

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

PRINTED: 12/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/30/2012
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Recertification Survey and an Abbreviated Survey investigating KY#00019400 was initiated on 11/27/12 and concluded on 11/30/12. KY#00019400 was unsubstantiated with no deficiencies cited. Deficiencies were cited on the Standard Survey with the highest Scope and Severity (S/S) being an "E".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain and promote the dignity of residents in a manner and in an environment that maintained or enhanced their dignity. The facility failed to ensure meal trays were served in a manner to promote dignity and enhance the residents individuality for unsampled residents on the second floor dining room. The findings include: Review of the facility's policy titled, "Dining service", dated 10/01/12, revealed the facility would provided all residents a pleasurable dining experience by offering nutritious attractive meals in a social setting served in a courteous, dignified manner. It further stated the facility would begin	F 241	F241 1. Unable to correct deficiency practice at identified time. Meal service times were adjusted on 12/4/12 by DM and Resident Food Committee so all trays would be available when serving 2 nd floor dining areas. Cart order rearranged and times are still acceptable by Committee. 2. Unable to correct deficiency practice at identified time Meal service times were adjusted on 12/4/12 by DM and Resident Food Committee so all trays would be available when serving 2 nd floor dining areas. Cart order rearranged and times are still acceptable by Committee. All residents were observed or interviewed regarding dignity during dining by DM and SSD beginning 12/4/12 thru 12/11/12 with no further issues noted. 3. Re-education of all licensed and certified nursing staff was conducted by DON on dignity and respect related to the serving of resident trays to all sitting at table. Education was conducted 12/18/12, 12/19/12, and 12/27/12.	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Adam Lewandowski</i>		TITLE NHA		(X6) DATE 1/11/13

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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 241	Continued From page 1 serving each table when all residents were present at the table. Observation, on 11/27/12 at 12:20 PM, of the lunch meal in the second floor dining room, revealed trays were being served and one (1) unsampled resident, Unsampled Resident B at table three (3) and one (1) unsampled resident, Unsampled Resident C at table four (4) did not receive their trays before staff served other tables. Observation further revealed the unsampled residents waited (10) minutes before receiving their trays, while other residents at their table were eating. Continued observation, on 11/27/12 at 12:30 PM, of the lunch meal in the second floor dining room, revealed Unsampled Residents D and Unsampled Resident E were at table seven (7) and did not receive their trays for approximately forty (40) minutes, while others residents at that table were eating. Interview with Licensed Practical Nurse (LPN) #2, on 11/27/12 at 12:35 PM, revealed residents had assigned seats and she did not know why all the trays were not delivered at the same time. Interview with the Dietary Manager, on 11/27/12 at 1:30 PM, revealed when serving meat trays, all residents should be served before moving to the next table. She stated residents were not sitting in their assigned seats, which caused a mix-up in serving the trays. However, review of the "Early Tray-Therapy" seating chart revealed residents were seated correctly according to the chart.	F 241	<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> Re-education of all dietary staff conducted by DM on dignity and respect related to the serving of resident trays to all sitting at table completed 12/4/12. Audit will be conducted by DM to observe dining service for resident dignity to include ten meals weekly for 2 weeks, then five meals weekly for 2 weeks, then weekly for 1 month. 4. All monitoring findings will be reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. 5. Date of Compliance: 1/13/2013	1/13/2013	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			

