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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185187		C 09/06/2012

NOV 2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENWOOD NURSING & REHABILITATION CENTER	5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104

(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 AMENDED 11/20/12 - Added F282 (D) An abbreviated survey (KY #18964) was conducted on 09/05/12 through 09/06/12 to determine the facility's compliance with Federal requirements. KY #18964 was substantiated with deficiencies cited with the highest scope and severity of a "D."	F 000	Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's fall investigation, and review of the facility's policy/procedure, it was determined the facility failed to follow the Comprehensive Care Plan developed for one resident (#3), in the selected sample of three residents. Resident #3 was assessed by the facility to require physical assistance of one staff member when ambulating in the room while the intervention on the Comprehensive Care Plan revealed staff was to provide "constant guidance" and physical assistance with transfers and ambulation. On 09/06/12, Resident #3 was observed ambulating in the room with a rolling walker without any facility staff present to assist	F 282		

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

11/21/12

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 282	Continued From page 1 him/her. Findings include: A review of the facility's policy and procedure for "Safe Resident Handling and Movement," dated 05/26/09, revealed the staff would follow the movement and handling procedures for each resident as determined through the admission and/or re-entry admission process and the Minimum Date Set (MDS) assessment process. A record review revealed the facility admitted Resident #3 on 01/03/12 with diagnoses to include Difficulty Walking, Hypertension, Cirrhosis, Renal Insufficiency, Osteoporosis, Depression, and Asthma. A review of the admission MDS, dated 01/09/12, revealed the facility identified Resident #3 as severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4. Further review revealed the facility assessed the resident's functional status to require extensive assistance of one staff for transfers, toilet use, and personal hygiene. Additionally, Resident #3 was assessed to require limited assistance of one staff for ambulating in the room. A review of the Falls Risk Assessment, dated 06/21/12, revealed Resident #3 was at risk for fall related to gait problems and required an assistive device for ambulation. Additional risk factors included medications and predisposing diseases, such as Hypertension, Osteoporosis, Incontinence, and Renal Insufficiency, as well as the need for assistance with elimination.	F 282 f282	Resident #3 care plan was updated by the MDS nurse on 9/26/12 to ensure that the resident's Care plan for Ambulation, tranfers, and toileting status is correct per nursing assessment as it relates to in room and level of assistance as indicated. All current residents were reviewed and reassessed with care plans updated to reflect current ambulation and transfer status to include in-room and staff assistance required as appropriate by Unit Coordintors and MDS nurse. In addition, for residents that expressed a desire to be independent with ambulation and/or transfers and who were capable of making decisions as determined by a review of BIMS scores, Therapy screen requests were made by the Unit coordinators and MDS nurse. Upon completion of these screens, residents' care plans and care guides were updated by MDS nurses to reflect the ability to transfer and/or ambulate safely and independently to include in room. All residents will continue to be reviewed upon admission, quarterly, and/or upon significant change in condition through the RAI process with the updating of care plans and care guides to ensure that staff assistance with ambulation and/or transfer to include in room is provided.	

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F 282	Continued From page 2 A review of the Comprehensive Care Plan, dated 01/17/12, revealed Resident #3 was care planned for "Alteration in balance and at risk for falls related to history of falls, and required assistance with ambulation and transfers secondary to impaired mobility and weakness." Additionally, Resident #3 was care planned to "require assistance with potential to restore and maintain maximum function of self-sufficiency for transferring from one position to another." The care plan interventions for Resident #3 included "provide one person constant guidance and physical assistance" and "assist during transfer and mobility (assist of 1 with transfers and ambulation)." Review of the Resident Care Guide, undated, utilized by the Certified Nurse Aides (CNAs) to guide resident care, revealed Resident #3 required assistance of one staff for transfers. A review of the facility's fall investigation, dated 08/24/12, revealed Resident #3 was found on the floor in front of a wheelchair. The resident was assessed by nursing staff and found to have an elevation in blood pressure and muscle weakness. An interview with CNA #2, on 09/06/12 at 3:15 PM, revealed, as she returned to the floor from the dining room, she was called to Resident #3's room. She found Resident #3 sitting on the floor in front of the wheelchair. Resident #3 stated he/she had lost his/her balance and fell when he/she tried to go to the sink in the room. CNA #2 stated the resident had not activated the call light. Observation of Resident #3, on 09/06/12 at 8:25	F 282	All nurses, administrative nurses and MDS nurses, were inserviced by the Staff Facilitator 9/27/12 and continued until all have signed. Ensuring that the facility is providing the correct assistance based on the resident's care plan, and followed as it relates to transfers and ambulation per the care plan and care guides as based upon the assessment and/or reassessment of residents current ambulation and transfer status to include in room A weekly QI audit to include Resident #3 will be performed utilizing a QI tool by the Q/I Nurse to monitor providing residents with appropriate assistance for ambulation and/or transfers to include in room and verification that the care plan and care guides are correct. The Q I Nurse will take appropriate action as indicated for any potential concern with the providing of appropriate ambulation and transfer assistance and to include that the care plan and care guide is correct upon identification. The results of these audits will be reviewed with the DON & Administrator weekly in the QI Committee meeting that is composed of the QI Nurse, DON, Administrator, Staff Facilitator, Unit Coordinators, MDS Nurse, Safety Nurse,Rehab Director, Social Worker, & Treatment Nurse with further corrective action taken as needed. Results and trends of audits will be reviewed in the monthly Executive QI meeting consisting of the Administrator, DON, QI Nurse, Safety Nurse, Medical Director, Social Services, Unit Coordinators, Activity Director, plus any other	

