

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



PRINTED: 04/29/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/15/2011
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NAME OF PROVIDER OR SUPPLIER  ROSEWOOD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE AND ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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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 000 INITIAL COMMENTS

An annual survey and abbreviated surveys (KY #16219, KY #16216, and KY #16215) were conducted on 04/12/11 through 04/15/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of "D". KY #16215 and KY #16219 were substantiated with deficiencies cited. KY #16216 was unsubstantiated with no deficiencies cited.

F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interviews and record review, it was determined the facility failed to identify and investigate an injury of unknown origin for one resident (#14), in the selected sample of 24. On 04/12/11 at 12:35 PM, Resident #14 was observed with purple discolorations on the right wrist, the back of the right hand, on the right ring finger and in the web space between the third and forth fingers of the right hand.  
Findings include:  
A review of the facility's policy and procedure, "Abuse Prevention," dated 04/28/09, revealed "injuries of unknown source were to be reported and investigated in accordance with the policy and supporting procedures."

F 000

*This Plan of Correction is the center's credible allegation of compliance.*

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F-226

5/23/11

F 226

1.) The event has been fully investigated by the Director of Nursing. A head to toe assessment was completed on resident #14 on 4/13/11 by the Unit Manager. An investigation determining the cause of the bruise to resident #14's right hand and wrist was completed on 4/14/11. Performance Improvement was completed by the Director of Nursing on 4/14/11 with Licensed staff and SRNA who failed to complete a thorough and accurate skin assessment of resident #14.

2.) A head to toe skin assessment will be done on all residents by a licensed nurse by 5/20/11. Any injuries of unknown origin will be investigated and appropriate action taken as needed per facility policy. According to facility policy observations of suspicious injury or injuries of unknown origin will be immediately reported to the charge nurse, Executive Director, Director of Nursing and investigated.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	5/23/11

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

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F 226	<p>Continued From page 1</p> <p>A record review revealed Resident #14 was admitted to the facility on 10/21/11 with diagnoses to include Alzheimer's, Seizure Disorder, Hypertension, History of Stroke, Coronary Artery Disease, History of Colon Cancer and a Cardiac Pacemaker.</p> <p>An observation, on 04/12/11 at 12:35 PM, revealed Resident #14 was asleep in the bed on his/her back. Dark purple discolored areas were observed on the right wrist, the right hand and on the third finger extending into the web space between the third and fourth fingers of the right hand.</p> <p>Reviews of weekly head to toe skin assessments dated 03/21/11, 03/28/11, 04/03/11, 04/06/11, 04/08/11 and 04/11/11 did not address any bruising/discolorations on the resident's right hand or the right wrist.</p> <p>During a skin assessment, the discolorations measured 2.6 centimeters (cm) x 3 cm on the right outer wrist, 6 cm x 5.2 cm on the outer aspect of the right hand, and 1.2 cm x 0.5 cm to the third finger/web space of the right hand.</p> <p>An interview with Resident #14, on 04/13/11 at 8:40 AM, revealed he/she was unaware how or when the bruising on the right hand and the right wrist occurred. The resident stated he/she bruised easily due to taking Aspirin.</p> <p>An interview with State Registered Nurse Aide (SRNA) #7, on 04/13/11 at 9:25 AM, revealed she was unaware how or when the bruising occurred. She stated the resident's roommate told her of an incident about Resident #14 hitting the door with his/her hand, but she did not recall</p>	F 226	<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>3.) All SRNA's will be in-serviced by the DNS, ADNS or SDC by 5/20/11 on reporting all bruises identified during care to the licenses nurse responsible for the resident. All Licensed nurses will be educated by the DNS, ADNS or SDC by 5/20/11 on performing a thorough head to toe skin assessments and proper documentation. Any bruises identified during head to toe skin assessments will be reported to the DNS or ADNS and investigated per facility policy.</p> <p>Injuries of unknown origin and allegations of abuse will be reviewed through the morning report process to ensure that the investigation and reporting process are completed and appropriate interventions have been implemented per facility policy.</p> <p>4.) The DNS, ADNS or designee will complete 3 head to toe skin assessment observations a day for 4 weeks and compare to the weekly skin assessments for accuracy. The results of these audits will be presented by the Director of Nursing at the monthly PIC meeting with corrective action taken as needed.</p>

