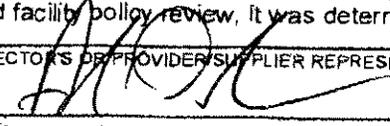


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2012
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey Investigating KY#00019086 was initiated on 09/25/12 and concluded on 09/28/12. KY#00019086 was substantiated with deficiencies cited. Deficiencies were cited with the highest scope and severity of a "D".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance. 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 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. 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, record review, interview, and facility policy review, it was determined the	F 280	1. Care Plan for Resident #1 reviewed and corrected as indicated to identify interventions. 2. 100% audit completed on all residents to ensure families is not practicing a procedure out of their scope of practice. 3. Education completed with all licensed and certified staff related to interventions put into place to protect Resident #1. Care conference conducted on 10/3/12 with Ombudsman, Administrator, Director of Nursing, and Licensed Social Worker with Resident #1's son. Interventions necessary explained to son and why the interventions were needed. Son verbalized understanding and agreement with the interventions. Audit will be conducted by DON or designee on compliance with interventions daily for one week, then 3 times a week for three weeks, then weekly for one month. 4. All monitoring findings will be reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. QA members consist	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
		Adam Lewandowski NHA		10/23/12

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 280	Continued From page 1 facility failed to revise the plan of care for one (1) of of four (4) sampled residents (Residents #1). Resident #1 was identified to have a bruise on the right upper extremity above the antecubital space on 09/14/12. The facility determined the bruise was unintentional as a result of Resident #1's son conducting Range of Motion (ROM) on Resident #1; however, the facility failed to revise the plan of care with new interventions to prevent Resident #1 from obtaining further bruising while Resident #1's son visited and attempted ROM exercises again. The findings include: Review of facility policy entitled "Care Plan Procedure", dated effective January 2012, revealed the comprehensive care plan must have measurable objectives with time frames and describe the services to be provided to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Further review of the policy revealed a well developed care plan provided information regarding how the cause and risk associated with issues and/or conditions can be addressed to provide for the resident's highest practicable level of well being. Medical record review revealed Resident #1 was admitted to the facility, on 07/22/11, with diagnoses which included Cerebral Vascular Accident (CVA), Right Hemiplegia, Coronary Artery Disease, Hypertension and Diabetes Mellitus. Review of an Annual Minimum Data Set (MDS) Assessment, dated 06/22/12, revealed the facility assessed Resident #1 to be severely impaired with cognition skills for daily decision	F 280	<i>This Plan of Correction is the center's credible allegation of compliance. 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> of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Social Services, Dietary Service Manager, MDS nurse, Education/Training Director, Therapy Manager and Maintenance Director. 5. Date of Compliance: 10/10/12	
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F 280	<p>Continued From page 2</p> <p>making; required extensive assistance of two (2) persons for bed mobility, dressing and toilet use; total dependence of two (2) persons for transfers; and extensive assistance of one (1) person for locomotion and personal hygiene; and as receiving skin treatments to include pressure reducing device to chair and bed. Review of a Skin Integrity Prevention and Treatment Plan of Care, dated 06/28/12, revealed Resident #1 was at high risk for impaired skin integrity and interventions included to provide ROM as applicable, position body with pillows and other support devices and to utilize assistive devices to reduce friction and facilitate resident movement such as turning sheets and mechanical lift.</p> <p>Review of the facility's incident report, dated 09/14/12, revealed a restorative aide identified that Resident #1 had two (2) bruises above antecubital space of flaccid right arm which were purple in color. Additional review of the investigative report revealed the facility believed the bruises on Resident #1's right arm were an unintentional result of range of motion exercises performed by Resident #1's son every evening he visited.</p> <p>Review of a skin assessment conducted by Licensed Practicable Nurse (LPN) #2 on 09/14/12 and interview with LPN #2, on 09/26/12 at 1:50 PM, revealed Resident #1 was noted to have dark purple scattered bruising to the right arm above the antecubital space. Further interview revealed Resident #1's son had told her he performed ROM on Resident #1, but she had never seen him do that because he kept the door closed. She stated the ADON was responsible for updating the plan of care and was not aware of</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>any interventions to monitor or supervise Resident #1's son while he was in the room to ensure proper ROM exercises were performed to prevent bruising.