

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

Acceptable

PRINTED: 10/02/2013  
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  09/19/2013
NAME OF PROVIDER OR SUPPLIER  WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO 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  A Standard Recertification Survey was initiated on 09/17/13 and concluded on 09/19/13. Deficiencies were cited with the highest Scope and Severity of an "E".	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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157 F157	1. Resident #11 was assessed by the DON when notified by Surveyor of the potential issue on 9/19/13. A treatment order was obtained from the MD and implemented after the assessment was completed. The POA was notified of the change in status and the new orders. Resident #2 was assessed and weighed to determine current weight and/or physical status and the MD was notified of the findings. 2. All Residents will be assessed the week of 10/14/13 for any changes in physical status. Any areas of concern will be addressed with the MD for appropriate orders and the families notified of any changes in care and/or condition. 3. A written protocol will be developed by the DON related to the requirements for notification of the MD and POA for changes in care and/or condition of a Resident. Re-education will be conducted 10/16/13 and 10/17/13 by the DON and EDT for licensed staff related to the requirements of notification of the MD and POA whenever there is a change in condition and/or care.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 10/11/13

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 157	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to notify the physician for a change in condition for two (2) of twenty-three (23) sampled residents (Residents #11 and #2).  Resident #11 was identified to have excoriation to the bilateral groin area during a skin assessment with the surveyor on 09/18/13; however, there was no documented evidence the Physician was notified in order to obtain a treatment until 09/19/13 after surveyor intervention.  Resident #2 experienced weight fluctuations with significant gains and losses. There was no documented evidence the Physician was notified of the weight gains and losses.  The findings include:  Interview with the Director of Nursing (DON) on 09/19/13 at 8:00 PM revealed the facility had no written policy related to physician notification. She stated the physician was to be notified of any change in condition.  1. Review of Resident #11's clinical record revealed diagnoses which included Dementia, and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/10/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a ten (10) indicating some cognitive impairment.	F 157	<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>  of a Resident. Re-education will be completed by 10/21/13. All changes in condition and/or care will be reviewed by the Unit Manager(s) and Weekend Nurse Manager starting the week of 10/21/13 for the appropriate notification of the MD and POA seven (7) times a week for three (3) weeks, then three (3) times a week for four (4) weeks.  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: 11/1/13	11/1/13	

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F 157	<p>Continued From page 2</p> <p>Observation of a skin assessment performed by Licensed Practical Nurse (LPN) #1 on 09/18/13, from 9:40 AM until 10:05 AM, revealed Resident #11 had red excoriation to the groin area bilaterally. LPN #1 acknowledged the resident had excoriation to the areas and did not apply a treatment to the areas during the skin assessment.</p> <p>Review of the Physician's Orders dated 09/13 revealed no documented evidence of treatment orders for this resident's bilateral groin area.</p> <p>Review of the skin assessments and the Nurse's Notes revealed there was no documented evidence the excoriation to the bilateral groin area was identified.</p> <p>Interview with LPN#1 on 09/19/13 at 2:30 PM, revealed Resident #11 did have excoriation to the bilateral groin area and needed a treatment. She stated she reviewed the Treatment Administration Record (TAR) before the skin assessment and did not see any treatment for the bilateral groin area; however, got confused and thought the resident must have a treatment to the areas which was applied during another shift. Further interview revealed if a new area of skin breakdown was identified the nurse was to notify the physician for an order for treatment.</p> <p>Review of Resident #11's Physician's Orders dated 09/19/13 after surveyor intervention, revealed orders to cleanse the groin folds with soap and water, pat dry, apply Interdry AG, secure with tape on sides daily (may use same Interdry AG for up to five (5) days and change as needed for saturation, and check placement of Interdry AG every shift.</p>	F 157		

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F 157 Continued From page 3

Interview on 09/18/13 at 7:00 PM with the Director of Nursing (DON), revealed LPN #1 should have looked to see if there was a treatment in place for the excoriation and if no treatment was ordered she should have called the physician the same day to obtain a treatment.

2. Review of Resident #2's medical record revealed the facility admitted the resident on 08/19/09 with diagnoses which included Cerebral Palsy, Non-Alzheimer's Dementia, Chronic Obstruction Pulmonary Disease (a lung disease), Peripheral Vascular Disease (affects blood vessels), and Huntington's Disease (a neurodegenerative genetic disorder that affects muscle coordination). Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 06/28/13, revealed the facility assessed the resident as moderately cognitively impaired. In addition, the MDS revealed the facility assessed the resident as having problems with swallowing and as receiving a mechanically altered diet.

Continued review of Resident #2's medical record revealed in 2013 significant weight fluctuations were recorded for the resident. The resident had an initial June weight of ninety-eight (98) pounds, no date listed, and on 06/14 had a weight of one hundred twelve (112) pounds which was a 12.5 % weight increase.

Continued review of the weights revealed an initial July weight, no date, of 112 pounds, and on 07/21 a weight of 88 pounds was recorded. Review of the Nutritional Progress Note 07/22/13 revealed a re-weight was done and the weight was 88 pounds. Further review of the Note

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F 157	<p>Continued From page 4</p> <p>revealed the Dietician questioned the accuracy of the weights done in June and July at 112 pounds and felt they had been recorded in error. However, review of the Dietary and Nurse's Notes for June 2013 revealed no documentation of a nursing assessment or physician notification related to the significant weight changes.</p> <p>Interview with Registered Nurse (RN) #3/Unit Manager (UM) Second Floor, on 09/19/13 at 4:54 PM, revealed the State Registered Nurse Aides (SRNA's) obtained the weights for the dietician. The RN/UM further stated if there was a concern related to weight loss or gain the dietician would notify the nurse.</p> <p>Interview with the Registered Dietician (RD), on 09/19/13 at 7:14 PM and 7:46 PM, regarding Resident #2 revealed they started obtaining weekly weights in June due to a 5% weight loss from May to June. The RD stated the resident had a diagnosis of Huntington's Disease and was getting supplements of a milk shake, but weight decline was expected as the disease progressed. She stated staff should have obtained a re-weight after the 06/16 weight of 112 pounds was recorded to verify the weight was accurate. The RD stated a re-weight was obtained on 07/22 of 88 pounds after obtaining a weight of 87 pounds on 07/21. Continued interview revealed the resident's nutrition care plan was revised for significant weight loss and enhanced foods were added; fortified oatmeal and yogurt for breakfast, cottage cheese and magic cup for lunch and dinner, and three times the butter for breakfast, lunch and dinner. She stated there was weekly triage meetings with nursing and other disciplines and weights were discussed and nursing was aware of the weight discrepancies. The RD also</p>	F 157		

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F 157	Continued From page 5 stated the Physician should have been notified of the resident's weight changes which was nursing's responsibility. She stated she did not contact the Physician for weight changes.  Interview with the Director of Nursing (DON), on 09/19/13 at 8:36 PM, revealed the nursing staff obtained the weights for the Dietician and the Dietician was to let nursing know if there was a significant weight change which indicated the need for an assessment. The DON further stated it appeared there was a communication problem between dietary and nursing related to monitoring weights. Continued interview revealed this was a breakdown in the system which was a concern for the residents.	F 157		
F 250 SS=D	483.15(g) (1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on Interview, record review, and review of the facility Social Service Director (SSD) Job description, it was determined the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being for two (2) of twenty-three (23) sampled residents (Resident #13 and #4).  Resident #13 was found in his/her room	F 250		