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F 282	Continued From page 3 AM, revealed the resident utilized a rolling walker to ambulate across the room. There were no staff members in the room at that time to assist Resident #3. Resident #3 was wearing cotton socks without shoes, and the call light was not activated. The resident voiced a need for assistance to go to the bathroom and staff was notified by this surveyor. Registered Nurse (RN) #1 responded and assisted Resident #3 to the toilet, and then left the room as soon as CNA #1 arrived. CNA #1 left Resident #3 sitting on the toilet unattended and returned to the nurse's desk for a "pull-up." CNA #1 returned to the resident after three minutes. After assisting Resident #3 to a standing position in front of the toilet, CNA #1 stepped away from the bathroom to get pants from the resident's closet. After assisting the resident to get dressed, CNA #1 assisted him/her to bed. An interview with RN #1, on 09/06/12 at 3:50 PM, revealed the resident was care planned for the assistance of one staff with ambulation and transfers due to a recent fall. RN #1 stated the care plan intervention of "constant guidance and physical assistance" meant the staff should not leave the resident in the bathroom alone. The staff was to provide as much privacy as possible, but not leave the resident alone. RN #1 stated she was not aware that CNA #1 left the resident's room to get the "pull-up." She stated CNA #1 should have turned the call light on or requested assistance from staff in the hallway. An interview with the Director of Nursing (DON), on 09/06/12 at 5:00 PM, revealed the care plan intervention of "constant guidance and physical assistance" for Resident #3 meant the staff	F 282	person deemed appropriate by the Administrator present. Completion Date 10/1/12	10/1/12

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F 282	Continued From page 4 should closely monitor the resident related to his/her decreased safety awareness and known lack of compliance. The DON stated she tried to ensure the care plan interventions were followed by having the nurses and Administrative staff out in the hallways and "lots of folks in the hallway checking on things."	F 282	F-323 Resident #3 was reassessed by MDS Nurse on 9/24/12 to ensure that the resident's environment remains as free from accident hazards as possible to include ambulation and transfer with the care plan updated to reflect current status of ambulation and transfer to include in room and level of assistance as indicated.	
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.	F 323	All current residents were reviewed and reassessed with care plans updated to reflect current ambulation and transfer status to include in-room and staff assistance required as appropriate by Unit coordinators and MDS nurses to ensure that the residents' environment remains as free from accident hazards as possible.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's investigation, and review of the facility's policy/procedure, it was determined the facility failed to ensure the resident's environment remains as free from accident hazards as is possible for one resident (#3), in the selected sample of three residents. Resident #3 was assessed by the facility to require the physical assistance of one staff member for ambulation in the room, and care planned for constant guidance and physical assistance when transferring from one position to another position; however, Resident #3 was observed ambulating with a rolling walker without the staff's assistance, while in his/her room.		In addition, for residents that expressed a desire to be independent with ambulation and/or transfers and who were capable of making decisions as determined by a review of BIMS scores, Therapy screen requests were made by the Unit coordinators and MDS nurse. Upon completion of these screens, residents' care plans and care guides were updated by MDS nurses to reflect the ability to transfer and/or ambulate safely and independently to include in room.	

