

AMENDED 05/25/10

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

PRINTED: 05/12/2010
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 04/30/2010
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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 000	INITIAL COMMENTS	F 000	This Plan of Correction is the center's credible allegation of compliance.	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review it was determined the facility failed to provide services to meet professional quality of care for one resident (#7), in the selected sample of 26. Resident #7 had a physician order for oxygen administration at three liter per minute (L/M). The facility failed to ensure the physician's orders were consistently followed. Findings include: A review of the facility's policy and procedures for oxygen administration, dated 10/31/07, required the flow meter reflect the physician's prescribed flow rate and the rate should be monitored by the licensed nurse at regular intervals. A review of the physician's order, dated 04/23/10, revealed the resident was to receive O2 at 3 L/M per nasal cannula. Observations on 04/27/10 at 10:00 AM and 3:05 PM revealed the O2 was set at 2 and 1/2 L/M and on 04/28/10 at 8:30 AM revealed the O2 was set at 3 and 1/2 L/M. A review of the April Respiratory Medication Record revealed the</p>	F 281	<p>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.</p> <p>F281 1) The nurses responsible for checking the oxygen flow rate for resident # 7 were individually counseled regarding correct procedures. 2) The Director of Nursing (DNS), Asst. DNS and Respiratory Therapist (RT) conducted an audit of the charts to identify residents who have an order for oxygen. The flow rate is listed on the residents' MAR and licensed nurses will check rate every two hours. The DNS and/or RT will observe the residents during daily rounds to assure the concentrator is set at prescribed flow rate. The SDC will review the facility procedure for recording monitoring of oxygen with licensed nurses. 3) The Staff Development Coordinator (SDC) will provide an inservice for all nursing staff on meeting professional standards of quality that include monitoring oxygen flow rate, to be completed by 5/20/10. The SDC will include this information in the orientation of new licensed personnel. SRNAs will be in-serviced by the SDC, RT or DNS on the monitoring of oxygen, with an emphasis on checking flow rate, 5/14 - 5/27/10.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lathy Skapp TITLE: Executive Director (X6) DATE: 05/24/10

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.

Amended Date from 5/20/10

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: K6MP11 Facility ID: 100410 If continuation sheet Page 1 of 13