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F 315	Continued From page 2 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's guidelines, it was determined the facility failed to ensure one (1) unsampled resident (Unsampled Resident F) was provided appropriate care and treatment related to an indwelling catheter. The facility failed to ensure proper infection control protocol was utilized for the re-use of the urinary drainage bag while the leg drainage bag was being utilized. The findings include: A review of the facility's procedure guidelines, "Lippincott's Textbook for Nursing Assistants", 2000 edition, revealed disconnecting the drainage bag from the tubing could allow harmful bacteria to enter the catheter. The guidelines further stated to be sure that the open tubing did not touch anything. Observation on initial tour, on 11/27/12 at 9:30 AM, revealed an indwelling catheter bag with seventy-five (75) millimeters (ml) of yellow liquid	F 315	<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> F315 1. Unsampled resident F indwelling catheter bag was removed by LPN#1 on 11/27/12. DON replaced indwelling catheter bag on 11/27/12. Unsampled resident F was assessed with no negative outcomes by DON on 11/27/12. 2. 100% audit of all residents with indwelling catheters to ensure cleanliness was conducted by Unit Managers on 11/27/12. All identified issues were replaced with new indwelling catheter bag. 3. All licensed and certified nursing staff will be re-educated by DON on appropriate procedure for care and storage of indwelling catheters by 12/28/2012. Observation audits will be completed by DON/ADON/Unit Managers of all shifts for compliance with care and storage of indwelling catheters four times a week for 2 weeks, then two times a week for 2 weeks, then weekly for 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.		

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F 315	Continued From page 3 was hanging in the resident's bathroom. The bag was draped over the safety grab bar. The tubing was not in a holder and was not covered to prevent bacterial contamination of the tubing. Interview, on 11/27/12 at 9:55 AM, with State Registered Nurse Aide (SRNA) #1, revealed the bedside drainage bag should have been emptied after the leg bag was attached and a plastic bag should have been placed over the drainage bag and the tip of the tubing put in a covered slot. Interview, on 11/27/12 at 9:50 AM, with Licensed Practical Nurse (LPN) #1 revealed the bedside drainage bag should not have be hanging on the safety grab bar with 75 ml of urine in the bag and the uncovered. It should have been covered with a plastic bag after it was emptied. Interview, on 11/30/12 at 12:05 PM, with the Director of Nursing (DON) revealed the process for removal of the bedside drainage bag for placement of the leg bag included the SRNA should clean the tip of the leg bag with alcohol, remove the bedside drainage bag, and place the cleaned leg bag to the urinary catheter. The bedside drainage bag should then be emptied, the output recorded and the tip of the tubing cleaned with alcohol and placed in a plastic bag. The bedside drainage bag may then be stored in the bathroom or night stand, per each resident's preference.	F 315			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371			

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F 371	Continued From page 5 (200) parts per million (ppm) range. Interview, on 11/27/12 at 9:20 AM, with Culinary Assistant #1, revealed she had been instructed that as long as the test strip had any green on it all, then the sanitizer was good to use. Interview, on 11/27/12 at 12:20 PM, with the Dietician revealed she had changed the sanitizer solution (and was using the new solution) after the initial kitchen tour by the Survey Agency (SA) earlier in the day. Further interview also revealed she had called in the sales representative. Interview, on 11/27/12 at 12:22 PM, with the Dietary Manager (DM) revealed the manufacturer said the sanitizing solution was good to use as long as the test strip had "a speck of green" on it. SA requested a copy of the manufacturers guidelines from the DM. The DM presented the label off the test strip bottle, not the actual guidelines. Further interview revealed the DM did not understand what the manufacturers instructions were. Interview with the Dietician, on 11/27/12 at 4:30 PM, revealed the EcoLab sales representative had been in and tested the solution. She further stated he had replaced the dispenser due to there being a crack in it and placed instructions on the wall. Further interview revealed the previous test strips were replaced due to being unreliable. Interview with the EcoLab sales representative, on 11/28/12 at 10:30 AM, revealed the solution test strips the facility had been using were defective, that the strip should change colors and not just have "a speck" of green on it.	F 371			

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F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide pharmaceutical services to meet the needs for one (1) of twenty-three (23) sampled residents (Resident #18). On 11/25/12 and 11/29/12, scheduled, controlled pain medications were not available for administration as ordered by the Physician.</p> <p>The findings include: Review of the facility policy titled, "Pharmacy</p>	F 425	<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>F425</p> <ol style="list-style-type: none"> Medication ordered for identified resident #18 was obtained and administered within 2 hours of DON being made aware of problem by surveyor. 100% audit started on 11/30/12 by DON/ADON/Unit Managers of resident medication orders to determine that medications ordered are available. No other resident was identified through audit process. Re-education of all licensed nursing staff was conducted on 12/18/12, 12/19/12 and 12/27/12 by DON related to procedure for ordering medications and procedure to follow if medication has not arrived from pharmacy. Audit will be conducted by DON/ADON/Unit Managers on 25% of resident medications availability five times a week for 1 week, then three times a week for 3 weeks, then weekly for 1 month. 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: 1/13/2013 	1/13/2013	

