

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

PRINTED: 11/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 11/21/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance on 11/21/15, as alleged.</p>	{F 000}		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185252	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/21/2015
Name of Facility SHADY LAWN NURSING AND REHABILITATION CENTER		Street Address, City, State, Zip Code 2582 CERULEAN RD. CADIZ, KY 42211

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0157</u> Reg. # <u>483.10(b)(11)</u> LSC _____	Correction Completed 11/21/2015	ID Prefix <u>F0282</u> Reg. # <u>483.20(k)(3)(ii)</u> LSC _____	Correction Completed 11/21/2015	ID Prefix <u>F0314</u> Reg. # <u>483.25(c)</u> LSC _____	Correction Completed 11/21/2015
ID Prefix <u>F0325</u> Reg. # <u>483.25(l)</u> LSC _____	Correction Completed 11/21/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>NOH</u>	Date: <u>11/12/15</u>	Signature of Surveyor: <u>Deborah C. Skidmore, MEd, DR</u>	Date: <u>11/12/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on:
10/12/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2182 CERULEAN RD CADIZ, KY 40211
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	<p>An Abbreviated Survey investigating Complaint #KY23908 was conducted on 10/08/15 through 10/12/15. Complaint #KY23908 was substantiated with deficiencies cited at the highest Scope and Severity of a "D".</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's</p>	F 157	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Y. Dawn M. Decker, Administrator TITLE: Administrator (X6) DATE: 10-29-15

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 60 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.

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2882 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 1</p> <p>legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to inform a family member/legal representative of a significant weight loss and the Physician of a Dietary recommendation for one (1) of five (5) sampled residents (Resident #1).</p> <p>Resident #1 weighed 176 pounds in March 2015 and 153 pounds on 09/08/15 which was a greater than 10% weight loss (twenty-two pounds) in six (6) months. Dietary recommendations were made for fortified foods, large portions with meals (double meats and eggs), and health shakes. However, further record review revealed the facility failed to notify the resident's family of the significant weight loss and any recommendations to address the resident's weight loss. In addition, the facility Dietician recommended an appetite stimulant on 08/26/15; however, the facility failed to notify Resident #1's physician of a Dietary recommendation for an appetite stimulant.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Weight Policy", not dated, revealed any weight variances and recommended interventions must be communicated with the physician and family according to regulatory requirement.</p> <p>Closed record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Diabetes Mellitus Type II.</p>	F 157	<p>This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p>F157 NOTIFY OF CHANGES (INJURY/DECLINE/ ROOM)</p> <p>Criteria #1 Resident #1 no longer resides at Shady Lawn Nursing and Rehabilitation.</p> <p>Criteria #2 An audit of nutritional recommendations and weight trends for active residents residing</p> <p>at the facility for the last 3-months will be completed by the Dietary Manager by 11/20/15, with first full day of compliance being 11/21/15.</p> <p>The Dietary Manager will notify Administrative Nursing (Director of Nursing or Assistant Director of Nursing) of any missing notifications in writing, and Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or a Licensed Nurse will notify the resident's physician, resident, resident's legal representative, or family member of any recommendations, notifications needing to be made, or significant weight issues (as indicated per regulations) regarding the specific resident identified.</p>		

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED G 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2382 CERULEAN RD. GADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 2</p> <p>Cerebrovascular Accident, Hemiplegia, Aphasia and Chronic Airway Obstruction. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/25/15, revealed the facility assessed Resident #1's cognition as severely impaired, and the resident required supervision with eating.</p> <p>Review of Resident #1's Weight Record revealed Resident #1 weighed 178 pounds in March 2015, 173 in April 2015, 171 in May 2015, 168 in June 2015, 164 pounds in July 2015, 157 in August 2015, and 153 pounds on 09/09/15 which was a total of twenty-two (22) pounds in six (6) months (which was greater than 10%). However, further review of the record revealed there was no documented evidence the family and physician was made aware of the weight loss.</p> <p>Review of the Dietary Departmental Notes, dated 09/28/15 and 09/11/15, revealed the Dietician recommended to provide fortified meals, consider a medication to stimulate appetite, and large portions with meals (double meats and eggs); however, further review revealed there was no documentation the physician or family were made aware of the recommendations.</p> <p>Interview with Resident #1's son, on 10/09/15 at 9:55 AM, revealed he was aware of Resident #1's weight loss because he could tell by looking at his/her face but he did not realize how much because the resident was always covered by a blanket. He stated no one had made him aware of his/her weight loss or any of the recommendations by the Dietician.</p> <p>Interview with Resident #1's attending Physician, dated 10/09/15 at 3:58 PM, revealed he was not made aware of any recommendation for an</p>	F 157	<p>This will be completed by 11/20/15, with first full day of compliance being 11/21/15.</p> <p>Criteria #3 The Administrator will provide training to the Director of Nursing, Assistant Director of Nursing, and the Dietary Manager by 11/15/15 (first full day of compliance 11/21/15) on the weight policy and procedure.</p> <p>The training provided by the Administrator will also include that the Dietary Manager is to give a copy of the written Nutritional Recommendations provided by the Dietician to Administrative Nursing (Director of Nursing or Assistant Director of Nursing), after each visit.</p> <p>The Director of Nursing and the Dietary Manager will sign off the copy of recommendations provided by the Dietician. The signed copy will be given to the Administrator.</p> <p>The Administrative Nurses (Director of Nursing and Assistant Director of Nursing) will be provided training by 11/15/15 on notification of the physician, resident, responsible party, and family member of any recommendations or significant weight changes (as indicated per regulations). This will be completed by 11/20/15, with first full day of compliance being 11/21/15.</p>		

