place a wanderguard to right ankle, and check function every night.</p> <p>The facility took the following immediate actions to correct the deficient practice:</p> <p>1. Upon Resident #18's return back to the facility on 08/09/12 at 4:45 PM, a skin assessment/head to toe physical and pain assessment was completed by the DON, with injuries noted. Wander guard was still in place to the right ankle and functioning properly.</p> | F 323 | | |
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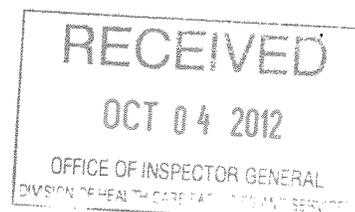
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2012 |
| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 | |
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| F 323 | Continued From page 19 2. On 08/09/12 the Maintenance Director completed a preventive maintenance check on all facility doors and found all doors to be locked and secure. As a further precautionary measure, all doors were monitored one on one until 10:00 PM. 3. On 08/09/12 all wander guard bracelets were validated for proper functioning by the Unit Managers and the DON. 4. On 08/09/12 the codes were changed to all entrance doors by the Maintenance department. 5. On 08/09/12 Maintenance sounded alarms and checked all locations on the main panel to validate proper signal of alarms when sounding and validated all windows were secured with six (6) inch opening. 6. On 08/09/12 a licensed nurse completed door security checks every hour from 11:00 PM to 7:00 AM, to ensure doors were still functioning properly. 7. On 08/09/12 the ED verified signage at all facility entrance doors to notify visitors that no resident was to be assisted outside of the facility. Safe Care and Vanguard door systems (outside vendors) visited the center and validated security of doors on 08/10/12 and 2:15 PM. 8. On 08/09/12 audits were performed by the Social Services Director of all in house residents at risk for elopement to determine all residents had eloped and behavior assessments were completed. On 08/13/12 the DON, Unit Managers and Social Services Director completed audits of | F 323 | | |



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| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 | |
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| F 323 | Continued From page 20 all in house resident behaviors by reviewing the behavior monitoring logs for the previous month to make sure all residents who needed to be identified for elopement was identified. 9. All direct care staff were inserviced on the definitions of levels of supervision on, Resident Monitoring tool and appropriate documentation based on the type of supervision on 08/10/12. Licensed nurses and CMT's were responsible to document on the Resident Monitoring tool. 10. All units were supervised at all times. 11. All door alarms must be responded to. Staff must go to the door and visuallize the inside and outside area to determine if a resident exited. Staff must check the alarm box on the wall to determine the location of the alarm. If staff cannot determine the cause of the alarm, a full facility resident head count must be conducted immediately. 12. Letters were sent to families and visiting groups related to the door protocol by the Admission Coordinator starting on 08/10/12. 13. On 08/15/12 Vanguard installed a new model 30/9450 key pad to the dining room door. 14. On 08/17/12 Vanguard validated alarms were at their highest level and applies an Enunciator mid way down the South Hall, the North Hall Enunciator was ordered on 08/17/12 and applied on 08/24/12. The State Agency validated the facility's actions as follows: | F 323 | | |



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| F 323 | <p>Continued From page 21</p> <p>1. The State Agency validated through record review of the facility's record for Resident #18 and found the resident was assessed on 08/09/12, was found to be without injury and was placed on one-to-one supervision. Interview with the DON, on 08/22/12 at 9:45 AM, revealed she had completed the skin assessment and initiated the 1:1 supervision. Review of Resident #18's Care Plan, revealed 1:1 was initiated on 08/09/12 related to 1:1 exit seeking behaviors. Review of the Monitoring Tool revealed on 08/09/12 at 6:00 PM monitoring was documented every 15 minutes.</p> <p>2. The State Agency validated through review of the Maintenance Preventative Checks that all doors were found locked and secured. On 08/9/12 the Maintenance Director completed a preventative maintenance check on all facility doors and found all doors to be locked and secured. As a further precautionary measure, all doors were monitored one on one until 10:00 PM. On 08/09/12 a licensed nurse completed door security checks every hour from 11:00 PM to 7:00 AM, to ensure doors were still functioning properly. Interview with the Maintenance Director, on 08/23/12 at 11:30 AM, revealed all locks were secured and locked once the Technician came out on 08/10/12 at 2:45 AM.</p> <p>3. The State Agency validated through record review all wander guard bracelets were validated for proper functioning. On 08/09/12 All wander guard bracelets were validated for proper functioning by Unit Managers and DON. Interview with the Director of Nursing, on 08/22/12 at 9:45 AM, revealed they immediately identified all of the</p> | F 323 | | |