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F 250	<p>Continued From page 6</p> <p>attempting to place a pillow case over his/ her head and made a statement he/she wanted to kill his/herself on 06/06/13. Although, the Social Service Director (SSD) initially intervened, there was no documented evidence of further Social Service's follow-up assessments and documentation with interventions related to this resident's mood and depression after the 06/06/13 incident.</p> <p>In addition, although Social Services (SS) was aware of Resident #4 making negative statements in the past, there was no documented evidence of the negative statements in the SS Notes with interventions related to the statements. In addition, Resident #4 made a negative statement to the surveyor regarding self harm and the surveyor notified the Social Service Director (SSD); however, there was no documented evidence the SSD followed up regarding the negative statement related to self harm.</p> <p>The findings include:</p> <p>Review of the job description for the SSD, revealed the SSD was responsible for planning, developing, organizing, implementing, evaluating, and directing the Social Services Department in accordance with federal, state, and local standards as well as established policies and procedures, to ensure that the medically related emotional and social needs of the patients/residents were met and maintained on an individual basis. Further review revealed the SSD would provide for therapeutic intervention to help residents cope with the social and psychological aspects of their illnesses, impairments or disabilities, maintain written</p>	F 250	<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>F250</p> <ol style="list-style-type: none"> <li>1. Resident #13 has had no further suicidal statements or actions since 6/6/13. This Resident has been assessed by Social Services for follow-up and the current interventions have been determined to be sufficient. Resident #4 has been assessed by Social Services. Documentation and interventions have been put into place to assist this Resident in coping. The comprehensive care plans of both Residents identified have been updated to reflect past history, current status and interventions.</li> <li>2. A 100% audit to be conducted the week of 10/21/13 of all the residents that have made negative statements in the past or have a prior history of suicidal statements have been assessed for current status and their comprehensive care plans have been updated to reflect current interventions.</li> <li>3. SSD re-educated related to responsibilities of medically related social services by the LNHA on 10/28/13. A written protocol will be developed by the DON and SSD related to required actions to be taken in the event of negative and/or suicidal statements</li> </ol>		

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F 250	Continued From page 7 documentation in the medical record per facility policy and state and federal guidelines, and develop the social service component of the resident's plan of care identifying specific problems, goals and approaches.  Review of Resident #13's medical record revealed the facility admitted the resident on 09/19/12 with diagnoses which included Cardiovascular Accident (CVA), Diabetes, Peripheral Artery Disease (PVA), Depression, and Non-Alzheimer's Disease. Review of the Annual Minimum Data Set (MDS) Assessment, dated 7/30/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) indicating the resident was cognitively impaired.  Review of the Nurse's Notes dated 06/06/13 at 3:00 PM revealed Resident #13 was observed to be pulling a pillowcase and stretching it across his/her face. According to the Note, the nurse asked the resident what he/she was doing and resident replied "trying to kill myself". Further review revealed the resident only had the use of one (1) arm and was being treated for a Urinary Tract Infection. Further review revealed the psychiatrist aware of the above and the Power of Attorney (POA) did not wish the resident to go to the hospital due to statements of this type in the past. Continued review revealed the resident had a jersey material pillow case and fitted sheet, replaced with a non stretching material. The Noted stated, will do every fifteen (15) minute checks.  Review of the Physician's Orders dated 06/06/13, no time noted, revealed an order for every fifteen (15) minute checks for twenty-four (24) hours.	F 250	<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>  or actions. All staff will be educated by the DON and EDT related to the protocol on 10/16/13 and 10/17/13 with Education completed by 10/21/13. Audits of actions taken, documentation and care plans will be conducted by the DON starting the week of 10/21/13 for any Resident that makes a negative and/or suicidal statement for the first thirty (30) days, then weekly for the next thirty (30) days 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: 11/1/13	
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F 250	<p>Continued From page 8</p> <p>Further review of the Orders dated 06/07/13 revealed orders to extend the fifteen (15) minutes checks for twenty-four (24) hours related to behavior.</p> <p>Review of the Social Service Note dated 06/06/13, no time noted, revealed the SSD spoke to the resident concerning negative statements. The Note stated the resident had no signs and symptoms of depression at this time and was talking to the writer about how happy he/she was to be married. Further review revealed, no suicidal tendencies noted</p> <p>Review of the Nurse's Notes revealed follow up charting on 06/06/13 and 06/07/13 with no further concerns noted. Review of the Nurse's Note on 06/07/13 at 2:00 PM revealed the resident was in the library and made a statement to the State Registered Nurse Aide (SRNA) that he/she wanted to see his/her spouse before he/she died. Further review revealed a new Physician's Order was obtained to extend the fifteen (15) minute checks for twenty-four (24) hours and the family was notified</p> <p>Review of the Geriatric Psychiatry Follow Up on 06/07/13, revealed the psychiatrist was called in reference to the resident's suicidal ideation and the family refused hospitalization. The recommendations were to continue medications at the current dose, and monitor for changes.</p> <p>There was no documented evidence of further Social Services interventions or documentation until 07/24/13 when the SS approached the resident about an unrelated subject.</p> <p>Review of Resident #13's Comprehensive Care</p>	F 250		

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F 250	<p>Continued From page 9</p> <p>Plan revealed a problem dated 11/08/12 of alteration in mood, Depressive Disorder and Anxiety with a goal to take prescribed medications, participate in at least one (1) group activity and will not talk about leaving. The interventions included administer medications per Physician's Orders, update for any changes in mood, continue psychiatric services, and encourage social activities and verbalization. There was no documented evidence the Care Plan was revised to indicate the suicide attempt and ideation with preventive interventions after this resident made the attempt to put the pillow case over his/her head and stated he/she was trying to kill himself/herself on 06/06/13.</p> <p>Interview with the Social Service Director, on 09/19/13 at 9:30 AM and 7:20 PM, revealed she and her assistant completed all mood, psychosocial well being, psychotropic and behavior care plans. She stated she had not revised the Care Plan after the incident on 06/06/13 until 09/19/13 after surveyor questioning, and had not yet printed it out of the computer. She stated she should have updated the Care Plan the day of the occurrence on 06/06/13. Further interview revealed she had not followed up with the resident after her initial visit with the resident on 06/06/13 to assess for mood and behavior because psychiatry had seen the resident on 06/07/13 and she felt that was sufficient. Furthermore, she stated the physician had said the resident was attending activities and there was no further concerns.</p> <p>Interview, on 9/18/13 6:25 PM and 8:10 PM, with the DON revealed there was no written policy or protocol related to what to do if resident has suicidal ideation or makes suicide attempt but the</p>	F 250		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185445</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODCREST NURSING &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3876 TURKEYFOOT ROAD ELSMERE, KY 41018</b>	

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F 250	<p>Continued From page 10</p> <p>protocol would be to; ensure she (DON) was notified immediately, ensure resident was safe, staff member to do one (1) on one (1) for the moment while she was being notified, and the psychiatrist was to be notified by the nurse on duty or by herself. She stated ninety-nine percent (99.9%) of the time they would send a resident out for direct admit to the behavioral unit. Continued Interview revealed if the family did not consent to admit the resident to a behavioral unit, staff would do the interventions needed based on the resident's needs. She stated sometimes this was one on one (1:1) monitoring or every fifteen (15) minute checks with the length of time for monitoring depending on specific resident statements, on their plan to kill self, or related to suicidal ideation. She further stated Resident #13's family would not consent to sending the resident to the hospital behavioral unit at the time of this incident. The DON stated they would also discuss medications with the psychiatrist and assess if the resident's plan or method to kill themselves was something the resident could do and complete a head to toe physical assessment and check laboratory values. Further interview revealed the SS staff was to interview the resident and should document the interview in her notes as well as do follow up documentation as needed. The DON stated there should have been a current care plan in the chart related to the history of suicide attempt with interventions to prevent re-occurrence. She further stated there should have been an immediate care plan put into place following the resident's suicidal attempt initiated by the nursing staff and either nursing or social services could ensure the care plan was revised because both nursing and social services were involved on the day of the incident. She further stated it just got overlooked and did not</p>	F 250		
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F 250 Continued From page 11  
get done.

2. Review of Resident #4's medical record revealed the resident was admitted by the facility on 03/28/11, then readmitted on 07/23/13, with diagnoses which included Right Hip Fracture, Depression, Insomnia, and Dementia. Review of the Minimum Data Set (MDS), dated 07/30/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of a nine (9), indicating the resident was moderately cognitively impaired. Continued review revealed the facility assessed the resident as scoring an eleven (11) on the Patient Health Questionnaire nine (9), (PHQ-9), on the depression scale, indicating the resident was within the moderate range for depression.

Interview with Resident #4, on 09/18/13 at 9:00 AM, revealed the resident was unhappy with the facility. Resident #4 made statements such as, "I give up, I'd rather be dead than here. These people don't care about us, I just want to be left alone, and I pray to God every day that I die." The resident concluded by stating he/she did not have family or anyone who came to visit him/her. The resident stated, "I have no one".