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F 226	Continued From page 2 the date she was told this information.  An interview with Registered Nurse (RN) #3, on 04/13/11 at 9:45 AM, revealed she was unaware of the bruising on Resident #14's right hand and right wrist but she would look into it.  An interview with SRNA #1, on 04/14/11 at 11:00 AM, revealed she assisted the laboratory technician with a blood draw recently, but she was uncertain of the date. She stated the technician made two attempts before she was able to draw the blood. On the first attempt, the vein "blew" and it was the following night when SRNA #1 noticed the resident's right hand was bruised at that site. She stated she did not notify her supervisor about the bruised area.  An investigation was initiated by the facility on 04/13/11 and it was determined the causative factor for the bruising on the resident's right hand/wrist was related to a blood draw on 03/25/11.  An interview with the Director of Nursing (DON), on 04/14/11 at 5:50 PM, revealed she expected the staff to identify any discolorations and report immediately. The nurses completed weekly head to toe skin assessments on the residents. She revealed the nurses did not complete a thorough head to toe assessment for Resident #14.	F 226	<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>  The PIC committee consists of the DNS, ED, ARNP, Medical Director, Activity Director, Social Service Director, Dietitian, Business office Manager, Human Resource Manager, Housekeeping supervisor and Maintenance Supervisor.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280			

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F 280 Continued From page 3

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review, it was determined the facility failed to develop a review and revise a care plan for one resident (#6), in the selected sample of 24, related to oxygen use. A physician's order for oxygen was obtained on 04/12/11; however, the facility failed to update the residents care plan to reflect the continuous use of oxygen.  
Findings include:

A record review revealed Resident #6 was admitted to the facility on 11/10/09 with diagnoses to include Alzheimer's Disease, Dementia, Anxiety Disorder, and Psychotic Disorder. A review of a Significant Change Minimum Data Set (MDS), dated 02/22/11, revealed Resident #6 was assessed to be cognitively impaired and required extensive assistance with transfers and wheelchair mobility.

F 280

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F-280

5/23/11

1) Resident #6 no longer has a physician order for oxygen. The facility received an order to discontinue oxygen on resident #6 on 4/14/2011.

2) The Respiratory Therapist, DNS or designee, will complete a review of all residents with orders for oxygen by 5/12/11 and ensure the order is reflected on the care plan with appropriate interventions. A review of the SRNA care plan will also be completed by the Respiratory Therapist, DNS or designee by 5/12/11 to ensure that residents with orders for oxygen are reflected accurately on the SRNA assignment sheet.

3) The SDC, DNS, ADNS or designee will educate the licensed nurses by 5/20/11 to place all new orders on the 24 hour report including orders for oxygen. All new orders will be reviewed in the facility stand up meeting by DNS or designee, effective 5/12/11, to ensure care plan and SRNA care plan updates occur per facility policy.

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F 280	<p>Continued From page 4</p> <p>A review of the "Respiratory Physician's Orders", dated 04/12/11, revealed an order for "Oxygen 2 liters per nasal cannula continuous".</p> <p>An observation, on 04/13/11 at 11:35 AM, revealed Resident #6 was sitting in his/her wheelchair in the activities room without any oxygen in use. His/her head was laid back and his/her eyes were closed.</p> <p>An observation, on 04/13/11 at 2:00 PM, revealed the resident was sitting up in his/her wheelchair at the nurses station without any oxygen in use.</p> <p>A review of the comprehensive care plan, dated 02/22/11, revealed the facility did not develop and/or implement the intervention of continuous oxygen per nasal cannula. A review of the State Registered Nurse Aide care plan, undated, revealed Resident #6 did include an intervention of oxygen per nasal cannula; however, it did not specify continuous use of the oxygen.</p> <p>An interview with State Registered Nurse Aide #5, on 4/13/11 at 2:00 PM, revealed she was familiar with Resident #6 and she was not aware of the intervention for oxygen to be used continuously for Resident #6.</p> <p>An interview with Licensed Practical Nurse #3, on 4/13/11 at 11:40 AM, revealed she was unaware of an order for oxygen.</p> <p>An interview with Registered Nurse #5/South Unit Supervisor, on 04/13/11 3:45 PM, revealed an order for continuous oxygen for Resident #6 was received on 04/12/11. She stated that the order was placed in the resident's chart, but was not transcribed in the computer or on the care plan.</p>	F 280	<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>According to the facility policy the care plan will be updated during the course of care delivery for new problems or updated to reflect physician orders.</p> <p>4) The Director of Nursing, or her designee, will monitor all oxygen orders through resident record review, at least monthly for three months to assure that physician orders for oxygen are care planned and placed on the SRNA care plan. Results of the record reviews will be reported by the DNS or designee to the PIC committee monthly for 3 months with corrective action taken as needed.</p>	

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F 280 Continued From page 5  
If an order was put into system, it would be the responsibility of the nurse assigned to ensure the resident wore the oxygen at all times.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  
SS=D  
The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:  
Based on observations, interviews and record review, it was determined the facility failed to ensure one resident (#6), in the selected sample of 24, received oxygen (O2) in accordance with the physician's order, dated 04/12/11.  
Observations, on 04/13/11, revealed the resident was sitting up in his/her wheelchair without O2 in use.  
Findings include:

A record review revealed Resident #6 was admitted to the facility on 11/10/09 with diagnoses to include Alzheimer's Disease, Dementia, Anxiety Disorder, and Psychotic Disorder.