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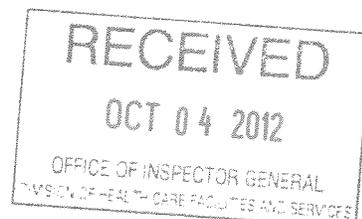
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185119 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2012 |
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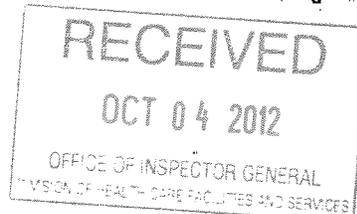
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| F 323 | <p>Continued From page 22</p> <p>residents who were identified as a wanderer, had there wanderguards on and were working properly on 08/09/12.</p> <p>4. The State Agency validated through interview with the Maintenance Director the codes were changed to all entrances. Interview with the Maintenance Director, on 08/23/12 at 5:15 PM, revealed the Maintenance Director changes the code monthly, however the day of the elopement the codes were changed on all doors to ensure the doors were secure. Interview with the Administrator, on 08/22/120 at 10:56 AM, revealed all the doors codes were changed by the Maintenance Director to ensure family members and visitors could not get in without a staff member, to ensure residents could not exit behind a family member.</p> <p>5. The State Agency validated through record review all alarms were checked of all locations and proper signage was posted. On 08/09/12 Maintenance sounded alarms and checked all locations on the main panel to validate proper signal of alarms when sounding and validated all windows were secured with six (6) inch opening. Observations made on 08/20/12 at 2:00 PM, revealed all doors were secure and all alarms were checked of all eight door locations. Interview with the Therapy Director, on 08/23/12 at 5:15 PM, revealed she had to sit at the door from 4:00 PM to 11:00 PM to ensure no resident exited the facility on 08/09/12. Maintenance checked all the doors until they felt the doors were secure.</p> <p>6. The State Agency validated through record review the door alarm checks for proper alarm and functioning was initiated, on 08/09/12 at</p> | F 323 | | |
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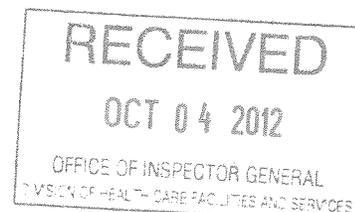
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2012 |
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| F 323 | Continued From page 23 11:00 PM and ended at 7:00 AM by the night shift nurse working at night. Record review of the locations monitored were the Dining Room Extension, the dining room double doors, kitchen #1, kitchen #2, North lobby, north side door, north back door, south lobby door, south side door, break room, and main entrance. 7. The State Agency validated through record review the notification provided to visitors by the Admission Coordinator, that no resident was to be assisted outside of the facility. On 08/09/12 the ED verified signage at all facility entrance doors to notify visitors that no resident was to be assisted outside of the facility. Safe Care and Vanguard door systems (outside vendors) visited center and validated security of doors on 08/10/12 at 2:15 AM Record Review of the letter dated 08/14/12, revealed to ensure the safety of the residents please do not allow any resident to go out as you enter and/or exit the facility. The doors have security codes that change frequently so please see staff for the code to exit. If a resident attempts to exit please alert a staff member immediately. Interviews conducted on 08/21/12 at 2:30 PM, with residents during the group meeting, revealed family members were upset that they had to use the front door to come into the facility. 8. The State Agency validated through record review, the audits performed by the Social Services Director of all in house residents at risk of elopement, through audits performed by the DON, Unit Managers in regards to behaviors. On 08/09/12 audits were performed by the Social Services Director of all in house residents at risk for elopement to determine all residents had | F 323 | | |