Interview with the Social Service Assistant, (SSA), on 09/18/13 at 9:30 AM, revealed Resident #4 made such statements in the past. She reported the resident would not go through with killing himself/herself because he/she did not have a plan to do so. She further stated, what worked for the resident was to reassure him, monitor him, and to redirect his statements. The SSA reported the resident was seen by the psychiatrist regularly. She stated she did not document statements the resident made in the past nor was

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F 250	Continued From page 12 the resident monitored after making such statements. The SSA stated the statements should been care planned with some interventions in place.  Review of the Social Service Notes and Care Plan on 09/19/13 revealed no documentation of the resident's previous negative statements of wanting to die and no documented evidence Social Services had intervened after being notified by the surveyor of the resident's negative statements on 09/18/13. Review of the resident's care plan, revised 08/01/13, stated, "Let "resident" vent about feelings and redirect conversation to something positive.  Interview with the Social Service Director, (SSD), on 09/19/13 at 4:45 PM, revealed she was aware this resident made statements of wanting to die, however; the resident did not have a plan to do so. The SSD revealed the procedure for any resident who made statements of wanting to die and/or kill themselves would be to complete the Patient Health Questionnaire nine (9), (PHQ-9) to determine the resident's level of "depression". If the resident displayed a high score, then psych would be called immediately. The resident would be placed on fifteen (15) or thirty (30) minute checks and if severe enough, would be placed on one (1) to one (1). The Psychiatrist, Director of Nursing (DON), as well as, family would be notified and a decision would be made to send the resident out to the hospital or to remain in the facility. In regards to Resident # 4, the SSD stated the resident was not provided the PHQ-9 questionnaire. She added the resident should have been provided the questionnaire with previous negative statements, further care plan interventions should have been in place, following	F 250			

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F 250 Continued From page 13  
Resident #4's statements, and the statements should have been documented in the SS Notes.

F 250

Interview with the Director of Nursing (DON), on 09/19/13 at 6:21 PM, revealed there was no policy/procedure related to residents who had suicidal ideations and/or suicide attempts. The DON stated she should be notified as soon as a resident make any statement of death, dying, suicidal ideations and/or suicide attempts. She revealed staff would make sure a resident, who made the statement, was safe. Then, the DON and Psychiatrist would be notified. The DON stated she would discuss the statements with the Psychiatrist and the resident would be sent to the behavioral unit at the hospital, if family agreed. If the family would not agree, the resident would remain at the facility and placed on fifteen (15) minute checks or on one (1) to one (1). The DON stated Social Service would assess the resident and document findings. The DON stated she was not told of the resident's prior statements of wanting to die, but indicated she should have been told so that staff could at least kept an eye on him. She added that even without a plan to commit suicide, the resident's statement should have been taken seriously.

F 252 483.15(h)(1)  
SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

F 252

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced

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F 252 Continued From page 14  
by:  
Based on observation, and interview it was determined the facility failed to provide a safe, clean, comfortable environment.

Observation during initial tour revealed resident bathrooms on the 120 to 132 hallway had toothbrushes, combs, denture cups, and hairbrushes unlabeled at the bathroom sinks which were shared by two (2) residents.

The findings include:

Interview with the Director of Nursing (DON), on 09/18/13 at 6:45 PM, revealed there was no written policy related to storage of toothbrushes, combs, hairbrushes, and denture cups.

Observation during initial tour on 09/17/13 at 10:30 AM, revealed;  
Room 122- an unlabeled toothbrush and an unlabeled hairbrush lying on a sink counter in a shared bathroom  
Room 125- an unlabeled denture cup at the sink in a shared bathroom  
Room 128- an unlabeled hairbrush at the sink in a shared bathroom  
Room 132- an unlabeled toothbrush in a glass and an unlabeled comb at the sink in a shared bathroom

Interview with Registered Nurse (RN) #1, on 09/17/13 at 11:45 AM, revealed she was the Unit Manager for the first floor residents. She stated toothbrushes were to be labeled with the resident's name and placed in a toothbrush holder, combs and brushes were to be labeled with the resident's name and place in their dresser drawer, and denture cups were to be

F 252

*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.*

F252

1. All identified rooms (122, 125, 128, and 132) had toothbrushes, hairbrushes, combs and denture cups replaced and labeled 9/17/13. After replacement and labeling the equipment was stored in the appropriate places in the Resident's rooms.
2. 100% rounds will be performed the week of 10/21/13 on all Resident rooms and the appropriate measures were taken for any identified concerns.
3. A written protocol will be developed by the DON related to the appropriate care and storage of Resident personal care items. All licensed and certified nursing staff will be re-educated on the protocol by the DON and EDT on 10/16/13 and 10/17/13 with all education completed by 10/21/13. Rounds will be made QS starting the week of 10/21/13 on each Resident room by the Unit Manager(s), Weekend Nurse Manager and Charge Nurses daily for two (2) weeks, three (3) times a week on alternating shifts for three (3) weeks and weekly on alternating shifts for three (3) weeks.

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F 252	Continued From page 15 labeled with the resident's name and could be left at the sink in the bathroom.  Further interview with the DON, on 09/18/13 at 6:45 PM, revealed brushes, combs, toothbrushes, and denture cups were to be labeled with the residents name and were to be stored in a clean and safe manner. She stated she had recently noticed there was no toothbrush holders; however, the toothbrushes could be left in a cup at the sink if labeled. She further stated the brushes and combs were to be placed in the residents dresser drawers and the denture cups could be kept at the sink if they were labeled.	F 252	<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>  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: 11/1/13	11/1/13
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		

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**F 278** Continued From page 16  
resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:  
Based on observations, interviews, and record review, it was determined the facility failed to ensure accuracy of the Minimum Data Set (MDS) Assessment for one (1) of twenty-three (23) residents (Resident #14). Review of the MDS, dated 06/19/13, revealed missing documentation in Section G.

The findings includes:

Interview with the Director of Nursing (DON), on 09/19/13 at 3:15 PM, revealed the facility did not have a policy/procedure related to completion of the MDS, but added that the facility followed what was in the MDS three-point-zero (3.0).

Record review revealed the facility admitted Resident #14 on 04/16/12 with diagnosis which included Left Hip Fracture, Coronary Artery Disease, Cardiomyopathy, Congestive Heart Failure, Hyperlipidemia, Chronic Obstructive Pulmonary Disease, Hearing Loss, and Chronic Anemia. Review of Resident #14's Quarterly Minimum Data Set (MDS), dated 06/19/13, revealed the resident was cognitively impaired. Further review of the MDS revealed Section G, which displayed the resident's Activities of Daily Living (ADL) Assistance was incomplete. Only portions of the resident's ADL's had been filled in.

**F 278** *This Plan of Correction is the center's credible allegation of compliance.*  
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**F278**

1. Resident #14 has suffered no ill effects from the incomplete MDS that was submitted 6/19/13. Unable to correct deficient practice for the identified MDS.
2. Audit will be conducted the week of 10/14/13 to review the past two weeks MDS that have been completed for accuracy.
3. Education of the DON was completed by the Regional Reimbursement RN on 10/8/13 related to sections of the MDS where a dash is not appropriate and the steps to take to obtain the information needed to complete the MDS. ADL documentation protocol will be developed by the DON. Education of the CRC, CRS, and ADON related to the above will be completed by the DON on 10/15/13. Re-education of all licensed and certified staff will be conducted by the DON and EDT on the documentation that must be completed related to all ADL's. The re-education will be conducted on 10/16/13 and 10/17/13 with completion by 10/21/13. Audits of documentation related to ADL's

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F 278

Continued From page 17

Resident's bed mobility, transfer, eating, and toilet use had been completed. However, the portion which addressed the resident's ability to walk in a room, walk in a corridor, locomotion on the unit, dressing, and personal hygiene were marked by having a line drawn through the box.

Observation of Resident #14, on 09/17/13 at 5:30 PM, revealed resident was not in his/her room. The resident was found in the dining room, seated in his/her wheelchair and the resident appeared content as he/she ate cheese quesadilla, Spanish rice, beans, and chocolate ice cream.