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F 323	Continued From page 5 Findings include: A review of the facility's policy/procedure for "Safe Resident Handling and Movement," dated 05/26/09, revealed the staff would follow the movement and handling procedures for each resident as determined through the admission/ re-entry admission process and the Minimum Data Set (MDS) process. A record review revealed the facility admitted Resident #3 on 01/03/12 with diagnoses to include Hypertension, Cirrhosis, Renal Insufficiency, Osteoporosis, Depression, Asthma, and Difficulty Walking. A review of the admission MDS, dated 01/09/12, revealed the facility identified Resident #3 to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4. Further review revealed the facility assessed the functional status for Resident #3 to require extensive assistance of one person for transfers, toilet use, and personal hygiene, and limited assistance of one person for walking in the room. A review of the Falls Risk Assessment, dated 06/21/12, revealed Resident #3 was at risk for falls related to gait problems and required an assistive device. Additional risk factors included predisposing diseases such as Hypertension, Osteoporosis, Incontinence, and Renal Insufficiency, 1-2 medications, and the need for elimination with assistance. A review of the Comprehensive Care Plan, dated 1/17/12, revealed Resident #3 was care planned to "require assistance with potential to restore	F 323	All residents will continue to be reviewed upon admission, quarterly, and/or upon significant change in condition through the RAI process with the updating of care plans and care guides to ensure that staff assistance with ambulation and/or transfer to include in room is provided to ensure that residents' environments remain as free from accidents as possible. All nurses, administrative nurses and MDS nurses, were inserviced by the Staff Facilitator 9/27/12 and continued until all have signed on ensuring that residents' environments remain as free from accident hazards as possible to include the provision of assistance with transfers and ambulation per the care plan and care guides as based upon the assessment and/or reassessment of residents current ambulation and transfer status to include in room. CNAs were inserviced by the Staff Facilitator on 9/27/12 and continued until all CNA's have signed on providing assistance with transfer and ambulate to include in room per the care plan and care guide and notification of charge nurse when a resident requires more or less assistance with transfers and ambulation than what is on the care guide. A weekly QI audit to include Resident #3 will be performed utilizing a QI tool by the Q/I Nurse to monitor providing residents with appropriate assistance for ambulation and/or transfers to include in room. The Q I Nurse will take appropriate action as indicated for any potential	

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F 323	Continued From page 6 and maintain maximum function of self-sufficiency for transferring from one position to another, and for "Alteration in balance and at risk for falls related to history of falls, and required assistance with ambulation and transfers secondary to impaired mobility and weakness." The facility assigned interventions for Resident #3 to include "provide one person constant guidance and physical assistance" and "assist during transfer and mobility (assist of 1 with transfers and ambulation)." A review of the Resident Care Guide, utilized by the facility's Certified Nurse Aides (CNAs), undated, revealed he/she required the assistance of one staff to transfer. Review of the fall investigation for Resident #3, dated 08/24/12, revealed he/she was found on the floor in front of a wheelchair. The resident was assessed by nursing staff and found to have an elevated blood pressure and muscle weakness. An interview with CNA #2, on 09/06/12 at 3:15 PM, revealed she was coming back from the dining room and was called to Resident #3's room. She found Resident #3 sitting on the floor in front of the wheelchair. Resident #3 stated he/she had lost his/her balance and fell when he/she tried to go to the sink in the room. CNA #2 stated the resident had not activated the call light. An observation of Resident #3, on 09/06/12 at 8:25 AM, revealed the resident was using a rolling walker to walk across the room. There was no facility staff in the room assisting Resident #3. Resident #3 was wearing cotton socks without	F 323	concern with the providing of appropriate ambulation and transfer assistance upon identification. The results of these audits will be reviewed with the DON & Administrator weekly in the QI Committee meeting that is composed of the QI Nurse, DON, Administrator, Staff Facilitator, Unit Coordinators, MDS Nurse, Safety Nurse,Rehab Director, Social Worker, & Treatment Nurse with further corrective action taken as needed. Results and trends of audits will be reviewed in the monthly Executive QI meeting consisting of the Administrator, DON, QI Nurse, Safety Nurse, Medical Director, Social Services, Unit Coordinators, Activity Director, plus any other person deemed appropriate by the Administrator present. Completion Date 10/1/12	10/1/12

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F 323	Continued From page 7 shoes and the call light was not activated. The resident verbalized a need for assistance to go to the bathroom. Staff was notified by this surveyor and Registered Nurse (RN) #1 who assisted the resident onto the toilet, and then left the room when CNA #1 arrived. CNA #1 left Resident #3 sitting on the toilet to return to the nurse's desk for a "pull-up." CNA #1 returned to the resident after three minutes. After assisting Resident #3 from the toilet, CNA #1 stepped away from the bathroom to get pants from the resident's closet. After dressing the resident, CNA #1 assisted him/her to bed. An interview with RN #1, on 09/06/12 at 3:50 PM, revealed the resident was care planned for the assistance of one staff for ambulation and transfers because of a recent fall. RN #1 stated the care plan intervention of "constant guidance and physical assistance" meant not to leave the resident in the bathroom, give as much privacy as possible, but not to leave the resident alone. RN #1 stated she was unaware CNA #1 left the room to get the "pull-up." She stated the CNA should have turned the call light on, or asked for assistance from someone on the hallway. An interview with the Director of Nursing (DON), on 09/06/12 at 5:00 PM, revealed the care plan intervention of "constant guidance and physical assistance" for Resident #3 meant the staff should closely monitor the resident related to his/her decreased safety awareness and noncompliance. The DON stated she tried to ensure the care plan interventions were followed as evidenced by the nurses being up and down the hallway, Administrative staff in the hallway, and "lots of folks in the hallway checking on	F 323		

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