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2862 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 157	<p>Continued From page 3 appetite stimulant for Resident #1.</p> <p>Interview with the Dietary Manager, on 10/08/15 at 3:10 PM, revealed Resident #1 was identified to have a decrease in intake in July 2015 and the Dietician had asked her to update the resident's like and dislikes. She stated in August 2015 the resident was identified as having a significant weight loss and fortified foods, health shakes and double meats or eggs was added for all meals. She stated the Dietician also recommended the appetite stimulant at the end of August but that order was not received. She stated nursing was responsible for notifying the physician and family and she did not know why the appetite stimulant was never ordered.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 10/09/15 at 12:10 PM, revealed when it was identified the resident had a nineteen (19) pound weight loss in five (5) months in July 2015 (greater than 10% weight loss), the resident should have been added to the weekly Weight Committee Meetings. She stated the nurses would have been notified at that time of the weight loss and any dietary recommendations so the physician and family could be notified.</p> <p>Interview with the Director of Nursing (DON), on 10/12/15 at 7:30 AM, revealed she did not recall Resident #1 ever being discussed in the weekly Weight Committee Meeting. The DON stated nursing was normally notified of a resident's weight loss and Dietary recommendations during the weekly meeting and nursing would notify the family and physician to obtain the physician's orders. She stated since all the recommendations related to the resident's diet were updated on the resident's dietary slip but</p>	F 157	<p>Training will also be provided by the Administrator by 11/15/15 (first full day of compliance 11/21/15) to the Dietary Manager and Administrative Nursing (Director of Nursing and Assistant Director of Nursing) that will include that (1) one time a month weekly weights will be reviewed for (3) months, and the quarterly.</p> <p>Training will also be provided by the Administrator by 11/15/15 to the Dietary Manager that one (1) time a month 30, 60, 90, and 180 day weight trends will be reviewed during the Quality Assurance Meeting.</p> <p>The members of the Quality Assurance Team consists of the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Manager. The Medical Director attends the Quality Assurance Meeting at least one (1) time monthly.</p> <p>At this time the Quality Assurance Team will review or identify any current resident that has had a significant change (as indicated per regulations). Administrative Nursing (Director of Nursing and Assistant Director of Nursing) or a Licensed nurse will make appropriate notifications to the physician, family member/resident/ responsible party.</p>		

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	Continued From page 4 there was no order for the dietary recommendations to include an appetite stimulant. She stated the lack of communication Dietary and Nuring about Resident #1 caused them to miss notifying the physician and family.	F 157	The Dietary Manager will notify the Dietician, and in writing communicate any recommendations to Administrative Nursing (Director of Nursing and Assistant Director of Nursing).		
F 282 SS-D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure staff provided services in accordance with the written plan of care for one (1) of five (5) sampled residents (Resident #1). Resident #1 was care planned for staff to obtain weights per facility policy and provide treatments per physician orders. Monthly Weights revealed Resident #1 weighed 178 pounds in March 2015 and on 09/09/15, the resident weighed a 151 pounds which was greater than a 10% weight loss (22 pounds) in six months; however, there were no weekly weights obtained per facility policy. In addition, documentation revealed Resident #1's yeast infection to the inside bend of right arm was treated every shift; however, on 09/27/15, the resident was sent to the emergency room and was identified as having a pressure sore to the inside bend of right arm with the tendon seen through the wound.	F 282	The Director of Nursing or Assistant Director of Nursing will provide training to the Licensed Nurses by 11/20/15 (first full day of completion 11/21/15) of completion of nutritional recommendations, including notification of family and physician. Criteria #4 Beginning 11/20/15 (1) one time a week for (3) three months, and then quarterly the Dietary Manager and Administrative Nursing (Director of Nursing or Assistant Director of Nursing) will audit nutritional recommendations and documentation for current residents to ensure that the physician, responsible party, and family member have been notified of any recommendations given by the Dietician. If notifications are needed, Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or a Licensed Nurse will notify the appropriate family/resident/physician of recommendations given for current resident.		