Interview with the MDS coordinator, on 09/19/13 at 3:50 PM, revealed the facility used a computer system called, "Accu Nurse". She reported that during the seven (7) day period in which the residents ADL's should have been recorded for the Certified Nursing Assistant's (CNA's) to complete a questionnaire about the resident, they were not. She added the system was not set up to record the CNA's, who wore headsets, to document resident's care. The MDS coordinator stated she should have set the system up, but somehow it was missed. She stated she looked at a seven (7) day period when completing the MDS, thus there was no written documentation of the resident's current ADL's and there was not enough time to question staff due to the limited time available to complete resident's MDS's. As far as the ADL's that were recorded, the MDS coordinator reported those ADL's were always recorded within the Accu Nurse system because it was set up that way.

Interview with the Assistant Director of Nursing (ADON), on 09/19/13 at 4:20 PM, revealed she

F 278

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will be conducted starting week of 10/21/13 by the EDT five (5) days a week for two (2) weeks, weekly for thirty (30) days. Audits of 10% of completed MDS's will be conducted before submission by the ADON for forty-five (45) days.

- All monitoring findings will be reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance.
- Date of Compliance: 11/1/13

11/1/13

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F 278	Continued From page 18 checked over the MDS for completeness. She reported the Accu System recorded the, "late loss" ADL's which were recorded every shift. She stated the CNA's would complete the questionnaire in which the system was set up to ask certain questions related to resident's ADL's. The ADON added that during the seven (7) day period, the system should have been set up for the CNA's to answer additional questions related to resident's ADL's. In this case, the ADON reported it was not done, but added she was only concerned about the late loss documentation on the MDS. She stated the other ADL's showed no impact on the resident.	F 278			
F 280 SS=E	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.	F 280			

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F 280	Continued From page 19  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to revise the Comprehensive Plan of Care for five (5) of twenty-three (23) sampled residents (Resident #13, #4, #1, #11, and #10)  Resident #13's Care Plan was not revised after the resident placed a pillowcase over his/her head and made a statement regarding wanting to kill himself/herself.  Resident #4's Care Plan was not revised after the resident made negative statements related to not wanting to live.  Resident #10's Care Plan was not revised to indicate the need for Buspar (antianxiety medication) and Risperdal (antipsychotic medication).  Resident #11's Care Plan was not specific to include behavior exhibited to substantiate the use of the antipsychotic medication -Trileptal and there was inadequate non-pharmalogical interventions for behaviors.  Resident #1's Care Plan was not revised related to the use of the wanderguard. Also, Resident #1's Care Plan was not specific to include behaviors exhibited to substantiate the use of Geodon (antipsychotic medication) with non pharmalogical interventions related to the behaviors. In addition, Resident #1's Care Plan was not specific to include the need for Ambien (Hypnotic medication) with non-pharmalogical interventions.	F 280	<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 admssion 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 provistsions of federal and state law.</i>  F280 1. The Comprehensive Care Plans were revised and updated for identified Residents #1, #4, #10, #11 and #13. 2. A 100% audit of all Comprehensive Care Plans will be conducted starting week of 10/14/13 will be completed for accuracy and corrections were made as indicated. 3. A written protocol will be developed by the DON related to the development of Immediate Need (INPOCs) and Comprehensive Care plans. All licensed staff (including Social Services) will be re-educated by the DON and EDT on the protocol for care planning. Re-education will be conducted on 10/16/13 and 10/17/13 with all re-education completed by 10/21/13. Audits of INPOCs and Comprehensive Care Plans will be conducted starting the week of 10/21/13 on 10% of current Residents by the DON, ADON, Unit Manager(s) and the Weekend Nurse Manager seven (7) times a week for three (3) weeks, four (4) times a week for three (3) weeks and weekly for two (2) weeks.	

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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 280 Continued From page 20

The findings include:

Interview on 09/18/13 at 6:25 PM, with the Director of Nursing (DON), revealed, the facility had no specific policy for Care Plan revision. According to the DON, the facility utilizes the regulations as a policy.

1. Review of Resident #13's medical record revealed diagnoses which included Cardiovascular Accident (CVA), Diabetes, Peripheral Artery Disease (PVA), Depression, and Non-Alzheimer's Disease. Review of the Annual Minimum Data Set (MDS) Assessment, dated 7/30/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) indicating cognitive impairment

Review of the Nurse's Notes dated 06/06/13 at 3:00 PM revealed Resident #13 was noted to be pulling a pillowcase and stretching it across his/her face. Further review revealed, the nurse asked the resident what he/she was doing and the resident replied "trying to kill myself". According to the Note, the resident only had the use of one (1) arm and was being treated for a Urinary Tract Infection. The Note stated, the psychiatrist aware of the above and the Power of Attorney (POA) did not wish the resident to go to the hospital due to statements of this type in the past. Further review revealed the resident had a jersey material pillow case and fitted sheet, replaced with a non stretching material. The Note stated, fifteen (15) minute checks would be done.

Review of the Physician's Orders dated 06/06/13, revealed an order for every fifteen (15) minute

F 280

*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.

- 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: 11/1/13

11/1/13

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F 280 Continued From page 21  
checks for twenty-four (24) hours. Review of the Orders dated 06/07/13 revealed orders to extend the fifteen (15) minutes checks for twenty-four (24) hours related to behavior.

Review of the Social Service Note written by the Social Service Director (SSD) dated 06/06/13, no time noted, revealed the SSD spoke to the resident concerning negative statements. The Note further stated the resident had no signs and symptoms of depression at this time and was talking to the writer about how happy he/she was to be married. According to the Note, there was no suicidal tendencies noted

Review of the Nurse's Notes revealed continued follow up charting on 06/06/13 and 06/07/13 with no further concerns noted. However, review of the Nurse's Note on 06/07/13 at 2:00 PM revealed the resident was in the library and made a statement to the State Registered Nurse Aide (SRNA) that he/she wanted to see his/her spouse before he/she died. The Note stated, a new order was obtained to extend the fifteen (15) minute checks for twenty-four (24) hours and the family was notified

Review of the Geriatric Psychiatry Follow Up, dated 06/07/13, revealed the psychiatrist was called in reference to the resident's suicidal ideation and the family refused hospitalization. The psychiatrist recommendations were to continue medications at the current dose, and monitor for changes.

Review of Resident #13's Comprehensive Plan of Care revealed a problem dated 11/08/12 of alteration in mood, Depressive Disorder and Anxiety with a goal to take prescribed

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F 280	<p>Continued From page 22</p> <p>medications, participate in at least one (1) group activity and will not talk about leaving. The interventions included; administer medications per Physician's Orders, update for any changes in mood, continue psychiatric services, encourage social activities and verbalization. There was no documented evidence the Care Plan was updated to indicate the suicide attempt and ideation with preventive interventions after this resident made the attempt to put the pillow case over his/her head and stated he/she was trying to kill himself/herself on 06/06/13.</p> <p>Interview with the Social Service Director on 09/19/13 at 9:30 AM and 7:20 PM revealed she and Social Service Assistant (SSA) completed all mood, psychosocial well being, psychotropic and behavior care plans. The SSD stated she had not revised the Care Plan after the incident on 06/06/13 until 09/19/13 after surveyor questioning, and had not yet printed it out of the computer. Continued interview revealed she should have updated the Care Plan the day of the occurrence on 06/06/13.</p> <p>Interview with Director of Nursing on 09/19/13 at 8:10 PM revealed, there should have been an immediate care plan put into place following this resident's suicidal attempt initiated by the nursing staff. She further stated, either nursing or social services could ensure the care plan was in place because both nursing and social services were involved on the day of the incident. The DON stated there should also have been a current care plan in the chart related to the history of suicide attempt with interventions to prevent re-occurrence. She stated it just got overlooked and did not get done.</p>	F 280		
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F 280	<p>Continued From page 23</p> <p>2. Review of Resident #4's medical record revealed diagnoses which included Right Hip Fracture, Depression, Insomnia, Congestive Heart Failure, Coronary Artery Disease, Diabetes Mellitus, Depression, and Dementia. Review of the Minimum Data Set (MDS) Assessment, dated 07/30/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of nine (9), indicating moderate cognitive impairment. Further review revealed the facility assessed the resident as scoring an eleven (11) on the Patient Health Questionnaire nine (9), (PHQ-9), on the depression scale, indicating the resident was within the moderate range for depression.</p> <p>Interview with Resident #4, on 09/18/13 at 9:00 AM, revealed the resident was unhappy with the facility. During the interview, Resident #4 made statements such as, "I give up, I'd rather be dead than here, These people don't care about us, I just want to be left alone, and I pray to God every day that I die." The resident concluded by stating he/she did not have family or anyone who came to visit him. He explained, "I have no one".</p> <p>Interview with the Social Service Assistant, (SSA), on 09/18/13 at 9:30 AM, revealed Resident #4 made such negative statements in the past. The SSA stated the resident would not go through with killing himself/herself because he/she did not have a plan to do so. She stated, what worked for this resident was to reassure and monitor him/her, and redirect his/her statements. She stated she did not document previous statements of the resident wanting to die and thus the resident was not monitored. The SSA stated the statements should have been care planned with specific interventions in place that would provide</p>	F 280		
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**F 280** Continued From page 24  
fifteen (15) or thirty (30) minute checks and possibly one (1) on one (1).