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| F 323 | Continued From page 24 elopement and behavior assessments completed. On 08/13/12 the DNS, Unit Managers and Social Services Director completed audits of all in house resident behaviors by reviewing the behavior monitoring logs for the previous month to make sure all residents who needed to be identified for elopement was identified. Interview with the DON, on 08/22/12 at 9:45 AM, revealed her and the managers did audits of the behavior logs for all residents. 9. The State Agency validated training performed to all staff members by reviewing the training provided and all signatures signed by staff members. All direct care staff were inserviced on the definitions of levels of supervision on, Resident Monitoring Tool and appropriate documentation based on the type of supervision on 08/10/12. Licensed nurses and Certified Medication Techs were responsible to document on the Resident Monitoring Tool. Training was validated by record review for the completion. Interviews conducted on 08/23/12, revealed four (4) LPN's, one (1) Certified Medication Tech, four (4) dietary staff members, six (6) Certified Nursing Assistants, two (2) Registered Nurses and three (3) therapy staff members were all familiar of the training provided by the facility. 10. The State Agency validated through interview with the Unit Manager, on 08/23/12 at 11:15 AM, there was always a staff member located at the nurses' station to provide supervision to the residents, whether it was the Unit Manager or the nurses. Interview with LPN #2, on 08/21/12 at 2:43 PM, revealed there was always a nurse at the nurses station to monitor residents. | F 323 | | | |



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| F 323 | <p>Continued From page 25</p> <p>11. The State Agency validated through interviews with staff who would respond to door alarms and how they were to respond to the alarming doors. All door alarms must be responded to. Staff must go to the door and visualize the inside and outside area to determine if a resident exited. Staff must check the alarm box on the wall to determine the location of the alarm. If staff cannot determine the cause of the alarm, a full facility resident head count must be conducted immediately. Interview with CNA #5, CNA #6, CNA #7, CNA #8, LPN #2, LPN #3 and RN #1 on 08/23/12 and 08/24/12 revealed all were knowledgeable of who should respond to an alarm and when to respond to an alarm.</p> <p>12. The State Agency validated through record review the letters provided to family members and visitors contained the door protocol. Letters were sent to Families and Visiting groups related to the door protocol by the Admission Coordinator started on 08/10/12 Interviews conducted on 08/21/12 at 2:30 PM, with residents during the group meeting, revealed family members were upset that they had to use the front door to come into the facility.</p> <p>13. The State Agency validated through record review the invoice for the installation of the 30/9450 key pad for the dining room door. Interview with the Administrator and the Maintenance Director, on 08/24/12 at 1:37 PM, revealed key pad was placed in the dining room on 08/15/12.</p> <p>14. The State Agency validated through observation of the Enunciator made on the South hall, on 08/22/12 at 5:00 PM, that it was</p> | F 323 | | |

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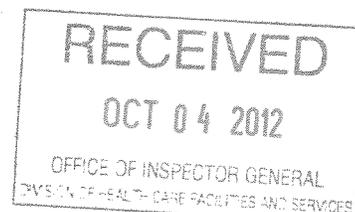
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| F 323 | Continued From page 26 functioning properly. 08/17/12 Vanguard validated alarms were at their highest level and applied Enunciator mid way down the South hall, North Hall Enunciator was ordered on 08/17/12 and applied on 08/24/12. Record review of the invoice for the Enunciator on the North hall revealed it was applied on 08/17/12. The South hall enunciator was ordered on 08/17/12 and applied on 08/24/12 through observation made by the State Agency. | 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 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. | F 441 | F-441 1. Unsampled Resident A was provided with the appropriate personal protective equipment (PPE) and appropriate notice was posted on the room entrance door 08/20/2012 as ordered by the physician. 2. DNS-RN reviewed all residents on 08/20/2012 that were currently in the center with physician orders for a Transmission-Based Precautions to validate appropriate personal protective equipment (PPE) and appropriate notice was provided and posted on the room entrance door. 3. Licensed nurses are responsible for obtaining the appropriate personal protective equipment (PPE) and posting the appropriate notice on the room door entrance for any resident that receives an order for Transmission-Based Precautions. | 10-7-12 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/24/2012 |
| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 | | |