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F 323	<p>Continued From page 2</p> <p>Observations during the survey revealed the facility failed to ensure the alarm was activated and the resident was observed transferring and toileting without staff intervention. Findings include:</p> <p>A review of the facility's policy and procedure for "Accidents and Supervision to Prevent Accidents", dated 08/06/07, revealed the facility provided supervision and assistive devices for each resident to prevent avoidable accidents. The facility assessed the need for assistive devices, care planned and implemented preventive measures for the residents at risk for falls and assessed the resident to determine whether supervision was necessary. The facility evaluated the accident risk data, analyzed accident risks and identified and designed interventions based on the immediacy of the risk. The facility implemented the interventions correctly and consistently, including adequate supervision. The facility evaluated interventions when necessary to make them more effective in addressing risks. Further review of the facility's policy "Accidents and Supervision to Prevent Accidents" revealed the definition of the lack of adequate supervision to prevent accidents occurred when the facility had 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>1. A record review revealed Resident #6 was admitted to the facility on 05/21/10 with diagnoses to include End Stage Alzheimer's Disease and Dementia with behavior disturbance.</p> <p>Observations of Resident #6 on 04/27/10 at 11:50</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>Alarms will be checked every two hours & SRNA and LN will document checks daily.</p> <p>3. Director of Nursing, ADNS or Unit Manager will review the MARs & SRNA flow sheets, of residents using bed or chair alarms, to assure checks are being made and documented. Appropriate corrective action will be taken if need identified. DNS, UM and SDC will complete a random check of six (6) alarms daily to ensure alarms are on and working properly. Staff have been in-serviced by the SDC or DNS on appropriate supervision methods and checks of residents with interventions utilizing alarms. In-services will be completed by 5/24/10 and will be included in the orientation of new employees.</p> <p>4. Results of these audits will be reviewed and analyzed with a plan of action developed and implemented as indicated. The Director of Nursing will report data related to resident alarms to the Performance Improvement</p>	
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F 323	<p>Continued From page 3</p> <p>AM, 3:10 PM and 4:15 PM and on 04/28/10 at 11:15 AM revealed the resident was sitting in his/her wheelchair with an attached seatbelt in place. The resident also wore a helmet, elbow and knee pads, rib protector pads and hip pads. The resident had purple, greenish-yellow bruising that extended to the left side of the forehead and both eyes.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 04/22/10, revealed the resident's cognitive skills were severely impaired and the resident was totally dependent on staff for transfers, was unable to walk and had experienced falls in the past 30 days and 30-180 days.</p> <p>A review of the Comprehensive Care Plan for "potential for trauma from falls", dated 04/21/10, revealed Interventions included a floor mat by a low bed, a saddle cushion to the resident's wheelchair, keep the resident in high traffic areas when up in wheelchair, a door sensor alarm to the doorway of the resident's room to alert staff when the resident entered the room and application of protective equipment (helmet, elbow, knee, rib and hip protectors), when up in a wheelchair.</p> <p>A review of a post fall evaluation, dated 02/14/10 at 6:30 PM, revealed the resident got out of the bed unassisted and was found lying on the floor of his/her room. The resident had a hematoma involving the left side of the resident's head. The evaluation indicated an intervention was initiated to toilet the resident after supper and then place the resident at the nurse's desk, where he/she was to remain until bed time.</p> <p>A review of a post fall evaluation, dated 02/16/10</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>Committee monthly for three months and quarterly thereafter.</p>	Completion Date 6/14/10
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F 323	<p>Continued From page 4</p> <p>at 5:30 PM, revealed the resident was found on his/her bathroom floor and sustained no injury. An intervention was added to the resident's care plan for the application of protective gear (helmet, knee and elbow pads, rib protector pads and hip pads).</p> <p>A review of a post fall evaluation, dated 03/15/10 at 6:00 PM, revealed the resident was found in his/her room on the floor and sustained no injury. An intervention was initiated to check and change the door alarm batteries on a weekly basis. Review of the evaluations revealed no evidence the facility identified Resident # [redacted] had fallen both times in his/her room after supper when the resident's care plan interventions required the resident be located at the nurse's desk for supervision.</p> <p>A review of post fall evaluations, dated 03/22/10 at 9:15 PM, 04/04/10 at 5:15 PM and 04/05/10 at 12:45 PM, revealed the resident sustained falls getting up from his/her wheelchair while located in the lobby area at the nurse's desk. The staff observed the resident stand up each time, but were unable to reach the resident and prevent a fall. New interventions included placing the resident on 15 minute checks for 72 hours on 03/22/10, two staff to assist the resident to stand and ambulate every two hours and placing the resident on 30 minute checks for 72 hours on 04/05/10. Review of the evaluations revealed no evidence the facility identified the resident continued to fall even when in sight of staff.</p> <p>A review of a nurse's note, dated 04/07/10 at 12:50 PM, revealed therapy was evaluating the application of a seatbelt to the resident's wheelchair and the note indicated the resident</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>had not attempted to stand up during the trial placement of the seatbelt. However, there was no evidence the facility provided an intervention for increased supervision when the seatbelt was not in place.</p> <p>A review of a post fall evaluation, dated 04/08/10 at 5:40 PM, revealed the resident was located in front of the nurse's desk in his/her wheelchair. The resident leaned forward in the wheelchair and fell to the floor and was found lying on his/her right side. Staff were unable to reach the resident in time to prevent the fall. The evaluation revealed the resident was placed on every thirty minute checks. The Interdisciplinary (IDT) team indicated on the post fall evaluation that the resident was currently on a trial intervention for a seatbelt to the wheelchair during therapy, but there was no intervention to address the resident continuing to have falls, while sitting at the nurse's desk in staff's sight.</p> <p>A review of a nurse's note, dated 04/09/10 at 10:30 AM, revealed the IDT team decided to use the seat belt continuously on the resident when up in the wheelchair for positioning and safety. A review of a condition change form, dated 04/09/10 at 11:30 AM, revealed a physician's order for a seat belt while up in wheelchair. However, review of condition change form, dated 04/09/10 at 12:30 PM, revealed Resident #6 was found lying on the floor in the doorway of the resident's room lying on his/her left side. There was a seatbelt attached to the wheelchair. The condition change form revealed the resident sustained a large hematoma (bruise) measuring 7.0 by 5.0 cm. to the left side of the forehead. The resident did not open his/her eyes or speak for three to five seconds.</p>	F 323		