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F 425	Continued From page 7 Protocol", revised 09/14/12, revealed a problem log should be initiated dally after the morning medication pass for any medications ordered by the Physician, but not available for adminlstration. The logs were then collected by the Unit Manager and pharmacy was to be contacted to resolve any problems listed. Record review revealed the facility admitted Resident #18 on 12/20/11 with diagnoses which included Diabetes Mellitus Type Two, Chronic Pain, Depression, Hypertension, Anxiety, Restless Leg Syndrome, Degenerative Disc Disease, Congestive Heart Failure, and Coronary Artery Disease. Record review of Resident #18's signlificant change Minimum data Set (MDS) Assessment, Section J, dated 06/18/12, revealed Resident #18 reported severe pain occurring frequently. Further review of the MDS, dated 06/18/12, revealed Resident #18 triggered for pain under the Care Area Assessment Summary (CAAS). Review of the most recent quarterly MDS Assessment, dated 08/17/12, revealed the facility assessed using the Brief Interview of Mental Status (BiMs) score for Resident #18 as fifteen (15) out of fifteen (15), thus indicating the resident was cognitively intact. Review of the Physician's Orders, dated 11/01/12, revealed Resident #18 was scheduled to be administered Oxycontin 10 milligrams (mg) twice a day by mouth for pain. Revlw of Resident #18's plan of care titled, "Pain Management", revised 11/20/12, revealed he/she had acute and chronic pain related to	F 425			

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F 425	<p>Continued From page 8</p> <p>Degenerative Disc Disease, Osteoarthritis, and Neuropathy. Goals of the plan of care stated Resident #18 would not have signs and symptoms of unrelieved pain and would not experience a decline in functional status related to pain. Interventions included administering pain medications as ordered, and monitoring the effectiveness of pain medications.</p> <p>Review of Resident #18's Medication Administration Record (MAR) for 11/01/12 through 11/30/12 revealed Resident #18 did not receive the morning or evening dose of Oxycontin 10 mg on 11/25/12. Further review of the MAR revealed Resident #18 did not receive his/her morning dose of Oxycontin 10 mg on 11/29/12. For all missed administrations, the initials of the nurse that was to give the medications were circled indicating Resident #18 did not receive medications as ordered. The reason for missed administration was noted to be unavailability of medication.</p> <p>Review of Resident #18's Controlled Drug Record for Oxycontin 10 mg, revealed the last dose on hand was given on 11/24/12 at 9:00 PM, and was not administered again until 11/26/12 at 8:00 AM after receiving a refill of six (6) Oxycontin 10 mg tablets. Continued review of the Controlled Drug Record for Oxycontin 10 mg revealed the last dose on hand was given on 11/28/12 at 9:00 PM, and was not available to be administered as ordered the morning of 11/29/12.</p> <p>Interview with Resident #18, on 11/29/12 at 5:32PM, revealed he/she was aware of the recent unavailability of his/her Oxycontin pain medication. He/she reported the nurses told him/her that</p>	F 425			