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 GERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 5 The findings include:</p> <p>Review of the facility policy titled, "Weight Policy", not dated, revealed Dietary will obtain monthly weights and enter them into the AHT for calculation of monthly variance report. Residents triggering a significant weight variance defined as 5% in one (1) month, 7.5 % in three (3) months and 10% in six (6) months will be placed on weekly weight monitoring. Resident Care Plans shall be updated and documentation of the interventions maintained as part of the medical record.</p> <p>Review of the facility policy titled, "Skin System Policy and Procedure", not dated, revealed a skin care plan will be developed that staff will utilize.</p> <p>Closed record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Diabetes Mellitus Type II, Cerebrovascular Accident, Hemiplegia, Aphasia and Chronic Airway Obstruction. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/25/15, revealed the facility assessed Resident #1's cognition as severely impaired, the resident required supervision with eating, had limited movement on one side of the body and a Stage I pressure sore.</p> <p>Review of the Comprehensive Care Plan for Nutritional Risk, dated 02/09/15, revealed an intervention to obtain weights per facility policy.</p> <p>Review of Resident #1's Weight Record revealed Resident #1 weighed 176 pounds in March 2015 and on 09/09/15 the resident weighed 151 pounds (loss of 22 pounds in 6 months) and no</p>	F 282	<p>Current residents' weights at 30 days, 90 days, and 180 days will be reviewed (1) time a month for (3) three months, and then quarterly by the Dietary Manager to determine further interventions needed to be taken to identify any significant trends (as indicated per regulations). Results of the audit will be reported during the Quality Assurance Meeting.</p> <p>The members of the Quality Assurance Team consist of the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Manager. The Medical Director attends the Quality Assurance Meeting at least one (1) time monthly.</p> <p>The Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or Licensed Nursing staff will notify the physician/family member/resident of any significant weight changes or recommendations (as indicated per regulations) from this review/audit. Results of monitoring completed by Dietary Manager and Administrative Nursing (Director of Nursing or Assistant Director of Nursing) will</p> <p>also be reviewed in monthly Quality Assurance Meeting to determine change of monitoring or regarding notification of family and physician of significant weight changes and recommendations for nutritional status.</p>		

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 8 evidence the resident was placed on weekly weights at this time.</p> <p>Interview with the Dietary Manager, on 10/08/15 at 3:10 PM, revealed the Restorative Aides obtain the monthly weights and enter them into the Accu-Nurse. The Dietary Manager stated she then enters them into the AHT to identify if there is a significant weight loss or gain identified, and if there is, the resident is placed on weekly weights. She was unable to provide an explanation as to why the resident was not placed on weekly weights.</p> <p>In addition, review of the Comprehensive Care Plan for risk for Impaired skin integrity related to CVA with left side Hemiplegia, dated 02/11/15 and last revised 08/03/15, revealed an intervention to provide treatment per physician order. Review of the Physician's Orders, dated September 2015, revealed an order for Nystatin 100,000 units/gram cream, apply topically every shift to crease in right arm until healed.</p> <p>Review of the September 2015 Treatment Administration Record (TAR) revealed Nystatin was documented as being applied to the crease of the resident's right arm on 09/27/15 during the 8:00 AM through 2:00 PM shift by Licensed Practical Nurse (LPN) #4, and during the 2:00 PM through 10:00 PM shift by Registered Nurse (RN) #1.</p> <p>Interview with LPN #4, on 10/09/15 at 7:50 AM, revealed she initialed the September 2015 MAR on 09/27/15 indicating she had completed the Nystatin treatment to Resident #1's inner arm but had failed to go back and circle her initial to indicate the resident had refused to let her do the</p>	F 282	<p>The members of the Quality Assurance Team consist of the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Manager. The Medical Director attends the Quality Assurance Meeting at least one (1) time monthly.</p> <p>*282 SERVICES BY QUALIFIED PERSON/PER CARE PLAN</p> <p>Criteria #1 Resident #1 no longer resides at the facility.</p> <p>Criteria #2 The Dietary Manager will complete an audit of current resident care plans to ensure that appropriate interventions are noted for nutritional status on each current resident's care plan. If interventions are not care planned the Dietary Manager will addend the care plan at time of audit. This will be done by 11/20/15, with first full day of compliance being 11/21/15.</p> <p>Full body assessments were offered/completed by Licensed Nurses to current residents of the facility by Licensed Nursing on 10/9/15 or 10/10/15. No new skin areas were identified,</p>	Criteria #5 11/21/2015	