A review of a significant change Minimum Data Set (MDS), dated 02/22/11, revealed Resident #6 was cognitively impaired and required extensive assistance with transfers and wheelchair mobility.

A review of a physician's order, dated 04/12/11, revealed to administer "continuous O2 at two liters per minute per nasal cannula "

Observations, on 04/13/11 at 11:35 AM and at 2:00 PM, respectively, revealed Resident #6 was sitting in his/her wheelchair in the activities room

F 280  
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F 281  
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F-281 5/23/11

1.) Resident #6 no longer has a physician order for oxygen. The facility received a physician order on 4/14/11 to discontinue oxygen on resident #6.

2.) The Respiratory Therapist, DNS or designee, will complete a review, by 5/12/11, of all residents with orders for oxygen and ensure that the oxygen is in use as ordered.

3.) The Staff Development Coordinator will educate the licensed staff and SRNA's by 5/20/11 to ensure that all physician orders for oxygen are executed as ordered per facility policy. According to facility policy physician orders will be implemented as ordered.

4.) Random audits of 4 residents will be completed weekly by the DNS, ADNS or designee for 8 weeks to validate residents with orders for oxygen are receiving oxygen as ordered. The Director of Nursing or designee will report the findings of the audits to the PIC committee monthly for 2 months to ensure compliance.

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F 281 Continued From page 6.  
and then at the nurses' station without his/her O2 in use.

An interview with Licensed Practical Nurse (LPN) #3, on 4/13/11 at 11:40 AM, revealed the only physician's order she located in the chart revealed Resident #6 was to have O2 while in bed.

An interview with Registered Nurse (RN) #5/South Unit Supervisor, on 04/13/11 at 3:45 PM, revealed there was a physician's order, dated 04/12/11, for continuous O2 for Resident #6. It was the responsibility of the nurse to ensure Resident #6 had his/her O2 on continuously.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  
SS=D

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 observations, interviews and record review, it was determined the facility failed to ensure one resident (#6), in the selected sample of 24, received appropriate care in accordance with the care plan. Resident #6 was care planned to wear geri-sleeves and bunny boots at all times. Observations, on 04/13/11, revealed the resident's geri-sleeves or bunny boots were not in place. Additionally, the care plan revealed the resident was to have a lap buddy in place when he/she was up in the wheelchair.  
Findings include:

F 281

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F-282

5/23/11

F 282

1.) Performance improvement will be completed with the SRNA's and Licensed nurses assigned to the resident at the time the deficient practice was identified with the expectation that resident #6 have geri sleeves or long sleeves, bunny boots and a lap buddy on as ordered by the physician by 5/12/11. The unit manager will complete the performance improvement.

2.) A audit of all residents with an order for geri sleeves, long sleeves, bunny boots or a lap buddy will be preformed by the DNS, ADNS or designee by 5/12/11 to ensure compliance with physician orders.

3.) Licensed staff and SRNA's will be in-serviced by the SDC by 5/20/11 regarding following the plan of care and MD orders per facility policy. According to facility policy care plans and physician orders will be implemented as completed or updated.

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F 282 Continued From page 7

A record review revealed Resident #6 was admitted to the facility on 11/10/09 with diagnoses to include Alzheimer's Disease, Dementia, Anxiety Disorder and Psychotic Disorder.

A review of a significant change Minimum Data Set (MDS), dated 02/22/11, revealed Resident #6 was cognitively impaired and required extensive assistance with transfers and wheelchair mobility.

A review of the comprehensive care plan, dated 02/22/11, revealed interventions included a bunny boot to the left foot and geri-sleeves or long sleeves to be worn at all times. Additionally, the care plan revealed the resident was to have a lap buddy in place when he/she was up in the wheelchair. The staff checked the lap buddy every 30 minutes and released the resident every two hours for range of motion exercise. The lap buddy was also to be released during the meal service.