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F 425	Continued From page 9 pharmacy had "messed up" and the medication was not available. He/she also reported his/her pain was worse when he/she did not receive his/her pain medications as ordered. Interview with Licensed Practical Nurse (LPN) #5, on 11/29/12 at 5:45 PM, revealed she was aware Resident #18 did not receive his/her morning dose of Oxycontin on 11/29/12 due to medication being out of stock. She reported she was unsure why the medication was out of stock, but stated this had occurred previously for an entire day on 11/25/12. She stated the usual process was to reorder medications when there was only one (1) week of medication available. She revealed pharmacy visited daily or more often if needed to make deliveries. However, she reported for controlled prescriptions such as Oxycontin, the Physician had to sign the order and this sometimes resulted in a delay. Furthermore, she stated it was the responsibility of the pharmacy to contact the Physician. Lastly, she reported when medications were not in stock, a pharmacy problem list was to be initiated as soon as possible. Interview with LPN #7, on 11/30/12 at 9:00 AM, whom passed medication to Resident #18 on 11/29/12, revealed she was aware Resident #18 had run out of medications on 11/29/12, but did not remember this happening previously. She reported any shift could refill medications and the only time there was a delay, was if the pharmacy needed a Physician's signature. Otherwise, she reported if medications were faxed into pharmacy to be refilled, they were usually received the same day. She revealed she was unsure as to why the medication was not in stock, and	F 425			

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F 425	Continued From page 10 reported she was unsure if this was placed on the pharmacy problem list during her shift. Interview with Unit Coordinator, on 11/30/12 at 10:40 AM, revealed medications were typically filled within twenty-four (24) hours of ordering. She reported the nurses were to inform her via a pharmacy problem list if they were out of medication. Once informed, she could get the medications "stat" delivered so that doses were not missed. She also reported if pharmacy was not sending medication due to needing a Physician's signature, she helped contact the Physician. In addition, she reported she was unaware Resident #18 did not receive medication on 11/25/12 or 11/29/12 as ordered. She stated she should have been informed of this and the pharmacy problem list should have been initiated to prevent the missed administrations. Interview with the Director of Nursing (DON), on 11/30/12 at 10:45 AM, revealed she agreed it appeared Resident #18 had not received his/her Oxycontin 10 mg as ordered on 11/25/12 and 11/29/12. She stated LPN #7 did not identify the unavailability of medication as a problem on the pharmacy problem list, thus the Unit Manager was unaware of the problem; therefore, there were no immediate steps taken to prevent Resident #18 from not receiving his/her medications as ordered.	F 425			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 11</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure all medications were stored in compartments separate from other chemical compounds. Observation of four (4) of six (6) medication carts located throughout the facility</p>	F 431	<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>F431</p> <ol style="list-style-type: none"> 1. All chemicals stored in identified medication carts were placed in plastic barriers to separate sani-wipe/hand sanitizer from medication within 1 hour of identification of problem. 2. All chemicals stored in all medication carts were placed in plastic barriers to separate sani-wipe/hand sanitizer from medication within 1 hour of identification of problem. 3. Re-education of all licensed nursing staff was conducted by DON on the rationale and procedure related to storage of chemicals in medication carts by 12/28/12. Audit will be conducted by DON/ADON/Unit Managers of all medication carts over all shifts for compliance five times a week for 1 week, then three times a week for 3 weeks, then weekly for 1 month. 4. All monitoring findings will be reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. 5. Date of Compliance: 1/13/2013 	1/13/2013	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 431	<p>Continued From page 12</p> <p>revealed Sani-wipes and hand sanitizers were stored in the same drawer and compartment with oral medications.</p> <p>The findings include:</p> <p>Review of facility's policy titled "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles", dated 12/01/07, revealed the following: "the facility should ensure that test reagents, germicides, disinfectants, and other household substances are stored separately from drugs".</p> <p>Observations, on 11/27/12 between 3:30 PM and 4:00 PM, revealed the medications carts located on One East, One South, One West, and Two South halls contained oral medications stored in the same compartment with Sani-Wipes and hand sanitizer.</p> <p>Interview with Registered Nurse (RN) #1, on 11/27/12 at 3:30 PM, revealed she was not sure what the rules were regarding the storage of medications with other chemicals.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 11/27/12 at 3:45 PM, revealed she did not recall any conversation about storage of medication and other chemicals.</p> <p>interview with LPN #6, on 11/27/12 at 3:55 PM, revealed he did not recall any discussion about storing oral medications and other chemicals in separate compartments.</p> <p>Interview with the Unit Manager, on 11/27/12 at 4:00 PM, revealed there was not much room in</p>	F 431			