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2962 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 7 treatment.</p> <p>Interview with RN #1, on 10/09/15 at 8:20 AM, revealed she cleansed the resident's inner arm in the crease with normal saline and then applied the Nystatin powder to the crease of Resident #1's right arm on 09/27/15 and there was no redness or skin breakdown to the resident's skin, however, the resident was identified with a pressure ulcer to the right inner band of arm and there was a tendon visible through the wound when he/she arrived at the hospital at approximately 8:30 PM that day.</p> <p>Review of the Nurse's Note, dated 09/27/15, revealed the resident was transferred to the hospital due to a low potassium level. Review of the Emergency Department Hospital Record, dated 09/27/15 at 8:32 PM, revealed Resident #1 weighed 144 pounds on admission and review of the Hospital Discharge Planner Late Entry Nurse's Note, dated 09/28/15 at 12:00 Midnight, revealed Resident #1 had a wound on admission to the antecubital area (inner band of arm) of the right arm measuring 1.8 by 6.2 centimeters (cm) with a depth of 0.5 cm., with what appeared to be a visible tendon. Review of the Hospital Discharge Summary, dated 10/10/15, revealed Resident #1 passed away on 09/30/15 with diagnose to include Urosepsis and probable underlining urinary malignancy.</p> <p>Interview with the hospital Registered Nurse/Clinical Manager, on 10/09/15 at 12:57 PM, revealed Resident #1's wound was in the band of the resident's contracted right arm and measured 1.5 centimeters (cm) by 3.5 cm by 0.7 cm. She stated it appeared the resident's tendon was showing and the wound had a red beefy</p>	F 282	<p>via body assessments on 10/9/15 or 10/10/15. No further care plan modifications were needed regarding skin integrity at that current time of assessment.</p> <p>Criteria #3 The Administrator will provide training to the Dietary Manager by 11/15/15 that current Resident Care Plans shall be updated and documentation of the interventions maintained as part of the medical record. Training will be completed, by 11/15/15 with first full day of compliance being 11/21/15.</p> <p>The Administrator will provide training to Administrative Nursing (Director of Nursing and Assistant Director of Nursing) by 11/15/15 on utilization of the full man body assessment form to be used each week when skin assessments are being completed/offered for the current resident. The skin assessment form should be turned into Administrative Nursing (Director of Nursing or Assistant Director of Nursing) for the current resident for review and any needed care plan modifications shall be completed by the Director of Nursing or Assistant Director of Nursing.</p>		

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2802 CERULAN RD. CADIZ, KY 42211	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8 border and no tunneling Interview with the Assistant Director of Nursing (ADON), on 10/08/15 at 12:10 PM, revealed when it was identified the resident had a nineteen (19) pound weight loss in five (5) months in July 2015 (greater than 10% weight loss) and twenty-three (23) pound weight loss in August 2015, the resident should have been placed on weekly weights per the resident's care plan. She was unable to provide an explanation as to why the weekly weights were not obtained. In addition, she stated she was not aware there was any break in the skin on Resident #1's right arm and was unable to provide an explanation as to why staff would not have identified the wound if they followed the residents care plan related to treatment.	F 282	Administrative Nursing (Director of Nursing or Assistant Director of Nursing) will educate Licensed Nurses on utilization of full man body assessment form for weekly skin assessments offered/completed for current residents by 11/20/15. First full day of compliance will be 11/21/15. Licensed Nurses will also be trained that these assessments need to be completed and turned in to Administrative Nursing (Director of Nursing or Assistant Director of Nursing).	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to ensure a resident who enters the facility without a pressure sore does not develop a	F 314	for review to ensure appropriate interventions are noted on the care plan and notifications are made to the family/responsible party, and physician. Notifications will be made by Administrative Nursing (Director of Nursing or Assistant Director of Nursing), or by a Licensed Nurse. Criteria #4 Beginning 11/20/15 one time a month for three (3) months, and then quarterly the Dietary Manager will audit current dietary care plans to ensure that current interventions regarding nutritional status are documented on the Resident Care Plan. If interventions need to be added for the current resident they will be added by the Dietary Manager at time of audit. First full day of compliance will be 11/21/15.	

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 9 pressure sore for one (1) of five (5) sampled residents (Resident #1).</p> <p>Resident #1 was assessed to have a contracture to the right elbow and was care planned and had physician orders to have weekly skin assessments and to apply Nystatin topically every shift in crease of right arm until healed; however, on 09/27/15, Resident #1 was sent to the emergency room due to a low potassium level and the resident was identified to have a pressure sore to the inside bend of the right arm and the resident's tendon could be observed through the wound. The facility had failed to identify the pressure sore.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Skin System Policy and Procedure", not dated, revealed a skin assessment will be completed on admission/readmission, with any falls and weekly thereafter. Upon identification of skin/wound impairment the nurse will complete a SBAR and obtain orders from the physician, notify responsible party, document on twenty-four (24) hour report, update treatment Administration Record (TAR), and notify the assigned nurse Manager, nurse assessment coordinator and Skin Committee of the change in the resident's skin condition requiring additional oversight and monitoring.</p> <p>Closed record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Diabetes Mellitus Type II, Cerebrovascular Accident, Hemiplegia, Aphasia and Chronic Airway Obstruction. Review of the Quarterly Minimum Data Set (MDS) assessment,</p>	F 314	<p>Beginning 11/20/15 one time a month for three (3) months and then quarterly Administrative Nursing will audit care plans for those residents with pressure areas to ensure interventions are noted on the care plan regarding wounds.</p> <p>If appropriate interventions are not present Administrative Nursing (Director of Nursing or Assistant Director of Nursing) will addend the care plan at that time with needed interventions for that current resident.</p> <p>The members of the Quality Assurance Team consists of the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Manager. The Medical Director attends the Quality Assurance Meeting at least one (1) time monthly.</p> <p>One time a week for three months, and then quarterly the Quality Assurance Team will review all skin assessments. Care plans will be reviewed at this time for those current residents identified to have any identified pressure areas to ensure accurate documentation or interventions. If further interventions are needed they will be documented at the time of the Quality Assurance Meeting by the Assistant Director of Nursing or Director of Nursing.</p>		