An observation, on 04/12/11 at 4:05 PM, revealed Resident #6 was sitting in his/her wheelchair and being assisted back to his/her room by the staff. He/she was not wearing the bunny boot to his/her left foot. Additionally, there was not a lap buddy in place on the resident's wheelchair, as care planned.

An observation, on 04/13/11 at 11:35 AM, revealed Resident #6 was sitting in his/her wheelchair in the activities area wearing a white short-sleeved shirt. No geri-sleeves or bunny boots were being utilized for the resident.

An interview with SRNA #5, on 04/13/11 at 2:20 PM, revealed she did not follow Resident #6's care plan for the bunny boot and the geri-sleeves.

F 282

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4.) The DNS, ADNS or designee will observe 2 residents a day for 8 weeks to ensure care plan and physician orders for lap buddies, bunny boots, geri sleeves or long sleeves are implemented. The DNS, ADNS or designee will report the findings of the audits to the PIC committee monthly for 2 months to ensure compliance.

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F 282 Continued From page 8  
She stated she must have overlooked that portion of the care plan which revealed he/she was to wear geri-sleeves or long sleeves, ad well as the bunny boot to his/her left foot

An interview with Licensed Practical Nurse (LPN) #3/Treatment Nurse, on 04/13/11 at 11:40 AM, revealed Resident #6 was care planned to wear the bunny boot and the geri-sleeves at all times. It was the nurse's responsibility to ensure care was provided according to the resident's plan of care.

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and record review, it was determined the facility failed to ensure appropriate care and services to prevent infections, related to catheter care, was provided for one resident (#7), in the selected sample of 24.

Findings include:

A review of the facility's policy "Indwelling Urinary Catheter Care", dated 04/28/10, revealed to wash the perineum beginning at the junction of the

F 282  
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F-315  
1.) Resident #7 no longer resides at Rosewood Health Care Center.

2.) The DNS, ADNS, or designee will observe catheter care performed by all SRNA's by 5/22/11 to ensure compliance with facility policy to prevent infections. According to facility policy care of a catheter is provided to prevent infection and/or reduce irritation and is also performed according to current standards of nursing practice.

3.) The SDC, DNS ADNS or designee will in-service all SRNA's on following the facility policy for providing indwelling catheter care. The Staff Development Coordinator will perform clinical competencies with SRNA's to ensure to ensure they complete catheter care per policy by 5/22/11.

5/23/11

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F 315 Continued From page 9  
catheter tubing and meatus, working outward to the surrounding perineal structures with soap and warm water (or a no rinse cleaning solution). Clean from front to back.

A record review revealed Resident #7 was admitted to the facility on 02/03/11 with a readmission date of 03/10/11. A review of the quarterly Minimum Data Set (MDS), dated 03/30/11, revealed the resident had an indwelling catheter and required total assistance with bathing and hygiene.

A review of the "Evaluation of Medical Justification for Indwelling Catheter Use", dated 03/10/11, revealed the resident had persistent overflow incontinence with symptomatic infections.

An observation, on 04/14/11 at 2:30 PM, revealed State Registered Nurse Aide (SRNA) #4 provided catheter care with a "baby wipe" for Resident #7. She used the "baby wipe" and cleansed the catheter tubing downward about four inches. Then she cleansed the outer perineum from front to back, using the same "baby wipe." SRNA #4 then cleansed between the labia, without folding over or obtaining a new "baby wipe."

An interview with SRNA #4, on 04/14/11 at 2:40 PM, revealed she assisted the resident with a shower, and felt a "baby wipe" was appropriate to provide catheter care. She revealed she should have cleansed the resident's perineal area before she cleansed the catheter tubing, and should have folded the "wipe" over after each contact with the resident.

An interview with the Director of Nursing (DON),

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4.) The Director of Nursing or designee will observe 3 SRNA's a week for 8 weeks perform catheter care to ensure compliance with the facility policy. The DNS or designee will report her findings to the PIC committee monthly for 2 months to ensure compliance.