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F 431	Continued From page 13 the carts. She stated she wasn't sure if storing oral medications and other chemicals in the same compartment would be a problem. She stated she would have to check the policy. Interview with the Director of Nursing (DON), on 11/28/12 at 9:30 AM, revealed she had spoken with the pharmacist about the matter. She stated Sani-wipes and hand sanitizers should be stored separately from medications.	F 431	<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 441 SS=E	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 direct contact will transmit the disease.	F 441	F441 1. Unsampled resident F indwelling catheter bag was removed by LPN#1 on 11/27/12. DON replaced indwelling catheter bag on 11/27/12. Unsampled resident F was assessed with no negative outcomes by DON on 11/27/12. LPN#5 was immediately re-educated on hand washing procedure by DON. LPN#6 was immediately re-educated on glucose monitoring device care specifically cleaning and disinfecting procedure by DON. 2. 100% audit of all residents with indwelling catheters to ensure cleanliness was conducted by Unit Managers on 11/27/12. All identified issues were replaced with new indwelling catheter bag. All licensed staff re-educated on hand washing and glucose monitoring device care by DON prior to reporting for duty on 11/28/12 thru 11/30/12. 3. All licensed and certified nursing staff will be re-educated by DON on infection control with strong focus on preventing infection and the appropriate handling, storage,		

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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 14 (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, interview and review of the facility's policies, it was determined the facility failed to ensure an effective Infections Control Program to help prevent the development and transmission of disease and infection. Observation revealed Licensed Practical Nurse (LPN) #5 failed to wash her hands between each resident during the medication pass. Continued observation revealed LPN #6 did not follow the facility's policy and the manufacturer's guidelines for disinfecting the blood glucose monitoring machine after each use. In addition, a urinary catheter drainage bag was observed hanging over the rail in a resident's bathroom. The drain was noted to be uncapped and open to the air. The findings include: 1. Review of the facility's policy titled "General Dose Preparation and Medication Administration", dated 12/01/07, revealed competent staff should follow facility infection control policies related to handwashing during the preparation and administering of medications.	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> and disinfection of equipment and supplies by 12/28/2012. Observation audits will be completed by DON/ADON/Unit Managers of all shifts for compliance with care and storage of indwelling catheters four times a week for 2 weeks, then two times a week for 2 weeks, then weekly for 30 days. Re-education of all licensed staff on the administration of medication process with a strong focus on infection control aspect by DON by 12/28/12. Observation audits will be completed by DON/ADON/Unit Managers of all shifts for compliance with care and storage of indwelling catheters four times a week for 2 weeks, then two times a week for 2 weeks, then weekly for 30 days. Observation audit will be completed by DON/ADON/Unit Managers on all staff to ensure proper hand washing and glucose monitoring device care and then randomly over all shifts five times a week for 1 week, then three times a week for 2 weeks, then weekly for 1 month. 4. All monitoring findings will be reviewed at monthly QA meeting.		

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F 441	Continued From page 15 Review of the facility's "Infection Control Protocol", dated 10/02/12, revealed facility infection control practices were intended to help prevent and manage the transmission of diseases and infections. Upon request for the policy related to hand washing, the facility provided a copy of the outline for staff training related to infection control. A policy on handwashing was not made available. Review of the training materials revealed the following: "practice good hygiene and use appropriate infection control procedures". Continued review revealed the most important thing staff could do to prevent the spread of infection was to wash their hands. Observation of the medication pass, on 11/27/12 at 5:15 PM, revealed LPN #5 failed to wash her hands between residents. Upon interview, the LPN stated, "I should have washed my hands between each resident". Interview with the Director of Nursing, (DON), on 11/28/12 at 9:30 AM, revealed she had been informed LPN #5 had not washed her hands between residents during the medication pass. The DON stated the nurses should wash their hands between each resident when administering medications. 2. Review of the manufacturer's guidelines for the Assure Platinum Blood Glucose Monitoring System revealed the monitoring device could be cleaned with an alcohol wipe, but should be disinfected with a 1:10 bleach solution. Continued review revealed the manufacturer	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> for compliance and or the need to update plan to reach 100% compliance. 5. Date of Compliance: 1/13/2013	1/13/2013