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2882 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 10 dated 07/25/15, revealed the facility assessed Resident #1's cognition as severely impaired, the resident had limited movement on one side of the body and a Stage I pressure sore.</p> <p>Review of the Comprehensive Care Plan for risk for impaired skin integrity related to CVA with left side Hemiplegia, dated 02/11/15 and last revised 08/03/15, revealed interventions for weekly skin checks; report increase drainage, odor, pain or redness; skin assessment quarterly and as needed, geri-sleeves at all times, and treatment per physician order.</p> <p>Review of the Physician's Orders, dated September 2015, revealed an order for geri sleeves at all times as preventative measure, weekly skin assessments on Wednesday 10 PM-6 AM shift and Nystatin 100,000 units/gram cream, apply topically every shift to crease in right arm until healed.</p> <p>Review of the September 2015 Treatment Administration Record (TAR) revealed the resident wore geri sleeves every day on all shifts; the last weekly skin assessment was conducted on 09/23/15 by Licensed Practical Nurse (LPN) #3 with no skin breakdown identified; and Nystatin was applied to the inside bend of the resident's right arm on 09/27/15 during the 6:00 AM through 2:00 PM shift by LPN #4, and during the 2:00 PM through 10:00 PM shift by Registered Nurse (RN) #1.</p> <p>Interview with LPN #3, on 10/09/15 at 8:25 AM, revealed Resident #1's right arm was contracted so it was always bent and he/she had a yeast infection in the bend of the arm. She stated when she conducted the skin assessment on 09/23/15,</p>	F 314	<p>The members of the Quality Assurance Team consist of the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Manager. The Medical Director attends the Quality Assurance Meeting at least one (1) time monthly.</p> <p>One time a week the Dietary Manager will complete a form for any recommendations or interventions given for each current resident and the care plan will be reviewed to ensure recommendations have been appropriately noted on the care plan.</p> <p>This will be reviewed (1) one time a week in the Quality Assurance Meeting, and the care plan modified as needed by the Dietary Manager.</p> <p>One time a month for three (3) months and then quarterly the Quality Assurance Team will review audit tools of care plans regarding pressure ulcers and dietary interventions to determine appropriate further monitoring. If further interventions are needed they will be documented on the care plan at this time. Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or a Licensed Nurse will complete notifications to family/responsible party/physician if indicated.</p>	Criteria #5 11/21/15	

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

PRINTED: 10/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2018
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2882 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 11</p> <p>there was only some redness and a yeast infection. She stated she did not see any break in the skin.</p> <p>Interview with LPN #4, on 10/09/15 at 7:50 AM, revealed she initiated the September 2015 MAR on 09/23/15 and 09/27/15 indicating she had completed the Nystatin treatment to Resident #1's inner arm but had failed to go back and circle her initial to indicate the resident had refused to let her do the treatment on both days. She stated the last time she saw Resident #1's right arm (prior to 09/23/15), it was red.</p> <p>Interview with RN #1, on 10/09/15 at 8:20 AM, revealed she cleaned the resident's inner arm in the crease with normal saline and then applied Nystatin powder to the crease of Resident #1's right arm on 09/26/15 and 09/27/15 and there was no redness or skin breakdown to the resident's skin. However, review of the Nurse's Note, dated 09/27/15, revealed the resident was transferred to the hospital due to a low potassium level and review of the Hospital Discharge Planner Late Entry Nurse's Note, dated 09/28/15 at 12:00 Midnight, revealed Resident #1 had a wound on admission to the right antecubital area (inner bend of arm) of the right arm measuring 1.8 by 6.2 centimeters (cm) with a depth of 0.5 cm., with what appeared to be a visible tendon.</p> <p>Review of the Hospital Discharge Summary, dated 10/10/15, revealed Resident #1 passed away on 09/30/15 with diagnose to include Urosepsis and probable underlining urinary malignancy.</p> <p>Interview with the hospital Registered Nurse/Clinical Manager, on 10/09/15 at 12:57</p>	F 314	<p>F314 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Criteria #1 Resident no longer resides at facility.</p> <p>Criteria #2 Full body assessments were offered/completed, by licensed nurses, to current residents who resided at the facility on 10/9/15 or 10/10/15. There were no new findings. No further notifications or care plan modifications were indicated for the current residents.</p> <p>Criteria #3 Administrative Nursing (Director of Nursing or Assistant Director of Nursing) will re-educate Licensed Nursing Staff on the Skin Policy and it's requirements by 11/20/15, with first full day of completion being 11/21/15. This includes completion of the SBAR.</p> <p>Licensed Nurses will also be provided training by Administrative Nursing (Director of Nursing or Assistant Director of Nursing) by 11/15/15 (with first full day of compliance 11/21/15) that the physician should be notified and the family or responsible party notified of any pressure sores or skin integrity issues.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 12 PM, revealed Resident #1's wound was in the bend of the resident contracted right arm and measured 1.5 centimeters (cm) by 3.5 cm by 0.7 cm. She stated it appeared the resident's tendon was showing and the wound had a red beefy border and no tunneling. Interview with the Assistant Director of Nursing (ADON), on 10/09/15 at 12:10 PM, revealed she was not aware of the area on Resident #'s right arm to ever have any break in the skin and was unable to provide an explanation as to why if the wound was there the staff did not identify it. Interview with the Administrator, on 10/09/15 at 12:30 PM, revealed she did not think the wound was on Resident #1's arm when he/she left the facility because if it was the staff would have identified it. Interview with Resident #1's attending Physician, dated 10/09/15 at 3:58 PM, revealed she was not aware of Resident #1 having a pressure sore to the inner right arm. She stated if the resident arrived at the hospital with a pressure sore and the tendon could be observed through the wound then it would have been there prior to leaving the facility and should have been identified. She stated in hindsight the identification of possible bladder cancer could be an explanation of why Resident #1 was having a gradual decline in weight and skin breakdown.	F 314	This training will be completed by 11/20/15, with first full day of compliance. being 11/21/15. Administrative Nursing (Director of Nursing or Assistant Director of Nursing) will provide training to Licensed Nurses on completing body assessments utilizing the full body skin assessment form and to ensure that Administrative Nursing (Director of Nursing or Assistant Director of Nursing) receives copies of completed body assessments for current residents to review to ensure no new findings. Any new findings will be documented on the comprehensive care plan for the specific current resident by the Director of Nursing or Assistant Director of Nursing. This will be completed by 11/20/15, with first full day of compliance being 11/21/15. Administrative Nursing (Director of Nursing and Assistant Director of Nursing) will also provide re-education to Licensed Nurses on how to document on TAR when a resident refuses treatment of any type. This training will be done by 11/20/15, with first full day of compliance being 11/21/15.		
F 325 SS-D	483.26(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325			