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F 315	Continued From page 10 on 04/14/11 at 2:45 PM, revealed she expected the staff to follow the policy for perineal care.  F 323 483 25(h) FREE OF ACCIDENT SS=D 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.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to provide adequate supervision to prevent an accident for one resident (#6), in the selected sample of 24.  Resident #6 was assessed with care plan interventions to include the use of a lap buddy, when the resident was up in a wheelchair. However, Resident #6 sustained a fall from the wheelchair on 04/11/11. The lap buddy was not in use at the time of the fall. The resident sustained a skin tear and bruising as a result of the fall. Findings include:  A review of the facility's policy and procedure, "Accidents and Supervision to Prevent Accidents", dated 08/06/07, revealed the facility would provide supervision and assistive devices for each resident to prevent avoidable accidents. The facility would conduct assessments for the need for assistive devices, develop care plans and implement preventive measures for the	F 315   F 323	<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-323  1.) Performance Improvement was completed with the Licensed Nurse and SRNA assigned to resident #6 on 5/6/11. The unit manager will complete the performance improvement with the Licensed Nurse and SRNA assigned to resident #6.  2.) The Director of Nursing, through record review and observation will identify all other residents with orders for lap buddies and ensure the lap buddies are in place per physician orders and ensure assessments are completed by 5/22/11. All licensed staff and SRNA's will be educated by 5/22/11 on following the care plan and ensuring devices such as lap buddies are in place to prevent accidents. The DNS, SDC or designee will complete the in-servicing.  3.) All licensed staff and SRNA's will be educated by the SDC by 5/20/11 on following the care plan for lap buddies per facility policy. According to facility policy care plans and physician orders will be implemented as completed or updated.	5/23/11

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F 323	<p>Continued From page 11</p> <p>residents identified as at risk for falls and assessed the resident to determine whether supervision was necessary. The facility would evaluate the accident risk data, analyze accident risks and identify and design interventions based on the immediacy of the risk. The facility would implement the interventions correctly and consistently and provide adequate supervision. The facility would evaluate interventions when necessary to ensure the interventions were effective to address risks. Further review of the facility's policy revealed the lack of adequate supervision to prevent accidents was defined as when the facility failed to accurately assess a resident to determine whether supervision to avoid an accident or injury was necessary and/or determined supervision of the resident was necessary, but failed to provide it.</p> <p>Resident #6 was admitted to the facility on 11/10/09, with diagnoses to include Alzheimer's Disease, Dementia, Anxiety Disorder, and Psychotic Disorder. A review of the Significant Change Minimum Data Set Assessment (MDS), dated 02/22/11, revealed Resident #6 was assessed as cognitively impaired and required extensive assistance with transfers and wheel chair mobility.</p> <p>An observation, on 04/13/11 at 11:35 AM, revealed Resident #6 was sitting his/her wheelchair in lobby area. The resident had a large skin tear to left side of elbow, with greenish-yellow bruising which extended the length of the elbow.</p> <p>A review of the "Interdisciplinary Physical Restraint Evaluation", dated 01/28/11, revealed Resident #6 was assessed as having decreased safety awareness secondary to Advanced</p>	F 323	<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>4.) All residents identified with orders for lap buddies will be visualized by the DNS, ADNS or designee daily for 3 months to ensure the lap buddy is in place per physician orders and validate that assessments are completed as appropriate. The DNS or designee will report the findings of the audits to the PIC committee monthly for 3 months to ensure compliance.</p>

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F 323	Continued From page 12  Alzheimer's Dementia and a lap buddy was implemented for safety and postural support. Supervision included checking on the resident every 30 minutes and releasing the lap buddy every two hours for exercise, positioning and toileting.  A review of the Comprehensive Care Plan, dated 02/22/11, revealed interventions included the use of the lap buddy and a footboard to the wheelchair for safety.  A review of a post fall evaluation, dated 04/11/11 at 5:00 PM, revealed Resident #6 sustained a fall from the wheelchair when He/She slid out of chair onto the knees in front of chair in lobby area. His/her head did not hit the floor and the lap buddy was not in place at time of fall. The fall caused a skin tear to the resident's left elbow to reopen and wound was cleaned and dressed.  An interview with Licensed Practical Nurse #3/Treatment Nurse, on 04/13/11 at 11:40 AM, revealed Resident #6's fall on 04/11/11 occurred while the resident was in the day room and staff did not ensure the lap buddy was in place on the resident's wheelchair.	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 -	F 441			

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(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:  
During an abbreviated survey conducted 03/14/11 through 03/15/11 the facility failed to implement an Infection Control program which assured investigation, control, and prevention of the spread of Scabies in the facility. An acceptable Plan of Correction (PoC) was received on 04/05/11 alleging "when a suspected or confirmed case of scabies is reported a licensed

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1.) A skin assessment was completed on 4/14/11 by Licensed nurses for residents 19, 25, 26, 27 and 28 which showed no signs or symptoms of scabies. The licensed nurse that did not complete the skin assessments for residents 19, 25, 26, 27 and 28 was counseled by the DNS on 5/6/11 on the facility policy for the prevention of scabies. According to the facility policy on the prevention of scabies an Infection Control and Prevention Program identifies and reduces the risk of acquiring and transmitting scabies among residents, staff, volunteers, students, and visitors. The program includes staff training, surveillance and infection tracking and trending.