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| F 441 | <p>Continued From page 27</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedures for Infection Control Program, it was determined the facility failed to provide and maintain an Infection Control Program to prevent the development and transmission of disease and infection. During the initial tour of the facility one (1) of twenty (20) sampled residents and two (2) unsampled residents, (Unsampled Resident A) was in isolation precautions without personal protective equipment (PPE) available for facility staff and visitor use prior to resident contact.</p> <p>The findings include:</p> <p>Record review of the facility's policy regarding Infection Control: Transmission-Based Precautions identified as PRO 68014 revealed communicate to staff the isolation interventions (i.e., 24-hour report, Nutrition/Nursing communication, stand-up meeting). Place and maintain an adequate supply of appropriate personal protective equipment (PPE) by the isolation room at the door or use of over-the-door</p> | F 441 | <p>All staff will be re-educated on facilities Infection Control Program to include Preventing Spread of Infection and Linens, beginning 8/20/2012 by the DNS-RN, Staff Development Coordinator-RN, and Unit Managers-LPN/RN by means of a presentation.</p> <p>Education will be on going until all staff has attended. No staff member will be allowed to work without having been in serviced. The facility does not employ agency staff, however, if the facility should employ agency staff, the agency staff will receive the in-service prior to working. This education will be added to general orientation for all new staff.</p> <p>4. The Unit Managers-LPN/RN and/or Weekend Supervisor-RN will review all physician orders daily to identify any residents that receive an order Transmission-Based Precautions and will at that time validate placement of appropriate personal protective equipment (PPE) and appropriate notice is posted on the room door entrance. Staff Development Coordinator-RN will review all physician orders daily (Monday-Friday) using a Selected Order Type Report to identify any residents that receive an order for Transmission-Based Precautions.</p> | 10-7-12 | |



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| F 441 | <p>Continued From page 28</p> <p>storage system (e.g., masks, gowns, gloves, goggles, etc.). Contact precautions- Use appropriate PPE such as gowns and gloves when entering the patient's room who is actively ill and when giving direct patient care. Post the appropriate notice on the room entrance door. The sign posted should state "See the nurses before entering the room". Multidrug-Resistant Organisms, identified as PRO 68027, revealed residents actively infected with methicillin-resistant staphylococcus aureus (MRSA). MRSA is a type of staph bacteria that is resistant to certain antibiotics and does not get better with the first-line antibiotics that usually cure staph infections. Residents with a risk of transmission remain on contact isolation until a clear culture report has been obtained.</p> <p>Record review of the "Annual Survey Review", provided by the facility's Staff Development on infection control, addressing precautions, new equipment use, signage, and handwashing was included in the training. The activity sign in sheet dated 05/07/12, 05/10/12, and 05/15/12 revealed facility staff attendance.</p> <p>Record review for Unsampled Resident A revealed, the facility admitted the resident on 05/17/11 with diagnoses of Chronic Airway Obstruction, Malnutrition, Anemia, and Lung Cancer. The facility identified Unsampled Resident A as requiring contact precautions after a positive MRSA culture of the residents sputum was confirmed by the laboratory. The physician wrote an order for antibiotics and isolation precautions on 08/02/12.</p> <p>Observation, on 08/20/12 at 1:45 PM, during</p> | F 441 | <p>Staff Development Coordinator-RN will conduct a weekly audit on any identified resident that receives an order for Transmission-Based Precautions to validate placement of the appropriate personal protective equipment (PPE) and appropriate notice is posted on the room door entrance. Results of this weekly audit will be reported by the Staff Development Coordinator-RN (at least monthly for 3 months then at least quarterly there after) at the Performance Improvement Committee Meeting with follow up action or education as needed. The Performance Improvement Committee will meet at least monthly for three months and then at least quarterly there after. The Performance Improvement Committee will determine the need to increase, decrease, or discontinue these weekly audits based on the finding.</p> | 10-7-12 |