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 13</p> <p>(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</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure there system for monitoring weights and to carry out Dietician Recommendations was effective for one (1) of five (5) sampled residents (Resident #1).</p> <p>Resident #1 weighed 176 pounds in March 2015 and 157 pounds on 08/28/15. The facility failed to identify Resident #1 had a greater the 10% weight loss in five (5) months and failed to initiate weekly weights and monitor the resident through the Weekly Weight Committee. In addition, the facility Dietician recommended an appetite stimulant on 08/28/15; however, the failure to monitor the resident in the Weekly Weight Committee caused the physician not to be made aware of the recommendation. On 09/27/15, the resident was sent to the emergency room due to a low potassium level and weighed 144 pounds and it was identified the resident had a possible cancerous tumor on his/her bladder. The resident passed away on 09/30/15.</p> <p>The findings include: Review of the facility policy titled, "Weight Policy".</p>	F 325	<p>Criteria #4 Beginning 11/20/15 Administrative Nursing (Director of Nursing or Assistant Director of Nursing will (1) one time weekly for (3) three months audit SBAR completion, family notification, and physician notification regarding pressure area development for current residents. Any issues noted will be corrected at the time of audit, and appropriate notifications made by Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or a Licensed Nurse. First full day of compliance will be 11/21/15.</p> <p>Beginning 11/21/15 Administrative Nursing (Director of Nursing or Assistant Director of Nursing will review skin assessments of current residents (1) one time a week for three months and then quarterly to ensure that skin assessments that document any new pressure areas have a SBAR completed, notifications to family/responsible party, and</p>		

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0361

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2982 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 14</p> <p>not dated, revealed an admission height and weight will be obtained, then weekly for four (4) weeks, then monthly thereafter, if stable. The weights will be obtained by nursing and entered into the Accu-nurse (computer system). Dietary will obtain monthly weights and enter them into the AHT for calculation of monthly variance report. Residents triggering a significant weight variance defined as 5% in one (1) month, 7.5 % in three (3) months and 10% in six (6) months will be addressed by the Weight Variance Committee and placed on weekly weight monitoring. The weight history log, Weight Change Comparison and monthly weight record from AHT and/or Accu-Nurse must be incorporated to provide necessary information needed for committee discussion. The facility Registered Dietician recommendations are to be reviewed weekly during the Weight Variance Meeting and any deviation should be discussed and documented. Resident Care Plans shall be updated and documentation of the interventions maintained as part of the medical record.</p> <p>Closed record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Diabetes Mellitus Type II, Cerebrovascular Accident, Hemiplegia, Aphasia and Chronic Airway Obstruction. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/25/15, revealed the facility assessed Resident #1's cognition as severely impaired, and the resident required supervision with eating.</p> <p>Review of the Comprehensive Care Plan for Nutritional Risk, dated 02/09/15, revealed interventions to provide diet as ordered and weights per facility policy.</p>	F 325	<p>pressure area is noted on the comprehensive care plan. Any corrections or notifications will be made by Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or a Licensed Nurse at time of identification of issue. Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or a Licensed Nurse will also notify the family, responsible party, and physician if indicated.</p> <p>Beginning 11/20/15 One time a week for three months and then quarterly, the Quality Assurance Team will meet and discuss all residents with pressure areas. The Team will ensure that all pressure areas are appropriately care planned, notifications are made by Licensed Nursing, and that an SBAR has been completed for the development of the pressure area. If any issues are noted they will be corrected as identified by Administrative Nursing (Director of Nursing or Assistant Director of Nursing).</p> <p>Members of the Quality Assurance Team consist of the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Manager. The Medical Director attends the Quality Assurance Meeting at least one (1) time monthly.</p>	Criteria #5 11/21/15	