2.) All current residents will have a skin assessment completed by 5/11/11 by a licensed nurse.

3.) All licensed staff will be in-serviced by the DNS or designee by 5/12/11 on completing a skin assessment when a suspected or confirmed case of scabies is confirmed.

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F 441	<p>Continued From page 14</p> <p>nurse will complete a skin assessment on all current residents on that hall on which the resident resides. Any residents or staff at risk will be simultaneously treated as ordered within the same 24 hour period. All nursing employees on that unit and all other employees with close resident contact will be interviewed and/or assessed to determine the need for treatment as directed by the Advanced Practice Registered Nurse or Medical Director, preferably within the same 24 hour time span". Based on interviews and record reviews, it was determined the facility's Infection Control program was not implemented for one resident (#19) in the selected sample of 24, and for four residents (#25, #26, #27, &amp; #28) not in the selected sample, related to not having a skin assessment completed after a case of scabies was diagnosed on 04/07/11.</p> <p>Findings include:</p> <p>A review of the policy entitled "Infection Control and Prevention Program" dated 10/13/09 revealed the program was designed to identify and reduce the risk of acquiring and spreading infection, and maintained to provide a safe, sanitary and comfortable environment.</p> <p>A review of the policy entitled "Scabies" dated 10/31/06 revealed the risk for residents becoming infested is minimized by early detection, isolation, and precautions. Treatment included treating all residents with scabies at the same time, evaluate all residents on the involved wing, all nursing employees, and all other employees with close resident contact.</p> <p>1. A record review revealed Resident #19 was</p>	F 441	<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>All licensed staff will be in-serviced by the DNS by 5/12/11 on the prevention of scabies' and how to identify signs and symptoms of scabies infestation.</p> <p>When a suspected or confirmed case of scabies is reported a licensed nurse will complete a skin assessment on that resident and on all current residents on that hall on which the resident resides during that shift the nurse is working. The skin assessments will be completed the same day that the suspected or confirmed case of scabies is identified. All staff working on the unit with suspected or confirmed scabies will be interviewed and assessed by a licensed nurse to determine if the employee has been exposed to scabies or is infected with scabies. Educational literature from the CDC website on the identification and treatment of scabies will be provided to any employee that has been exposed or is infected with scabies. Any employee that is confirmed to be infected with scabies will be treated with pharmaceuticals by the facility ARNP.</p>

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F 441	<p>Continued From page 15</p> <p>admitted to the facility on 10/06/09 with diagnoses to include Osteoarthritis, Coronary Artery Disease, Depression and Diabetes Mellitus.</p> <p>Further review of the Treatment Record dated 04/01/11 through 04/30/11 revealed on 04/07/11 at 12:00 PM, Resident #19 received a treatment of Elimate cream (scabicide alters the parasite cell membrane function) from his/her neck to toes.</p> <p>A review of the record revealed there was no previous documentation of the resident complaining of itching or having a rash. A review of "Resident Progress Notes" and "Physician Telephone Orders," dated 04/07/11 at 9:00 AM, revealed documentation by Licensed Practical Nurse (LPN) #2 related to the dermatologist being in the facility and examining the resident. The progress note revealed Resident #19 with scattered red areas. The physician gave an order "Elimate cream from his/her neck to toes. Wash off after 14 hours and repeat in one week".</p> <p>A review of the "Resident Weekly Skin Check Sheet" revealed a skin assessment was completed on 04/02/11 and 04/09/11. The resident was identified with scabies on 04/07/11 and there was no evidence a skin assessment was completed at that time.</p> <p>2. A record review revealed Resident #25 was admitted to the facility on 12/6/06 and readmitted to the facility on 12/11/08 with diagnoses to include Hypertension, Status Post Cerebral Vascular Accident, and Hypokalemia. He/she resided on the "D" hall.</p> <p>A review of the "Resident Weekly Skin Check Sheet" revealed a skin assessment was</p>	F 441	<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>Licensed nurses will notify the physician, infection control nurse and/or Director of Nursing immediately when there is a confirmed or suspected case of scabies. The infection control nurse or designee will validate resident skin assessments and staff interviews are completed when scabies is suspected or confirmed. The infection control nurse will track and trend all suspected or confirmed cases of scabies.</p> <p>This validation will be completed by the use of a daily validation tool that will track and trend skin assessment results and staff interviews. The tool will include a facility diagram reflecting suspected or confirmed cases of scabies.</p> <p>4.) The DNS, ADNS or designee will validate skin assessments that were completed on any resident with a suspected or confirmed case of scabies including all residents on the same hall daily for 4 weeks to ensure compliance. This validation will be completed by the use of a daily validation tool that will track and trend skin assessment results and staff interviews.</p>	

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F 441 Continued From page 16  
completed on 04/01/11 and 04/12/11. A resident (#19) living on the "D" hall was identified as having scabies on 04/07/11 and the facility failed to provide evidence of a skin assessment completed within the 24 hours of discovering a resident had a rash. Additionally, on 04/07/11 there was no documentation in the resident progress note of a skin assessment or a description of any skin issues.