</p> <p>Interview with Certified Nursing Assistant #2, on 09/26/12 at 11:25 AM revealed Resident #1's son had told her he performed ROM exercise on Resident #1; however, she had never observed him doing this because he closed the door when he visited. CNA #2 indicated she was unaware of any Interventions that she should monitor or supervise Resident #1's son while he was conducting ROM exercises on Resident #1.</p> <p>Observation during a skin assessment conducted by Licensed Practical Nurse (LPN) #3, on 09/26/12 at 3:40 PM, revealed Resident #1 had a fading quarter sized bruise on his/her right arm above the antecubital space.</p> <p>Although the facility documented on the Skin Integrity Assessment Prevention and Treatment Plan of Care as a problem that Resident #1 had a bruise to the right upper extremity, the facility failed to document the cause and risk of the bruise or revise the plan of care to include new interventions to ensure how the facility was going to supervise and monitor Resident #1's son during visits to ensure he was either not performing ROM exercises or performing ROM exercises in a manner to prevent bruising from reoccurring.</p> <p>Interview with LPN #4, on 09/26/12 at 1:30 PM, revealed she was unaware of any care plan interventions that she should be monitoring or supervising Resident #1's son while he was</p>	F 280		
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F 280	Continued From page 4 conducting ROM exercises. Interview with the Director of Nursing, on 09/26/12 at 1:15 PM, revealed the facility had shown Resident #1's son how to do ROM exercises correctly because he had been so insistent on doing ROM with Resident #1. She indicated the facility thought he possibly caused the bruise while doing ROM exercises with the resident; however, the facility had not revised the plan of care to include new interventions for supervision and monitoring after the bruising incident on 09/14/12 to prevent further bruising.	F 280	<i>This Plan of Correction is the center's credible allegation of compliance. 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 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to provide adequate supervision and monitoring to prevent accidents for one (1) of four (4) sampled residents (Resident #1). Resident #1 who had a diagnosis of Cerebral Vascular Disease (CVA) with Right Hemiplegia was assessed by the facility to require extensive assistance of two (2) persons for bed mobility, total dependence of two (2) persons for	F 323	F-323 1. Care Plan for Resident #1 reviewed and corrected as indicated to identify interventions. 2. 100% audit completed on all residents to ensure families is not practicing a procedure out of their scope of practice. 3. Education completed with all licensed and certified staff related to interventions put into place to protect Resident #1. Care conference conducted on 10/3/12 with Ombudsman, Administrator, Director of Nursing, and Licensed Social Worker with Resident #1's son. Interventions necessary explained to son and why the interventions were needed. Son verbalized understanding and agreement with the interventions. Audit will be conducted by DON or designee on compliance with interventions daily for one week, then 3 times a week for three weeks, then weekly for one month. 4. All monitoring findings will be reviewed at monthly QA meeting for compliance and/or the need to update plan to reach 100% compliance. 5. Date of Compliance 10/10/12	

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F 323	<p>Continued From page 5</p> <p>transfers and received Children's Aspirin which increased the risk for bruising. The facility failed to develop an individualized plan of care to direct staff on how to ensure Resident #1 received care, supervision and monitoring to prevent bruising while Resident #1's son visited and conducted Range of Motion (ROM) exercises on the resident's upper extremities. On 09/14/12, Resident #1 was noted to have a bruise on the right upper extremity above the antecubital space. The facility determined the bruising had occurred while Resident #1's son had been conducting ROM exercises; however, the facility failed to develop new interventions to prevent further bruising.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Weekly Skin Assessment Procedure", dated April 2009, revealed to monitor areas of skin impairment until healed using the Treatment Administration Record (TAR) for areas including but not limited to bruises. Further review of the policy revealed to document significant changes in the nursing progress note, obtain a physician's order for treatment protocol and communicate interventions to staff using the Skin Assessment Prevention and Treatment Plan of Care.</p> <p>Review of facility policy entitled "Care Plan Procedure", dated effective January 2012, revealed the comprehensive care plan must be well developed to provide information regarding how the cause and risk associated with issues and/or conditions can be addressed to provide for the resident's highest practicable level of well</p>	F 323		