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**
**PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0381**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2882 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 15</p> <p>Review of Resident #1's Weight Record revealed Resident #1 weighed 176 pounds in March 2015, 173 in April 2015, 171 in May 2015, 168 in June 2015, 164 in July 2015, and 157 in August 2015, which was a loss of nineteen pounds in five (5) months (which was greater than 10%). However, further review revealed the resident was not placed on weekly weights at this time. Further review of the weight records revealed the resident's next weight was not obtained until September 2015 and was 144 pounds with a reweigh completed on 09/08/15 and the resident weighed 151 pounds (loss of 22 pounds in 6 months) and no evidence the resident was placed on weekly weights at this time or of any further weights obtained.</p> <p>Review of the Dietary Departmental Notes, dated 07/01/15 and 07/28/15 revealed the resident percentage of intake had dropped from 78% to 70%. On 08/14/15, the resident's intake was identified to have decreased to 60% with the action taken to update food preferences. On 08/28/15, the resident's intake had dropped to 56% and his/her weight was noted to have dropped to 157 pounds which was a 6.55% decrease in sixty-nine days. However, the note did not identify the greater than 10% weight loss in five (5) months. The resident's intakes had also dropped to 56%. The recommendation was made to provide fortified meals and consider a medication to stimulate appetite. Review of the resident's dietary slip in the kitchen revealed it was updated to include fortified foods; however, review of the Physician Orders revealed there was no order for an appetite stimulant or fortified foods. On 09/11/15, the resident's weight was noted to have dropped further to 151 pounds which was a twenty-two (22) pound weight loss</p>	F 325	<p>F325 MAINTAIN NUTRITIONAL STATUS UNLESS AVOIDABLE.</p> <p>Criteria #1 Resident #1 no longer resides at Shady Lawn Nursing and Rehabilitation.</p> <p>Criteria #2 An audit of nutritional recommendations and weight trends for all active residents residing at the facility for the last 3-months will be completed by the Dietary Manager by 11/20/15, with first full day of compliance being 11/21/15.</p> <p>The Dietary Manager will notify Administrative Nursing (Director of Nursing or Assistant Director of Nursing) of any missing notifications in writing, and Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or a Licensed Nurse will notify the resident's physician, resident, resident's legal representative, or family member of any recommendations, notifications needing to be made, or significant weight issues (as indicated per regulations) regarding the specific current resident identified.</p> <p>This will be completed by 11/20/15, with first full day of compliance being 11/21/15.</p>		

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

PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 16</p> <p>(greater than 10% in 6 months) with large portions with meals. On 09/16/15, the resident's meal intake for the past seven (7) days was noted at 60% with no further recommendation noted.</p> <p>Review of the Nurse's Note, dated 09/27/15, revealed the resident was transferred to the hospital due to a low potassium level. Review of the Emergency Department Hospital Record, dated 09/27/15 at 8:32 PM, revealed Resident #1 weighed one-hundred and forty-four pounds on admission. Review of the Hospital Discharge Summary, dated 10/10/15, revealed Resident #1 passed away on 09/30/15 with diagnose to include Urosepsis and probable underlining urinary malignancy.</p> <p>Interview with the Dietary Manager, on 10/08/15 at 3:10 PM, revealed the Restorative Aide obtain the monthly weights and enter them into the Accu-Nurse. The Dietary Manager stated she then enters them into the AHT to identify if there is a significant weight loss or gain identified, and if there is, the resident is placed on weekly weights and discussed in the weekly weight committee meeting. She further revealed Resident #1 was identified to have a decrease in intake in July 2015 and the Dietitian had asked her to update the resident's like and dislikes. She stated in August the resident was identified as having a significant weight loss and fortified foods, health shakes and double meats or eggs was added for all meals. She stated the Dietician also recommended an appetite stimulant at the end of August but that order was not received. She revealed she did not know why the appetite stimulant was never ordered and she missed placing the resident on weekly weights.</p>	F 325	<p>Criteria #3</p> <p>The Administrator will provide training to the Director of Nursing, Assistant Director of Nursing, and Dietary Manager by 11/15/15 (first full day of compliance 11/21/15) on the weight policy and procedure.</p> <p>The training provided by the Administrator will also include that the Dietary Manager is to give a copy of the written Nutritional Recommendations provided by the Dietician to Administrative Nursing (Director of Nursing or Assistant Director of Nursing, after the Dietician's visit.</p> <p>Administrative Nursing (Director of Nursing or Assistant Director of Nursing), and the Dietary Manager will sign off the copy of the current recommendations provided by the Dietician. The signed copy will be given to the Administrator.</p> <p>The Administrative Nurses (Director of Nursing and Assistant Director of Nursing) will be provided training by 11/15/15 on notification of the physician, resident, responsible party, and family member of any recommendations or significant weight changes (as indicated per regulations). This training will be completed by the Administrator by 11/15/2015, with first full day of compliance being 11/21/15.</p>		