Review of the Social Service Notes and Care Plan on 09/19/13 revealed no documentation of the resident's previous negative statements of wanting to die and no documented evidence Social Services had intervened after being notified by the surveyor of the resident's negative statements on 09/18/13. Review of the resident's care plan, revised 08/01/13, stated, "Let "resident" vent about feelings and redirect conversation to something positive

Interview with the Social Service Director, (SSD), on 09/19/13 at 4:45 PM, revealed she was aware the resident made statements of wanting to die. She reported the statements were not documented and a revised care plan was not developed related to the statements. She stated the resident's care plan should have been revised to reflect the resident's statements of wanting to die with specific interventions in place.

3. Review of Resident #11's medical record revealed diagnoses which included Dementia, and Atypical Psychosis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/10/13 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a ten (10) indicating some cognitive impairment. Further review revealed the facility assessed the resident as having no behaviors.

Review of the Physicians's Orders dated 09/13 revealed orders for Trilafon (antipsychotic medication) two (2) milligrams daily at bedtime.

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F 280	<p>Continued From page 25</p> <p>Review of the Comprehensive Plan of Care dated 11/07/12 revealed the resident was at risk for side effects related to psychotropic drug use with a goal that the resident would show no side effects or minimal side effects of medications taken. The interventions included psyche referral as needed, psychotropics per medication orders, monitor for changes in cognitive status and functional status, and evaluate effectiveness and side effects of medications.</p> <p>Review of the Comprehensive Plan of Care dated 04/05/13 revealed a problem of refusing care and medications, and being combative with care. The interventions included; remove resident from common areas during times of unacceptable behavior, refer to psyche services as needed with exacerbation or inability to effectively redirect behaviors, one (1) on one (1) as needed, social service visits as needed, and ask family to speak with resident related to refusals. However, there was no mention in the Care Plan of the antipsychotic medication Trilafon, a diagnoses for the medication, or psychotic behavior. In addition, there was inadequate interventions for the behaviors noted in the care plan.</p> <p>Interview with the Social Service Director on 09/19/13 at 9:30 AM revealed she and her assistant completed all mood, psychosocial well being, psychotropic and behavior care plans. She indicated the Care Plan needed to be more specific related to the use of Trilafon, behaviors and non pharmacological interventions related to the behaviors.</p> <p>Interview with the Director of Nursing (DON) on 9/19/13 at 7:00 PM, revealed the resident showed</p>	F 280		
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F 280 Continued From page 26

paranoid behaviors at times and would only allow her to administer the insulin injections. She stated she had informed staff not to argue with the resident but to check to see if the resident needed to be toileted, was hungry or thirsty, or was in pain when agitated. Continued interview revealed the Care Plan should have been specific for the use of Trilafon and the behaviors noted indicating the need for the medication and should have had more specific interventions on what to do if the resident was having behaviors.

4. Review of Resident #1's medical record revealed diagnoses which included Alzheimer's Dementia with Behaviors, Depression, and Psychosis. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/02/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) out of fifteen (15) indicating cognitive impairment. Further review revealed the facility assessed the resident as having wandering behavior daily.

Review of the Physician's Orders dated 09/13 revealed orders for a wanderguard to the wheelchair related to increased wandering and decreased safety awareness.

Observation of Resident #1 on 09/18/13 at 9:00 AM revealed the resident was in the hall by the activities room in a high back wheelchair. There was a wanderguard on the wheelchair.

Review of the Comprehensive Plan of Care revised 04/29/13, revealed the resident had a problem of wandering around the unit and possibly into other resident rooms/staff offices with a goal the resident would remain safe in the

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F 280 Continued From page 27

facility. The interventions included redirect away from areas of doorways, involve in activities of interest, assess for hunger/thirst and assess for toileting. There was no intervention for a wanderguard on the Care Plan.

Interview with Clinical Reimbursement Specialist (CRS) #2 on 09/18/13 at 9:00 AM, revealed she and the other CRS completed the MDS's and developed and revised the care plans. She stated the CRS's received copies of all Physician's Orders and updated the care plans daily or at least weekly according to the orders. CRS #2 stated she had completed the MDS and the Care Plan for Resident #1 during the last quarterly review. She reviewed the Care Plan and stated the wanderguard should have been on the Care Plan and she must have missed it.

5. Further review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment dated 07/02/13 MDS revealed the resident was coded as receiving an antipsychotic medication and a hypnotic medication for the past seven (7) days.

Review of the Physician's Orders dated 09/13, revealed orders for Geodon (antipsychotic medication) 20 milligram (mg) vial, reconstitute each vial with 1.2 milliliters (ml's) of sterile water and inject 20 mg's Intramuscular (IM) every twelve (12) hours prn for agitation, and Geodon 80 mg's capsule two (2) times daily with meals.

Further review of the Physician's Orders dated 09/13 revealed orders for Ambien 2.5 milligrams at night for sleeplessness.

Review of the Comprehensive Plan of Care dated 10/25/12 revealed the resident was at risk for side

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F 280	<p>Continued From page 28</p> <p>effects related to psychotropic drug use: Hypotension, movement disorder, gait disturbance, cognitive/behavior impairment, discomfort, and constipation with a goal the resident would show no side effects of medications taken. The interventions included psyche referral as needed, administer Psychotropic per MD order, monitor for changes in cognitive and functional status, evaluate side effects and effectiveness of medications for decrease/elimination of psychotropic drugs, and monitor behaviors.</p> <p>The Care Plan was not specific to include a diagnosis or behaviors exhibited indicating the need for the Geodon and there was inadequate non pharmaceutical interventions for behaviors. In addition, the Care Plan was not specific related to sleeplessness indicating the need for Ambien and there was inadequate non pharmaceutical interventions related to sleeplessness.</p> <p>Interview on 09/19/13 at 2:30 PM with Licensed Practical Nurse (LPN) #1 revealed she was consistently assigned to Resident #1. She stated the resident's behaviors included signs and symptoms of agitation including sweaty warm skin and looking mad and aggravated and the resident would make statements saying, "leave me alone and get away". She further stated the scheduled or prn (as needed) Geodon calmed the resident immediately. Continued interview revealed at times when the resident became agitated she would offer pain medication, offer toileting, and offer snacks and fluids.</p> <p>Further interview with the Social Service Director on 09/19/13 at 9:30 AM revealed she was responsible for Resident #1's psychotropic and</p>	F 280		
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F 280	<p>Continued From page 29</p> <p>behavior care plans. She stated the Care Plan should have been more specific related to the resident's diagnosis of Delusions and Psychosis and should state the specific behaviors the resident exhibited to indicate the need for the Geodon with non pharmacological interventions also listed for the behaviors. She further stated there should have been a care plan in place related to the residents Insomnia and need for Ambien with non pharmacological interventions for the sleeplessness.</p> <p>Further interview with the DON on 09/19/13 at 7:00 PM, revealed the care plan should have been more specific related to Resident #1's diagnoses and need for the psychotropic medications with interventions needed when the resident was having behaviors or couldn't sleep.</p> <p>6. Review of Resident #10's medical record revealed diagnoses which included Dementia with Behavior Disturbances, Atypical Psychosis, Organic Mood Disorder, and Depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 08/24/13, the resident was assessed by the facility as severely cognitively impaired for daily decision making and having an altered level of consciousness. In addition, under the Behavior section, the facility assessed the resident with wandering behavior.</p> <p>Continued review of Resident #10's medical record revealed the resident was seen by Geriatric Psych for follow-up, on 08/19/13, related</p>	F 280		

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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  09/19/2013
NAME OF PROVIDER OR SUPPLIER  WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3878 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
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F 280 Continued From page 30 to diagnoses of Anxiety and Atypical Psychosis.