3. A record review revealed Resident #26 was admitted to the facility on 07/23/06 and readmitted on 11/24/06 with diagnoses to include Alzheimer's Disease, Anemia and Altered Mental Status.

A review of the "Resident Weekly Skin Check Sheet" revealed a skin assessment was completed on 04/05/11 and 04/12/11. The facility failed to provide evidence a skin assessment was completed on the resident within 24 hours of discovering another resident on the hall had a rash. There was no documentation in the progress note of a skin assessment and/or identification of any skin issues on 04/07/11.

4. A record review revealed Resident #27 was admitted to the facility on 05/12/09 with diagnoses to include Altered Mental Status, Diabetes Mellitus, Hypertension and Chronic Obstructive Pulmonary Disease.

A review of the "Resident Weekly Skin Check Sheet" revealed a skin assessment was completed on 04/05/11 and 04/12/11. The facility failed provide evidence a skin assessment was completed on the the resident with in 24 hours of discovering another resident on the hall had a

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Results of the audits will be reported by the DNS at the PIC meeting for one month. The infection control nurse will report the tracking and trending of suspected or confirmed scabies to the PIC committee monthly on an ongoing basis.

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F 441	<p>Continued From page 17</p> <p>rash. The progress note revealed there was no documentation on 04/07/11 of a skin assessment and/or description of any skin issues.</p> <p>5. A record review revealed Resident #28 was admitted to the facility on 05/12/09 and readmitted on 11/19/09 with diagnoses to include Hypertension, Congestive Heart Failure and Alzheimer's Disease.</p> <p>A review of the "Resident Weekly Skin Check Sheet" revealed a skin assessment was completed on 04/04/11 and 04/11/11. The facility did not provide evidence a skin assessment was completed on the resident within 24 hours of discovering another resident on the hall had a rash. The progress notes revealed no documentation on 04/07/11 of a skin assessment and/or description of any skin issues.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 04/14/11 at 11:15 AM, revealed there was no documentation a skin assessment was completed for Resident #19, #25, #26, #27, and #28. She stated there was no documentation in the nurse's notes of the resident being checked for complaints of itching or rash. She stated "if it is not documented it was not done".</p> <p>An interview with the Infection Control Nurse, on 04/15/11 at 10:05 AM, revealed when a resident was identified with a rash consistent with scabies, then the residents living on that hall were assessed from head to toe. The resident identified with the rash was put in contact isolation and the family and physician were contacted. The residents personal items were removed and remained bagged for 10 days. Housekeeping came in to deep clean the room and removed all</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  ROSEWOOD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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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 441 Continued From page 18

of the bedding and curtains to wash. She stated she reviewed the skin assessments on the residents to ensure they were completed timely. The staff who had close contact with the resident were interviewed and followed up with the Unit Manager, Advanced Registered Nurse Practitioner (ARNP) or the Infection Control Nurse, if skin issues developed. She stated the skin assessments for the residents who resided on the same unit should be started when a resident was identified with a rash consistent with scabies and completed within a 24 hour time period. She could not provide an explanation for Residents #19, #25, #26, #27, and #28 not having a head to toe skin assessment completed.

An interview with Licensed Practical Nurse (LPN) #2, on 04/15/11 at 10:25 AM, revealed once Resident #19 was identified with scabies, then he/she was put into isolation. She stated the resident was treated with Elimate cream and the resident's room was cleaned. The other residents living on the hall received head to toe skin assessments. LPN #2 stated she did not complete a head toe skin assessment on Resident #19. She also reported after she checked the chart "there was no documentation in the record of a skin assessment completed" and could not explain why it was not completed.