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F 323	<p>Continued From page 6 being.</p> <p>Review of the medical record revealed the facility admittted Resident #1 on 07/22/11, with diagnoses which included Cerebral Vascular Accident (CVA), Right Hemiplegia, Coronary Artery Disease, Hypertension and Diabetes Mellitus. Review of an Annual Minimum Data Set, dated 06/22/12, revealed the facility assessed Resident #1 to be severely impaired with cognition skills for daily decision making; required extensive assistance of two (2) persons for bed mobility, dressing and toilet use; total dependence of two (2) persons for transfers; and extensive assistance of one (1) person for locomotion and personal hygiene, and as receiving skin treatments to include pressure reducing device to chair and bed.</p> <p>Review of Resident #1's Care Area Assessment (CAA) summary, dated 06/28/12, revealed the facility would develop a plan of care related to skin. Review of a Skin Integrity Prevention and Treatment Plan of Care, dated 06/28/12 revealed Resident #1 was at high risk for impaired skin integrity and interventions included to provide ROM as applicable, position body with pillows and other support devices and to utilize assistive devices to reduce friction and facilitate resident movement such as turning sheets and mechanical lift.</p> <p>Review of the Physician's Orders, dated 09/13/11, revealed Resident #1's Physician ordered for Resident #1 to be administered 81 milligrams (mg) Children's Aspirin Daily for Coronary Artery Disease and CVA. Review of a Physician's Desk Reference/ Rx Drug Interactions and Side Effects at www.pdrhealth.com revealed Aspirin is</p>	F 323		
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F 323	<p>Continued From page 7</p> <p>sometimes used to treat or prevent heart attacks and strokes (CVA) and side effects can be increased bleeding or bruising.</p> <p>Further review of the Plan of Care revealed there was no evidence the facility revised the Skin Integrity Plan of Care to include new interventions to prevent bruising, for Resident #1 who was receiving Aspirin.</p> <p>Review of the facility's incident report, dated 09/14/12, revealed a restorative aide identified that Resident #1 had two (2) bruises above antecubital space of flaccid right arm which were purple in color. Further review of the facility's investigative incident report revealed the Director of Nursing (DON) and the Administrator had observed Resident #1's son perform ROM exercises on the resident's left arm by placing his hands above the antecubital space and wrist and stopped the son from performing ROM. Additional review of the investigative report revealed the facility believed the bruises on Resident #1's right arm were an unintentional result of range of motion exercises performed by Resident #1's son every evening he visited.</p> <p>Review of a skin assessment conducted by Licensed Practicable Nurse (LPN) #2 on 09/14/12 and interview with LPN#2, on 09/26/12 at 1:50 PM, revealed Resident #1 was noted to have dark purple scattered bruising to the resident's right arm above the antecubital space. Further interview revealed Resident #1's son had told her he performed ROM on Resident #1, but she had never seen him do that because he kept the door closed. She stated the ADON was responsible for updating the plan of care and was not aware of</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>any interventions to monitor or supervise Resident #1's son while he was in the room to ensure proper ROM exercises were performed to prevent bruising.</p> <p>Interview with Restorative Certified Nursing Assistant #1, on 09/26/12 at 12:05 PM, revealed when she went to do restorative ROM exercises on Resident #1 on 09/14/12 she noted a bruise on Resident #1's right upper arm above the antecubital space which appeared to have bruising in the shape of a thumb and fingerprint. Further interview revealed she was unaware Resident #1's son had been giving Resident #1 ROM exercises in the evening because she worked day shift and the son came to visit in the evenings.</p> <p>Interview with Certified Nursing Assistant #2, on 09/26/12 at 11:25 AM, revealed Resident #1's son had told her he performed ROM exercise on Resident #1; however, she had never observed him doing this because he closed the door when he visited. CNA #2 indicated she was unaware of any interventions that she should monitor or supervise Resident #1's son while he was conducting ROM exercises on Resident #1.</p> <p>Observation during a skin assessment conducted by Licensed Practical Nurse (LPN) #3, on 09/26/12 at 3:40 PM, revealed Resident #1 had a fading quarter sized bruise on his/her right arm above the antecubital space.</p> <p>Review of a Physician's Order, dated 09/14/12, revealed an order to monitor scattered bruising to resident's right arm directly above antecubital space that was purple/green in color until</p>	F 323		
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F 323 Continued From page 9
resolved related to skin integrity.