Review of the September 2013 monthly Physician's Orders revealed orders for Risperdal (an antipsychotic medication) 0.25 milligrams (mg) twice a day for Dementia with Behavioral Disturbances and Atypical Psychosis. In addition, the resident was ordered Buspar (antianxiety medication) 15 mg for Anxiety.

Review of Resident #10's Comprehensive Care Plan revealed the resident was care planned for the wandering behavior, dated 10/31/12, only and not revised to include behaviors of anxiety/agitation. Further review of the Comprehensive Care Plan revealed the resident was care planned for being at risk for the side effects related to psychotropic drug use.

Interview with the Social Services Director (SSD), on 09/19/13 at 8:30 PM, revealed the resident was not showing any signs of psychosis or anxiety. The SSD stated the only behavior observed was wandering which was care planned and also care planned at risk for side effects related to the psychotropic drugs. Further interview with the SSD revealed even though the behaviors associated with diagnoses of Psychosis and Anxiety were not observed by staff, the resident's care plan should have been revised to include the potential for the behaviors not just for the medications ordered.

Interview, on 09/19/13 at 8:36 PM, with the Director of Nursing (DON) revealed the resident was being seen by Psych for Anxiety and Psychosis and is getting antipsychotic medications. She stated the facility had a new system in place and the care plans were not as

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F 280 Continued From page 31  
detailed as there were under the old system. The DON further revealed Resident #10 should have been care planned for the behaviors associated with the diagnoses.

F 280

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

F 281

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and record review, it was determined the facility failed to ensure services provided meet professional standards of quality for one (1) of twenty-three (23) sampled residents (Resident #1).

Resident #1's Physician's Orders were not followed related to ensuring TED Hose (thromboembolism deterrent hose) were worn.

The findings include:

Interview with the Director of Nursing (DON) on 09/18/13 at 6:45 PM, revealed it was a regulation to follow Physician's Orders and the facility did not have a policy related.

Review of Resident #1's medical record revealed

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F 281 Continued From page 32  
diagnoses which included Alzheimer's Dementia with Behaviors, Depression, Psychosis, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/02/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) out of fifteen (15) indicating cognitive impairment.

Review of the Comprehensive Plan of Care revised 04/29/13 revealed the resident had the potential for alteration in circulation related to Hypertension.

Review of the Physician's Orders dated 09/13 for Resident #1 revealed orders to apply TED Hose to the bilateral lower extremities, on at 6:00 AM and remove at bedtime related to edema.

Observation of Resident #1 on 09/18/13 at 9:00 AM, 9:30 AM, 10:00 AM, 10:47 AM, 11:15 AM, 1:00 PM and 1:30 PM revealed the resident was sitting in a wheelchair and no TED hose were noted.

Interview on 09/18/13 at 2:00 PM with State Registered Nursing Assistant (SRNA) #4, revealed she was assigned to Resident #1. She stated the night shift staff were to apply the TED Hose, and she did not notice the resident did not have the TED Hose on. She pulled out a reference from her pocket which she called the Nurse Aide Care Plan, and after reviewing, stated the resident should have had TED Hose on.

Interview on 09/18/13 at 2:05 PM with Licensed Practical Nurse (LPN) #1, revealed she was assigned to Resident #1 and she usually checked the Treatment Administration Record (TAR) to

F 281 *This Plan of Correction is the center's credible allegation of compliance.*  
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- F281
1. Resident #1 has been observed daily by the Unit Manager to ensure that the ordered TED hose were in place since 9/20/13.
  2. A 100% audit and observation will be performed the week of 10/14/13 to ensure that all appliances and equipment are in place as ordered.
  3. All licensed and certified staff will be re-educated by the DON and EDT to follow MD orders as indicated on the CNA Care Plan and/or TAR for each Resident. Re-education will be conducted on 10/16/13 and 10/17/13. All re-education will be completed by 10/21/13. All licensed and certified staff were re-educated on their responsibility to ensure that the appliances and equipment are used as ordered. Observation of all Residents will begin the week of 10/21/13 conducted by the Unit Manager(s), Shift Supervisor(s) and Weekend Manager for compliance with ordered appliances and equipment QS daily for two (2) weeks, three (3) times a week on alternating shifts for three (3)

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F 281

Continued From page 33

ensure devices or TED Hose were in place but had not had a chance to check it today. She checked the Physician's Orders and confirmed the resident was to have TED Hose.

2. Review of Resident #2's medical record revealed the facility admitted the resident on 08/19/09 with diagnoses which included Cerebral Palsy, Non-Alzheimer's Dementia, and Huntington's Disease ( a neurodegenerative genetic disorder that affects muscle coordination). Review of the Significant Change Mlnimum Data Set (MDS) Assessment, dated 06/28/13, revealed the facility assessed the resident as being moderately cognitively impaired. In addition, the MDS revealed the resident was assessed as having problems with swallowing and had a mechanically altered diet.

Continued review of Resident #2's medical record revealed the the September 2013 Physician monthly orders had a plan of treatment order for safe swallow strategies. The swallowing strategies order included having the resident alternate liquids and solids, liquids were to be consumed one (1) sip at a time, have a slow rate of intake, supervision for all intake to provide cues and assist resident to eat at bedside table to decrease distraction during meals. Further review of the orders revealed the resident was on a Pureed Diet with thickened liquids.

Observations, on 09/18/13 at 8:47 AM and at 1:04 PM, revealed the resident seated in his/her wheelchair in the hallway near the nurses station with a bedside table eating breakfast and lunch with no staff supervising the resident's intake as ordered. Staff were observed walking by the resident and interacting with the resident at times during the observation.

F 281

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- weeks and weekly on alternating shifts for three (3) weeks.
- 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: 11/1/13

11/1/13

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F 281	Continued From page 34  Interview with the Speech Therapist (ST), on 09/19/13 at 8:41 AM, revealed the resident had Cerebral Palsy, Huntington's Disease, and has been declining in his/her swallowing ability and has Dysphagia. The ST stated there was very specific swallow precautions in place after evaluating the resident and they were ordered 06/19/13. She stated a Barium swallow on 06/24/13 showed the resident had silent aspiration of thin liquids and recommended nectar thickened liquids and mechanical soft diet, however the ST kept the resident on a Pureed diet due to fatigue and coughing episodes. She further stated since the resident was put on thickened liquids there had been no choking episodes or signs of aspiration, but the resident would need to be re-evaluated to determine if the swallowing precautions were still appropriate. The ST stated the swallow precautions included supervision during meals and her expectation of supervision of the resident was to visually monitor the resident to ensure he/she followed the swallow procedures and was not distracted. The ST further stated it was not acceptable if no one was watching the resident and if the nurses were sitting at the nurse station or if staff were down the hallway they could not watch the resident. In addition, she stated the hallway was not conducive to prevent the resident from getting distracted.  Interview, on 09/19/13 at 9:49 AM, with Certified Nursing Assistant (CNA) #3 revealed Resident #2 sat out in the hallway for meals and enjoyed being by the nursing station. The CNA stated, during meals there was only one aide on the floor and they were unable to supervise the resident at all times when the resident was eating because	F 281			

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F 281 Continued From page 35  
they were expected to answer call lights and pass trays. She stated if they were down the hall they could not observe the resident. She further stated she was not aware of any choking episodes since the thickened liquids were being given, but the swallow precautions were put in place to prevent choking.