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

PRINTED: 10/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2682 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 17</p> <p>Interview with the Assistant Director of Nursing (ADON), on 10/09/15 at 12:10 PM, revealed when it was identified the resident had a nineteen pound weight loss in six months in July 2015 (greater than 10% weight loss) the resident should have been placed on weekly weights and should have been reviewed in the weekly Weight Committee Meetings. She stated the nurses would have been notified at that time of the weight loss and any dietary recommendations so the physician could be notified and an order obtained.</p> <p>Telephone interview with the facility Registered Dietician, on 10/09/15 at 11:30 AM, revealed she remembered they had identified Resident #1 had a weight loss and a decline in intake so she recommended double meats/eggs and fortified foods. She stated without the resident's record she did not recall if she had made any other recommendations. She stated nursing was responsible for obtaining the physician's orders for her recommendations if needed.</p> <p>Interview with the Director of Nursing (DON), on 10/12/15 at 7:30 AM, revealed she did not recall Resident #1 ever being discussed in the weekly Weight Committee Meeting. The DON stated during the meeting is when nursing was normally notified of any Dietary recommendations and nursing would obtain the physician's orders. She stated since all the recommendations related to the resident's diet were updated on the resident's dietary slip but there was no no physician order for the Dietary recommendations to include the appetite stimulant she believes believes there was a lack of communication between Dietary and Nursing about Resident #1.</p>	F 326	<p>Additional training that will be provided by the Administrator by 11/15/15 (first full day of compliance 11/21/15) to the Dietary Manager and Administrative Nursing (Director of Nursing and Assistant Director of Nursing) will include that (1) one time a month weekly weights for current residents will be reviewed for (3) months, and the quarterly.</p> <p>Training will also be provided by the Administrator by 11/15/15 to the Dietary Manager that one (1) time a month 30, 60, 90, 180 day weight trends will be reviewed during the Quality Assurance Meeting.</p> <p>At this time the Quality Assurance Team will review or identify any resident that has had a significant change (as indicated per regulations). Administrative Nursing (Director of Nursing and Assistant Director of Nursing) or a Licensed Nurse will make appropriate notifications to the physician, family member/resident/ responsible party.</p> <p>Members of the Quality Assurance Team consists of the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Manager. The Medical Director attends the Quality Assurance Meeting at least one (1) time monthly.</p> <p>The Dietary Manager will notify the Dietician, and in writing</p>		

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

PRINTED: 10/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/12/2015
NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2552 CERULEAN RD. CADIZ, KY 42211		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	Continued From page 18 Interview with Resident #1's attending Physician, dated 10/09/15 at 3:58 PM, revealed in hindsight the identification of possible bladder cancer could be an explanation of why Resident #1 was having a gradual decline in weight.	F 325	communicate any recommendations to Administrative Nursing (Director of Nursing or Assistant Director of Nursing). The Director of Nursing or Assistant Director of Nursing will provide training to the Licensed Nurses by 11/20/15 (first full day of completion 11/21/15) of completion of nutritional recommendations, including notification of family and physician. Criteria #4 Beginning 11/21/15 one time a week for (3) three months, and then quarterly the Dietary Manager and Administrative Nursing (Director of Nursing and Assistant Director of Nursing) will audit nutritional recommendations and documentation to ensure that the physician, responsible party, and family member have been notified of any recommendations given for current residents by the Dietician. If notifications are needed, Administrative Nursing (Director of Nursing or Assistant Director of Nursing) or a Licensed Nurse will notify the appropriate family/resident/physician of recommendations given.		

Cont'd next page &

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

PRINTED: 10/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/12/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SHADY LAWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2482 CERULEAN RD. CADIZ, KY 42211
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 325	Continued From page 18 Interview with Resident #1's attending Physician, dated 10/09/15 at 3:58 PM, revealed in hindsight the identification of possible bladder cancer could be an explanation of why Resident #1 was having a gradual decline in weight.	F 325	<p>Beginning 11/20/15 current residents' weights at 30 days, 90 days, and 180 days will be reviewed (1) time a month for (3) three months, and then quarterly to determine further interventions needed to be taken to identify any significant trends (as indicated per regulations). This will be completed by the Dietary Manager.</p> <p>The Nursing Department will notify the physician/family member/resident of any significant weight changes or recommendations (as indicated per regulations) from this review/audit.</p> <p>Results of monitoring completed by Dietary Manager and Administrative Nursing (Director of Nursing and Assistant Director of Nursing) will also be reviewed in monthly Quality Assurance Meeting to determine change of monitoring or regarding notification of family and physician of significant weight changes and recommendations for nutritional status.</p> <p>Members of the Quality Assurance Team consists of the Director of Nursing, Assistant Director of Nursing, Administrator, Social Services Director, and Dietary Manager. The Medical Director attends the Quality Assurance Meeting at least one (1) time monthly.</p>	Criteria #5 11/21/2015
-------	---	-------	---	---------------------------