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F 323	Continued From page 6 An interview with Licensed Practical Nurse (LPN) #1 on 04/29/10 at 3:00 PM, revealed all staff should have monitored Resident #6 to ensure the resident was at the nurse's desk. The resident wheeled him/herself down the hall and staff did not notice. When the resident fell, the seatbelt was on the wheelchair but staff had not been informed the seatbelt was to be implemented for the resident. Interviews with LPN #3, Unit Manager on 04/29/10 at 9:10 AM, revealed she tracked and trended all falls for each resident by hall, shifts and times. She stated Resident #6's falls were noted to occur right after lunch and supper meals when the resident went to his/her room and tried to transfer to the bed or the toilet. Interventions were implemented to toilet the resident after meals and place the resident at the nurse's desk to increase supervision of the resident; however, the issue of the resident continuing to fall in his/her room after meals when he/she was supposed to be at the nurse's desk was not identified. She stated when the resident continued to have falls at the nurse's desk, new interventions were put in place but none of the interventions provided adequate supervision for the resident as evidenced by the fact the resident continued to stand and fall during staff supervision at the nurse's desk. She revealed when the resident fell in the room doorway, the nurse documented she received a physician's order for the seatbelt and conducted the restraint assessment, but had not notified staff of the need to implement the seatbelt. 2. Resident #14 was admitted to the facility with diagnoses to include Depressive Disorder,	F 323		

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F 323	<p>Continued From page 7</p> <p>Anemia, and Hypertension.</p> <p>A review of the quarterly MDS, dated 02/18/10, revealed the resident was moderately impaired in his/her cognition, with poor ability to make decisions and required reminders, cues and supervision in planning, organizing, and correcting daily routines.</p> <p>Observation, on 04/27/10 at 10:55 AM, revealed the resident self propelled his/her wheelchair into the resident's room and the bathroom and transferred him/herself from the wheelchair to the commode. A sensor alarm was attached to the resident's wheelchair, which did not sound. State Registered Nursing Assltant (SRNA) #3 was summoned to the room by the surveyor to assist the resident. SRNA #3 stated the sensor alarm to the resident's wheelchair was off and should have been activated. The same day, at 3:30 PM, Resident #14 was observed once again in the bathroom toileting himself/herself and the resident's alarm to the wheelchair did not sound. Additionally, an observation on 04/28/10 at 8:55 AM, revealed Resident #14 was in his/her spouse's room in his/her wheelchair and the sensor alarm to the resident's wheelchair was not activated.</p> <p>A review of the comprehensive care plan entitled "Falls", dated 02/12/10, revealed interventions included a sensor pad to the wheelchair, which would be checked every shift for working order and functioning. Other interventions included a low bed, locked bed brakes, and a bed alarm in place, which would be checked every shift for proper functioning.</p> <p>An interview, on 04/27/10 at 11:00 AM, with</p>	F 323	
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F 323	<p>Continued From page 8</p> <p>SRNA #3 revealed she assisted the resident with transferring from the toilet back to the wheelchair. She stated the alarm to the resident's wheelchair was not activated when she assisted the resident. SRNA #3 stated the wheelchair alarm was supposed to be activated when the resident was in the wheelchair.</p> <p>An interview, on 04/27/10 at 3:45 PM, with SRNA #5 revealed she was assigned to provide care to the resident on 04/27/10 during the 3-11 shift. She stated the resident's alarm to the bed did not sound when the resident got up from the bed to transfer to the wheelchair. "When we come in on our shift, we are supposed to check the alarms to make sure they are functioning properly. I have not had a chance to check the alarms since arriving to work. I don't know if the alarm is broke or not working". SRNA #5 was observed to activate Resident #14's alarm at 3:52 PM.</p> <p>An interview, on 04/29/10 at 9:50 AM, with SRNA #4 revealed she was assigned to provide care to Resident #14 on 04/27/10 during the 7-3 shift. She stated she checked the alarm when she came on duty but thought the charge nurse documented on the form the alarms were checked. SRNA #4 stated the alarms were checked at the beginning of the shift and periodically throughout the day because Resident #14 turned the alarms off at times.</p> <p>An interview, on 04/30/10 at 10:15 AM, with LPN #1 revealed she was the charge nurse on the unit. She arrived on the unit at 6:00 AM and completed a walking round to check the alarms. She also checked the alarms periodically throughout the day and before she left at the end of the shift. LPN #1 stated "The aides check the</p>	F 323			