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| F 441 | <p>Continued From page 29</p> <p>Initial tour of the facility for room twenty-five (25) revealed three (3) male residents occupied the same room. The door was absent of a PPE bag hanging from the door.</p> <p>Observation, on 08/21/12 at 2:00 PM, revealed two (2) facility maintenance staff were re-hanging the bathroom door in room twenty-five (25). Both maintenance staff were in the room working without mask, gowns, or gloves. Room 25 had a black mesh bag with multiple pockets for PPE hanging from the room door filled with PPE, gowns, gloves, and mask. Within one of the pockets revealed a green sign asking to please see the nursing staff prior to a visit with those residents.</p> <p>Interview, on 08/21/12 at 5:00 PM, with Licenses Practical Nurse (LPN) #2 revealed during tour on 08/20/12 their was no PPE hanging from the door from room 25. She further stated she did not get a report of any contact isolation for any of the three residents in that room. LPN #2 stated contamination or spread of infection to visitors and other roommates was some of the risks.</p> <p>Interview, on 08/21/12 at 5:15 PM, with the Director of Maintenance revealed he did not even notice the bag of PPE hanging from the door and acknowledged he was not wearing any PPE while in room 25 while he re-hung the residents bathroom door. He further stated the purpose of the PPE was to protect himself and others from any infections or passing infections to others. The Director of Maintenance revealed he had received training on blood borne pathogens and infection control. He stated he should have put on PPE before going into the room. The</p> | F 441 | | |

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| F 441 | <p>Continued From page 30</p> <p>Director of Maintenance revealed he would ask the nursing staff about precautions prior to entering the room when a PPE sign was present. But was not aware of a process of notification to the maintenance department when residents had been identified for any new PPE needs.</p> <p>Interview, on 08/23/12 at 1:00 PM, with North Unit Manager Registered Nurse (RN) #2 revealed Unsampld Resident A had recently be placed in isolation for MRSA and at that time he was transported to a private room for a period of time. She stated when the unsampled resident returned back to the North Unit he/she did not have PPE hanging on the door for staff to use and to be informed a resident was in isolation status.</p> <p>Interview, on 08/23/12 at 1:30 PM, with Infection Disease Nurse/Staff Development Nurse, RN #3 revealed Unsampld Resident A was placed in contact isolation for MRSA of the sputum 08/02/12 and remained in contact isolation according to the facility's policy until the resident was recultured and a confirmed resolution of the infection. She further stated this resident should have been in contact isolation when he/she was transported back to a shared room. She stated anybody that entered the room was at risk for infection and the cross contamination of infection. She further stated all staff had been trained on infection control precautions and it was important for the facility staff to know when and how to use PPE for residents in isolation.</p> <p>Interview, on 08/23/12 at 2:45 PM, with the Director of Nursing (DON) revealed she was aware of the PPE issue with room 25 and the lack</p> | F 441 | | | |

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| F 441 | Continued From page 31 of PPE use was overlooked. She acknowledged the risks were spread of infection for anybody that entered that room as the bathroom and door were used by staff for all three (3) residents sharing room 25. The DON stated she attended the infection control meeting and the tracking and trends had been about the same. She further stated all staff including the Maintenance Department were educated on facility infection control and isolation precautions. | F 441 | | |
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| K 000 | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II (installed in 2009).</p> <p>A standard Life Safety Code survey was conducted on 08/22/12. Woodland Terrace Health Care Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p> | K 000 | | |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| <p>K 000</p> <p>K 025 SS=D</p> | <p>Continued From page 1 deficiency identified at D level. CFR: 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, approximately forty-five (45) residents, staff and visitors. The facility has one-hundred and twelve (112) certified beds and the census was ninety-nine (99) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/22/12 at 10:15 AM, with the Maintenance Director revealed the fire resistant rated smoke barrier located in the Front Hall, had</p> | <p>K 000</p> <p>K 025</p> | <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>K25 It is the practice of this center to assure that all fire/smoke cubicles remain within compliance at all times to include: smoke barrier located in front hall.</p> <p>The front hall smoke barrier was repaired on 08.22.12 using materials designed specifically for this purpose.</p> <p>Immediately, and daily, Maintenance Supervisor or, if absent, the Maintenance Assistant will check work of contractors, working on or about smoke barriers, to confirm and document that barriers are intact or repaired.</p> <p>All smoke barrier walls will be inspected/sealed by 10-07-12 to ensure compliance throughout center. <i>10-6-12 per Jeremy Reson</i></p> <p>All smoke/fire barrier walls will be inspected monthly for 3 months and quarterly thereafter. <i>10-17-12</i></p> | <p>10.07.12</p> |