Interview, on 09/19/13 at 5:45 PM, with Registered Nurse (RN)/Unit Manager (UM) of the second floor revealed Resident #2 was moved from the dining room because he/she was getting food from other residents. She stated the resident was then moved to the nurse station, but would not eat because he/she talked to the nurses. The RN/UM stated the resident had an order for swallow precautions and was to be supervised at all times. However, she stated when the resident was moved out in the hallway they were not able to supervise the resident at all times. She stated the resident had no choking episodes. The RN/UM further stated the nurses should have watched the resident during meals or referred the resident to ST for a re-evaluation.

Interview, on 09/19/13 at 10:30 PM, with the Director of Nursing (DON) revealed they had educated the aides on safe swallow strategies. The DON stated Resident #2 had dysphagia and was moved to the hallway from the dining room because he/she got distracted and upset when he/she couldn't get the food wanted and got food from the other residents. The DON further stated it was not her understanding the resident was to be supervised at all times (with meals), but admitted that was what the order stated and was on the Treatment Administration Record that was initiated by nursing. She stated if there was a problem with the swallow precautions, the

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F 281 Continued From page 36  
Speech Therapist should have informed nursing. In addition, the DON stated it was a shared responsibility between nursing and Speech Therapy to ensure the order was followed or the resident was re-evaluated to determine if the swallow precautions were appropriate.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  
  
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, and review of facility policy's, it was determined the facility failed to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for one (1) of twenty-three (23) sampled residents (Resident #11).

Resident #11 was identified to have excoriation to the bilateral groin area during a skin assessment with the surveyor on 09/18/13; however, there was no documented evidence a Physician's Order was obtained until 09/19/13 after surveyor intervention.

F 281 *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.*

- F309
1. Resident #11 was assessed by the DON when notified by Surveyor of the potential issue on 9/19/13. Documentation of the assessment was completed and a treatment order was obtained from the MD and implemented
  2. Skin assessments were completed and treatment orders reviewed the week of 10/14/13 for appropriateness on all Residents. Any concerns identified were addressed by revision of present treatments and documentation.
  3. All licensed staff will be re-educated by the DON and EDT on the protocol for identification, documentation and treatment of any identified concerns. All licensed and certified staff will be re-educated on the protocol for notification of identified concerns utilizing the SBAR and Stop and Watch systems. The re-education will be conducted on 10/16/13 and 10/17/13 with all re-education completed by 10/21/13. Audits of identified concerns will be conducted starting the week of 10/21/13 for appropriate action and

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F 309 Continued From page 37  
The findings include:

Review of the facility "Wound Skin Treatment Options" Policy, undated, revealed when a new skin issue was discovered, be it on the weekly skin assessment or between assessments, staff was to measure the wound, immediately initiate a treatment, write an order for treatment and post it on the Treatment Administration Record (TAR), and call the physician and the family.

Review of Resident #11's medical record revealed diagnoses which included Dementia, and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/10/13, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) of a ten (10) indicating some cognitive impairment. Further interview revealed the resident required extensive assistance of staff for dressing, hygiene and bathing, and was incontinent of bowel and bladder.

Observation of a skin assessment performed by LPN #1 on 09/18/13 from 9:40 AM until 10:05 AM, revealed Resident #11 had red excoriation to the bilateral groin area. The nurse acknowledged the resident had excoriation to the areas and did not apply a treatment to the areas during the skin assessment.

Review of the Physician's Orders dated 09/13 revealed there was no treatment orders for this resident's groin area.

Further review of the skin assessments and the Nurse's Notes revealed there was no documented evidence the excoriation to the bilateral groin area was identified.

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documentation by the Unit Manager(s), Shift Supervisor(s) and Weekend Manager for compliance daily for two (2) weeks, three (3) times a week for three (3) weeks and weekly for three (3) weeks.

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: 11/1/13

11/1/13

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F 309	<p>Continued From page 38</p> <p>Interview with Licensed Practical Nurse #1 on 09/19/13 at 2:30 PM, revealed the resident did have excoriation to the bilateral groin area and needed a treatment to help with moisture. She stated she checked the Treatment Administration Record (TAR) before the skin assessment and did not see any treatment for the bilateral groin area; however, got confused and thought the resident must have a treatment to the areas which was applied during another shift. Continued interview revealed if a new area of skin breakdown was identified the nurse was to notify the physical for an order for treatment, add the area to the skin assessment in the computer, and make an entry in the Nurse's Note.</p> <p>Review of the Physician's Orders dated 09/19/13 after surveyor intervention, revealed orders to cleanse the groin folds with soap and water, pat dry, apply Interdry AG, secure with tape on sides daily (may use same Interdry AG for up to five (5) days and change as needed for saturation, and check placement of Interdry AG every shift.</p> <p>Interview on 09/18/13 at 7:00 PM with the Director of Nursing (DON), revealed LPN #1 should have looked to see if there was a treatment in place for the excoriation and if none noted, called the physician the same day to obtain a treatment. She further stated the nurse should have documented the excoriation on the skin assessment.</p>	F 309		
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a</p>	F 325		

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F 325 Continued From page 39  
resident -  
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and  
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of the facility's protocol, it was determined the facility failed to ensure one (1) of twenty-three (23) sampled residents (Resident #2) maintained acceptable parameters of nutritional status. Resident #2 had documented weight fluctuations with significant weight changes and no documented evidence the facility obtained re-weights or assessments related to the weight fluctuations.

The findings include:

Review of the facility's: "Weight Protocol - Weight Assessment and Intervention", revised date 10/01/12, revealed the facility would strive to prevent, monitor, and intervene for undesirable weight loss. Review of "Procedure:" revealed any weight change of 5% or more since the last assessment would be retaken for confirmation. In addition, under procedure the policy stated the Dietitian would review (the weights) and respond with appropriate interventions.

Review of Resident #2's medical record revealed the facility admitted the resident on 08/19/09 with

F 325  
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F325

1. Assessment and review of Resident #2 by the DON and RDL, in consultation with the MD, determined that all appropriate interventions are in place to maintain an acceptable nutritional status.
2. A 100% audit of all current Resident's weights and nutritional interventions will be conducted starting the week of 10/14/13. Any concerns will be addressed at the time of the audit.
3. All licensed and certified staff will be re-educated by the DON and EDT related to the skill of obtaining weights (with return demonstration) and the Resident Body Weight Collection Protocol. The re-education will be conducted on 10/16/13 and 10/17/13 with completion by 10/21/13. The IDT will review any weight issues every Thursday in triage and the third week of every month. Weights and the need for re-weights will be reviewed weekly as weights are obtained by the RDL, Dietary Manager, DON and ADON for

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NAME OF PROVIDER OR SUPPLIER  <b>WOODCREST NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3876 TURKEYFOOT ROAD ELSMERE, KY 41018</b>
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F 325 Continued From page 40  
diagnoses which included Cerebral Palsy, Non-Alzheimer's Dementia, and Huntington's Disease ( a neurodegenerative genetic disorder that affects muscle coordination). Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 06/28/13, revealed the facility assessed the resident as being moderately cognitively impaired. In addition, the MDS revealed the resident was assessed as having problems with swallowing and had a mechanically altered diet.

Review of Resident #2's medical record revealed in 2013 significant weight fluctuations were recorded for the resident. In June, the resident had an initial June weight of 98 pounds, no date listed and then on 06/14 had a weight of 112 pounds which was a 12.5 % weight change. There was no documented evidence a re-weight was done per the facility's protocol. In addition, review of the Nutritional Progress Note for June 06/27/13 revealed no assessment related to the weight change was performed. Review of the Evaluation of Nutritional Needs, dated 07/01/13, revealed the dietician noted the resident had weight fluctuations and initial June weight of 98 pounds was a decrease of 5.8% from the May weight of 104 pounds and also recorded the weights of 112 pounds on 06/16 and 111 pounds on 06/23 but did not question the weight accuracy or evaluate reason for the significant weight gain. Review of the Nurse's Notes for June 2013 revealed no documentation related to the weight gain or Physician notification of the weight change. Further review of Resident #2's June weight revealed the resident's weight was recorded on 06/23 as 111 pounds.