F 323

Although the facility documented on the Skin Integrity Assessment Prevention and Treatment Plan of Care as a problem that Resident #1 had a bruise to the right upper extremity, the facility failed to document the cause and risk of the bruise and failed to document the Physician's treatment to monitor the bruise until healed. Further review of the plan of care revealed there were no new interventions to ensure how the facility was going to supervise and monitor Resident #1's son during visits to ensure he was either not performing ROM exercises or performing ROM exercises in a manner to prevent bruising from occurring again.

Interview with LPN #4, on 09/26/12 at 1:30 PM, revealed Resident #1's son had told her he wanted Resident #1 out of bed when he visited so he could do the ROM therapy. Additional interview revealed when Resident #1's son visited Resident #1 in the evenings that he usually closed the door and therefore she had not observed him doing the ROM. LPN #4 was unaware of any care plan interventions that she should be monitoring or supervising Resident #1's son while he was conducting ROM exercises.

Interview with CNA #1, on 09/26/12 at 11:00 AM, revealed she had observed Resident #1's son perform ROM exercises on Resident #1 which seemed a little rough about a month and a half ago and she had reported to the charge nurse at that time what she had seen. CNA #1 was unaware of any interventions that she was supposed to check on Resident #1 while the son

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NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018		
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F 323	<p>Continued From page 10</p> <p>was in the room to ensure he was conducting ROM appropriately.</p> <p>Interview with Resident #1's son, on 09/26/12 at 4:20 PM, revealed he had never been shown how to do ROM on Resident #1 but had observed Physical Therapy conducting ROM. Additional interview revealed he knew the facility was conducting ROM, but did not feel like fifteen (15) minutes was enough per shift to get Resident #1 better and wanted to give him/her more ROM every evening.</p> <p>Interview with the Registered Nurse Education and Training Director, on 09/26/12 at 6:15 PM, revealed she was responsible for overseeing the Restorative Nursing Program. Further interview revealed Resident #1 received fifteen (15) minutes of ROM on all his/her extremities three (3) times a day. She indicated at times Resident #1 would moan or cry and therefore ROM would be conducted in shorter sessions. Additional interview revealed Resident #1's son had told her that fifteen (15) minutes was not enough.</p> <p>Interview with Physical Therapist (PT) #9, on 09/27/12 at 12:05 PM, revealed although not documented that he had educated Resident #1's son related to Resident #1's condition and how PT was not going to improve Resident #1's condition. Further interview revealed since the son was insistent on having PT, he had shown the son how to do some ROM exercises and that he should do slow rhythmic movements and not to pull on the resident's arm. PT #9 indicated that it could be a safety issue by the son conducting ROM because even though he had been shown how to do ROM, he had not been thoroughly</p>	F 323			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2012
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	
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F 323	<p>Continued From page 11</p> <p>trained to do ROM and had not been evaluated and monitored to see if he was conducting it correctly.</p> <p>Interview with the Director of Nursing, on 09/26/12 at 1:15 PM, revealed the facility had shown Resident #1's son how to do ROM exercises correctly because he had been so insistent on doing ROM with Resident #1. She indicated the facility thought he possibly caused the bruise while doing ROM exercises with the resident; however, the facility had not developed new interventions after the bruising incident on 09/14/12 to prevent further bruising because it was nothing nursing did or did not do and the son causing the bruising was unintentional.</p>	F 323	