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| K 025 | <p>Continued From page 2</p> <p>been penetrated by newly installed data lines above the ceilings. The space around the penetration had not been filled with a material rated equal to the smoke barrier and could not resist the passage of smoke.</p> <p>Interview, on 08/22/12 at 10:15 AM, with the Maintenance Director revealed he was unaware of the penetration in the smoke barrier and acknowledged the penetration was a result of recently installed data lines. It was his understanding that the Contractor installing the new data lines was required to properly seal the penetrations as part of their scope of work.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. | K 025 | <p>These inspections will be documented in the center Preventive Maintenance Log.</p> <p>Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance for one year following the noted issue.</p> | |
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| <p>K 025</p> <p>K 147 SS=D</p> | <p>Continued From page 3</p> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty (20) residents, staff, and visitors. The facility has one-hundred and twelve (112) certified beds and the census was ninety-nine (99) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/22/12 at 2:30 PM, with the Maintenance Director revealed a power strip was being used to power medical equipment (an oxygen concentrator and a mini-nebulizer) in resident room 3. Further observation, at 2:45 PM, with the Maintenance Director revealed a power strip was used to power medical equipment (an oxygen concentrator) in resident room 33.</p> <p>Interviews, on 08/22/12 at 2:30 PM and 2:45 PM,</p> | <p>K 025</p> <p>K 147</p> | <p>K147</p> <p>It is the practice of this center to assure compliance with NFPA 70, National Electrical Code at all times to include: one power strip being used to power medical equipment in room 3; and one power strip being used to power medical equipment in room 33.</p> <p>Medical equipment was immediately unplugged from power strips and plugged into appropriate receptacles on 08.22.12. Four-plex receptacles installed in rooms 3 and 33 on 08.22.12.</p> <p>Beginning October 1, 2012 and as part of its preventative maintenance program, Maintenance supervisor will conduct a house wide assessment and identify and maintain a weekly log of those rooms with power strips.</p> <p>All rooms will be inspected for power strips, by 10-07-12, to assure compliance with NFPA 70. <i>10-6-12 per Jeremy Rosenbaum</i></p> <p><i>by 10-10-12</i></p> <p>Facility will insure that no medical equipment, or any other inappropriate item, is being plugged into breaker bar power strips; if found immediate action will be taken to resolve issue.</p> <p>As part of his ongoing weekly rounds, at the all staff inservice on 09.28.12, and as part of his orientation presentation for new hires, the Maintenance Supervisor will educate all staff about proper use of receptacles to power medical equipment.</p> | |
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| NAME OF PROVIDER OR SUPPLIER WOODLAND TERRACE HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 147 | Continued From page 4 with the Maintenance Director revealed he was not aware of the misuse of power strips in resident rooms 3 and 33. He acknowledged the requirement for medical equipment to be plugged directly into a wall mounted electrical outlet. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. | K 147 | Beginning 10.01.12, Maintenance Supervisor will conduct weekly room inspections to guard against the misuse of power strips and to assure the proper use of receptacles. These inspections will be documented in the center's Preventive Maintenance Logs. The facility Safety Committee will review room inspection documentation on a monthly basis and monitor through bi-monthly inspections for 3 months, and thereafter annual inspections, to insure compliance with NFPA 70 and the Preventative Maintenance Program. Findings will be reported to PI committee quarterly and action taken to resolve any issues identified. | |