An interview with Registered Nurse (RN) #3, on 04/15/11 at 1:00 PM, revealed she was the Unit Manager for halls "A", "B", "C" and "D". She stated the dermatologist was in the facility on 04/07/11 and completed a skin assessment on the resident. She stated "I think the hall nurse reported the resident's complaint to the physician and thought his/her assessment was enough. We completed the skin assessments on the

F 441

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NAME OF PROVIDER OR SUPPLIER  ROSEWOOD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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F 441 Continued From page 19  
other residents and gave the information to the Director of Nursing (DON). We found no skin assessment on the resident, but should have had one completed".

F 505 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS

The facility must promptly notify the attending physician of the findings

This REQUIREMENT is not met as evidenced by:

Based on observations, interviews and record review, it was determined the facility failed to promptly notify the attending physician of laboratory findings for one resident (#3), in the selected sample of 24. Resident #3 required therapeutic monitoring for the drug Dilantin. A laboratory test was obtained on 03/17/11 but the attending physician was not notified of the findings.

Findings include:

A review of the facility's policy and procedure titled, "Physician Notification Vital Signs or Laboratory Values", dated 10/31/10, revealed "any drug level above the therapeutic level to notify the physician on the next office day."

A record review revealed Resident #3 was admitted to the facility on 07/28/10 with diagnoses to include Dementia, Depressive Disorder and Seizure Disorder.

A review of a quarterly Minimum Data Set (MDS), dated 02/07/11, revealed Resident #3 was cognitively impaired and required extensive assistance with transfers and was mobile per a wheelchair

An observation, on 04/13/11 at 9:00 AM, revealed Resident #3 was sitting in a wheelchair in his/her

F 441

*This Plan of Correction is the center's credible allegation of compliance.*

F 505

*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*

F-505

5/23/11

1.) For resident #3 a STAT dilantin level was drawn on 4/13/11 by a licensed nurse, reported to the physician by the DNS and the dose of dilantin was adjusted per physician orders. All licensed nurses working within 24 hours of the original lab draw of dilantin have been counseled by the Director of Nursing on notifying the physician of lab results per facility policy. The counseling occurred on 5/6/11.

2.) All residents receiving dilantin will have their labs and orders reviewed by the DNS by 5/9/11 to ensure timely labs were performed and physician notification occurred for the results.

3.) A newly developed log was implemented on 4/5/2011 by the ADNS for all labs to ensure that draws occur timely, results are received and the physician is notified of the results. Results will also be placed in the chart after the physician is notified and is checked off in the log by the licensed nurse.

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NAME OF PROVIDER OR SUPPLIER  ROSEWOOD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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F 505 : Continued From page 20

room with a breakfast tray on the over bed table in front of him/her. The resident's head was bowed, eyes were closed and he/she did not respond when spoken to.

An observation, on 04/13/11 at 10:30 AM, revealed Resident #3 was in the dining room with several peers who were participating in a group activity. The resident was sitting at a table in a wheelchair and had his/her head resting on the table with his/her eyes closed. He/she did not respond to repeated attempts of staff to wake him/her. The resident was taken to his/her room and assisted to bed.

A review of physician's orders, dated February 2011 and March 2011, revealed Dilantin levels were to be obtained. A Dilantin level was obtained on 02/08/11; however, there was no evidence of a Dilantin level in the resident's record for March 2011.

After surveyor questioning, on 04/13/11, the Assistant Director of Nursing (ADON) obtained laboratory test results from the laboratory computer data base, dated 03/17/11. The result was a Dilantin level of 25.0 (high).

An interview with the ADON, on 04/14/11 at 10:45 AM, revealed she did not know how the laboratory results were missed. Abnormal results, which could have indicated a need for change in treatment, were supposed to be faxed to the facility from the laboratory and there was no evidence those results for Resident #3 were faxed.

The physician was not notified of the abnormal result that would have changed the course of the resident's treatment. A stat Dilantin level was ordered 04/13/11 and the result was 27.4 (high). The physician was notified and new orders were obtained which included to hold the Dilantin for two days and obtain another level on 04/18/11.

F 505

*This Plan of Correction is the center's credible allegation of compliance.*

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All licensed staff and the ward clerk will be in-serviced by the DNS, ADNS or designee by 5/12/11 on the log to ensure compliance with facility policy on physician notification of laboratory values. According to facility policy the physician will be notified by a licensed nurse of the lab result when the facility receives the lab report. The unit manager will be responsible to maintain the lab log and validate that the results are placed in the medical record.

4.) The lab log will be reviewed daily by the DNS, ADNS or designee to ensure compliance. The lab log will be brought by the DNS to the monthly PIC monthly for three months to ensure compliance.

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NAME OF PROVIDER OR SUPPLIER  ROSEWOOD HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  04/12/2011
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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and conducted on 04/12/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		
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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.