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F 323	Continued From page 9 alarms at the beginning and end of the shift." She did not know what the problem was regarding alarms being found not activated. She stated, "I don't know if the aides are forgetting to turn them on or if the resident is turning them off". An interview, on 04.28/10 at 4:25 PM, with the Director of Nursing (DON) revealed the resident got up unassisted and turned off the alarms. Staff had observed the resident turn the alarms off. The DON stated at every change of shift the nurse and SRNA checked the alarms to ensure they were on and functioning properly.	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 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to provide food prepared in a form designed to meet individual needs for one resident (#6) in the selected sample of 26 and one resident (#28) not in the selected sample. Findings include: A review of the facility's Dining Standards policy and procedure, dated 10/31/09, revealed residents rights and wishes were respected and reasonable accommodations were made for what residents wanted to eat. Supplements were not served with the meal unless the rationale for doing so was documented or a physician's order indicated to serve with meals.	F 365	F 365 1. Residents #28 trays are being served with items identified on cards. Resident #6 in no longer at Rosewood. Trays are checked by Nutritional Services manager (NSM) or Asst. NSM before delivery to residents. 2. Tray cards will be audited for correct utensils, diet and consistency. The NSM or Registered Dietician (RD) will ensure that all discrepancies are corrected during review. Dietary and nursing staff have been inservice on providing meals per recommendations and resident needs identified on the meal tray cards. Inservice provided by SDC, RD or NSM, to be completed by 5/24/10. 3. The DNS, RD or NSM will review new diet orders on a weekly basis		

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F 365	Continued From page 10 1. Observation of the noon meal, on 04/27/10 at 11:30 AM, revealed Resident #27 was sitting at the table with his/her lunch tray in front of him/her and feeding him/herself. The resident was not eating the carrots. A review of the meal slip revealed the resident disliked carrots. An interview with the resident revealed he/she did not like carrots. 2. Observation of the breakfast meal, on 04/28/10 at 8:35 AM, revealed Resident #6 was sitting in his/her wheelchair with the over-the-bed table in front of him/her. The breakfast tray was delivered and set up. A review of the resident's meal slip revealed the resident was supposed to receive buttermilk with every meal and Ensure pudding with meals and coffee. Observation revealed there was no coffee, buttermilk or Ensure pudding served on the resident's tray. Interviews with State Registered Nurse Aide (SRNA) #1 and SRNA #2, on 04/29/10 at 3:00 PM and 3:05 PM, revealed the SRNAs were supposed to check the meal slips of the residents when trays were delivered to ensure the meals were served in accordance with the meal slips related to likes, dislikes and supplements.. An interview with the Dietary Manager, on 04/29/10 at 3:15 PM, revealed there were three staff working on the tray line responsible for tray preparation. She stated each staff member should check the tray to ensure the meal was served in accordance with the meal slip on the tray.	F 365	<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> form meeting the resident's needs. To bring attention to and assist in meal trays being prepared to meet residents' preference, likes and dislikes will be highlighted on the resident's tray card. To ensure residents trays are prepared correctly, staff serving the meal tray will review tray with card before delivery to resident. 4. The Tray cards will be audited weekly for 1 month and continue audits monthly for 3 months. The results of the audit will be discussed at the monthly PI Meeting.	Completion Date 6/14/10
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment	F 369	F 369 1. Residents #17, # 27 & #28 trays are being served with assistive devices as identified on cards. Trays are	