Continued review of the weights recorded for

F 325

*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.*

thirty (30) days, then weekly for two (2) weeks, then monthly for two (2) months.

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: 11/1/13

11/1/13

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NAME OF PROVIDER OR SUPPLIER  <b>WOODCREST NURSING &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3878 TURKEYFOOT ROAD ELSMERE, KY 41018</b>	

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F 325 Continued From page 41

Resident #2 revealed in July the resident had an initial July weight, no date, of 112 pounds, 07/14 weight 112 pounds, and then on 07/21 had a weight of 87 pounds. Review of the Nutritional Progress Note 07/22/13 revealed a re-weight was done and the weight was 88 pounds. Further review of the note revealed the Dietician questioned the accuracy of the weights of 112 pounds done in June - July and felt they had been recorded in error. In addition, the dietician noted the resident had no edema and had an average food consumption of less than 50%.

Further review of Resident #2's weights revealed on 08/18 a weight of 86 pounds, on 08/25 the resident's weight was recorded at 100 pounds, a 14 % weight gain. There was no documentation of a re-weight or assessment. Further review of the September weights revealed the resident had an initial weight, no date, again had a weight of 86 pounds. The 09/08 weight was also 86 pounds. Review of the Nutritional Progress note dated 09/16/13 revealed no assessment of the 08/25 weight record of 100 pounds.

Interview with Certified Nursing Assistant (CNA) #3, on 09/19/13 at 10:00 AM, revealed they did not have the same CNA weigh the resident, but did monthly weights usually at the beginning of each month on the resident's shower day and weekly weights were done on the weekends. The CNA stated whoever was assigned to the resident would do the weight. The CNA further stated they reported the weights to the nurse and if the weight was off the nurse may have the CNA to obtain a reweight.

Interview with Registered Nurse (RN)/Unit Manager (UM) Second Floor, on 09/19/13 at 4:54

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NAME OF PROVIDER OR SUPPLIER  WOODCREST NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3878 TURKEYFOOT ROAD ELSMERE, KY 41018	

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F 325 Continued From page 42  
PM, revealed weights were taken to the dietician. The RN/UM further stated if there was a concern the dietician would talk to the nurse or read the notes.

Interview with the Registered Dietician (RD), on 09/19/13 at 7:14 PM and 7:46 PM, regarding Resident #2 revealed they went to weekly weights in June due to a 5% weight loss from May to June. The RD stated the resident has a diagnosis of Huntington's Disease and was getting supplements of a milk shake, but weight decline was expected as the disease progressed. She stated weekly weights were done on Sundays and she usually reviewed the weights on Monday or Tuesday and put out a re-weigh list if needed. She stated they should have done a re-weigh after the 06/16 weight of 112 pounds was recorded to verify the weight was accurate. The RD stated on 07/22/13 (88 pounds) a re-weigh was done after the 07/21 weight of 87 pounds, in addition, they updated the resident's nutrition care plan for significant weight loss and added an enhanced foods: fortified oatmeal and yogurt for breakfast, cottage cheese and magic cup for lunch and dinner, and three times the butter for breakfast, lunch and dinner. Continued interview with the RD revealed after the weight of 08/25/13 of 100 pounds there should have been verified because the resident's weight on 08/18/13 was 86 pounds. The RD also stated the Physician should have been notified of the resident's weight changes. She stated, they had weekly triage meetings with nursing and other disciplines and weights were discussed. She stated she did not contact the Physician, the nurses did that.

Interview with the Director of Nursing (DON), on

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F 325	Continued From page 43 09/19/13 at 8:36 PM, revealed she could not explain why there were not any re-weights for the resident. The DON stated the re-weight requests comes from the dietician, she gets the weights and should let nursing know if a re-weight was needed or if the significant weight change indicated the need for an assessment. The DON further stated it appeared there was a communication problem between dietary and nursing, it was a breakdown in the system and was a concern for the residents.	F 325		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		

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F 441	Continued From page 44 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: Based on observation and interview, it was determined the facility failed to 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. Observation of dining service revealed a Certified Nursing Assistant (CNA) was observed handling a roll with her bare hands when setting up a resident's meal.  The findings include:  Interview with the Director of Nursing (DON)/Infection Control Nurse, on 09/19/13 at 5:00 PM and 8:36 PM, revealed the facility did not have a specific infection control policy that addressed the touching of food by servers in the dining areas and rooms, but staff were educated on the proper handling of food. She further stated staff were not supposed to touch food with their hands.  Observation, on 09/17/13 at 12:36 PM, revealed	F 441	<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>  F441 1. No Resident was identified. 2. Observation in Dining rooms and of room trays has been conducted daily since 9/20/13 to ensure the correct handling of food during its service. 3. Re-education of all licensed and certified staff will be conducted by the DON and EDT related to the proper handling of food during the meal service. The re-education will be conducted 10/16/13 and 10/17/13 with completion by 10/21/13. Observation of meals will be conducted daily starting the week of by the Unit Manager(s), Shift Supervisor(s), and the Weekend Nurse Manager daily for seven (7) days, then four (4) times a week for three (3) weeks, then weekly for three (3) weeks. 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: 11/1/13	11/1/13

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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 441 Continued From page 45  
CNA #3 had served a meal to a resident and was observed to have handled the residents roll with her bare hands when buttering the roll.

F 441

Interview with CNA #3, on 09/19/13 at 10:04 AM, revealed she had not really been given any specifics on food preparation in terms of touching the food with her hands. The CNA stated she had sanitized her hands between each tray, but verified she had used her hands to butter the roll. The CNA further stated she probably should not have touched the food with her hands, because there could be a risk to the resident.

Continued interview with the DON, on 09/19/13 at 8:36 PM, revealed the aides were trained once a year on food service. The DON stated she was not sure food service was specifically discussed during orientation, but expected it was covered during floor training. The aide should not have touched the food with her hands, it was an infection control problem.

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70 (a)  BUILDING: 01  PLAN APPROVAL: 1998  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: Two stories, Type II (111) Unprotected  SMOKE COMPARTMENTS: Four smoke compartments  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLED, SUPERVISED (DRY and Wet SYSTEM)  EMERGENCY POWER: Type II Diesel Generator  A life safety code survey was initiated and concluded on 09-18-13 for compliance with Title 42, Code of Federal Regulations, 483.70 and Found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. The facility is licensed for 127 beds and the census was 115 on the day of survey. The highest S/S identified was a "D".	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE 10/11/13

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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K 062	<p>Continued From page 1</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained according to National Fire Protection Association (NFPA) standards.</p> <p>The findings include:</p> <p>Observation, on 09/18/13 at 10:05 AM, revealed a total of two (2) corroded sprinkler heads located outside under the canopy of the second floor balcony. Sprinkler heads that are corroded must be replaced. The observation was confirmed with the Assistant Maintenance Director and the Administrator.</p> <p>Interview, on 09/18/13 at 12:00 PM, with the Assistant Maintenance Director, revealed the sprinkler heads were in a location not frequently accessed by the Maintenance staff, so they were not noticed.</p> <p>Interview on 09/18/13 at 12:15 PM, with the Administrator revealed that area stays locked all the time so no one goes out there.</p> <p>Reference NFPA 25 (1998 edition)</p> <p>Refer 2-2.1.1* Sprinklers shall be inspected from the floor level</p>	K 062	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <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>K062</p> <ol style="list-style-type: none"> <li>No resident was affected by corrosion on the outside sprinkler heads.</li> <li>100% audit to be conducted by Maintenance Director to identify corrosion on outside sprinklers.</li> <li>Facility will replace the 2 identified dry sprinklers under the canopy of the second floor balcony. Re-education conducted by NHA to Maintenance Staff on importance of maintaining sprinkler heads and the decreased ability to react as intended with the built up corrosion. Maintenance Director or Assistant will update TELS system and audit sprinkler heads quarterly to ensure the sprinklers are free of corrosion.</li> <li>All monitoring findings will be reviewed at monthly QA meeting for compliance and/or the need to update plan to reach 100% compliance.</li> <li>Date of Compliance: 11/1/13</li> </ol>	11/1/13

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annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.  
Exception No. 1:\* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.  
Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.

K 062