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

PRINTED: 05/12/2010
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 04/30/2010
NAME OF PROVIDER OR SUPPLIER ROSEWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	
(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 369	<p>Continued From page 11</p> <p>and utensils for residents who need them.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to provide special eating equipment and utensils for one resident (#17) in the selected sample of 26 and two residents (#27 and #28) not in the selected sample. Findings include:</p> <p>A review of the facility's Dining Standards policy and procedure, dated 10/31/09, revealed residents were provided with special eating equipment and utensils, as needed.</p> <p>1. Observation of the noon meal, on 04/27/10 at 11:30 AM, revealed Resident #27 was sitting at the table with his/her lunch meal in front of him/her. A review of Resident #27's lunch meal slip revealed the resident should have a divided plate for meals. Observation revealed the resident had a regular plate.</p> <p>2. Observation of the noon meal, on 04/27/10 at 11:30 AM, revealed Resident #28 was sitting at the table with his/her lunch meal in front of him/her. A review of Resident #28's meal slip revealed the resident was supposed to receive weighted utensils. Observation revealed the resident was feeding him/herself with a regular fork and spoon. The resident's hands shook as he/she lifted the utensil to his/her mouth.</p> <p>3. Observation of the breakfast meal, on 04/29/10 at 8:55 AM, revealed Resident #17 was sitting on the side of the bed with the over-the-bed table in front of him/her. A sign from speech therapy was</p>	F 369	<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>checked by Nutritional Services manager (NSM) or Asst. NSM before leaving the kitchen area.</p> <p>2. The NSM will review each resident's diet order and tray card to identify needed assistive devices. Any discrepancies noted will be corrected during the review. Dietary staff will be in-serviced on 5/21/10 by the RD or NSM on identification and use of assistive devices.</p> <p>3. The RD or NSM will review new diet orders daily during morning meeting and assure residents' tray cards are updated to note identified assistive devices. Updates will be reviewed with tray line staff when devices are noted.</p> <p>4. The RD or NSM will monitor through observation and record review, at least monthly for three months, , then at least quarterly, to assure residents receive assistive devices as needed. The results of these audits will be presented to the monthly PIC.</p>	Completion Date 6/1/10

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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 04/30/2010
NAME OF PROVIDER OR SUPPLIER ROSEWOOD HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 369	<p>Continued From page 12</p> <p>posted above the bed which revealed the resident was to use a small plastic spoon for meals. The SRNA entered the room and placed the resident's tray on the table and set the tray up. A review of the resident's dietary slip revealed the resident was supposed to receive a small plastic spoon. Observation revealed the resident had a regular spoon and was observed placing large bites of ice cream in his/her mouth.</p> <p>Interviews with State Registered Nurse Aide (SRNA) #1 and SRNA #2, on 04/29/10 at 3:00 PM and 3:05 PM, revealed the SRNAs were supposed to check the meal slips of the residents when they delivered the trays to ensure assistive devices were available in accordance with the meal slips.</p> <p>An interview with the Dietary Manager, on 04/29/10 at 3:15 PM, revealed three staff worked on the tray line and were responsible for preparation of the trays. These staff members were responsible for ensuring the trays contained assistive devices in accordance with the meal slips.</p>	F 369		

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

PRINTED: 02/16/2012
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/27/2010
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(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 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 04/27/10 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			
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.