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F 441	<p>Continued From page 16</p> <p>recommended the device be disinfected between each patient use.</p> <p>Review of the facility's policy titled "Assure Platinum Blood Glucose Monitoring System", undated, revealed the devices were to be cleaned and disinfected after each resident use. Continued review revealed the machine should be wiped down with a "wipe" after each use.</p> <p>Observation, on 11/27/12 at 5:30 PM, revealed LPN #6 cleaned the Assure Platinum Blood Glucose Monitoring System with an alcohol pad after using the device to check a resident's blood sugar level. Upon interview, LPN #6 stated the machine was new and he had received training. He further stated he thought the use of alcohol pad was the proper procedure for cleaning the device.</p> <p>Interview with LPN #15, on 11/27/12 at 5:42 PM, revealed the proper procedure for cleaning the glucose monitoring device was to use Sani-Wipes, a commercial disinfectant wipe. Observation of the Sani-Wipe container revealed it contained a 1:10 bleach solution.</p> <p>Interview with the DON, on 11/28/12 at 9:30 AM, revealed the glucose monitoring devices must be cleaned with Sani-Wipes which were available on every medication cart. She stated every staff member had attended the mandatory inservice when the new machines arrived, and all should know the correct procedure.</p> <p>3. A review of the facility's procedure guidelines, "Lippincott's Textbook for Nursing Assistants", 2000 edition, revealed disconnecting the drainage bag from the tubing could allow harmful bacteria</p>	F 441			

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F 441	<p>Continued From page 17</p> <p>to enter the catheter. The guidelines further stated to be sure that the open tubing did not touch anything.</p> <p>Record review revealed Unsampled Resident #F was admitted by the facility on 04/16/12 with diagnoses which included Left Subcapital Hip Fracture, Coronary Artery Disease, Chronic Heart Failure, Chronic Kidney Disease-Stage 3, Hypertension, and Chronic Heart Failure.</p> <p>Observation on initial tour, on 11/27/12 at 9:30 AM, revealed an Indwelling catheter bag with seventy-five (75) millimeters (ml) of yellow liquid hanging in the resident's bathroom. The bag was draped over the safety grab bar with the tubing not in a holder or covered to prevent bacterial contamination of the tubing.</p> <p>Interview, on 11/27/12 at 9:55 AM, with State Registered Nurse Aide (SRNA) #1, revealed the bedside drainage bag should have been emptied after the leg bag was attached and a plastic bag should have been placed over the drainage bag and the tip of the tubing put in a covered slot.</p> <p>Interview, on 11/27/12 at 9:50 AM, with LPN #1 revealed the bedside drainage bag should not have been hanging on the safety grab bar with 75 ml of urine in it and uncovered. It should have been covered with a plastic bag after emptying.</p> <p>Interview, on 11/30/12 at 12:05 PM, with the Director of Nursing (DON) revealed the process for removal of the bedside drainage bag for placement of the leg bag included the SRNA should clean the tip of the leg bag with alcohol, remove the bedside drainage bag, and place the</p>	F 441			

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F 441	Continued From page 18 cleaned leg bag to the urinary catheter. The bedside drainage bag should then be emptied, the output recorded and the tip of the tubing cleaned with alcohol and placed in a plastic bag. The bedside drainage bag may then be stored in the bathroom or night stand, per each resident's preference.	F 441	<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 492 SS=C	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to comply with all Federal, State, and local laws, regulations, and codes. Information about Human Immunodeficiency Virus (HIV) and Auto Immune Deficiency Syndrome (AIDS) provided by the facility did not meet the statutory requirements of KRS 214.620(4) which states information on the HIV infection shall be presented to any person who receives treatment in a skilled nursing facility. The information shall include, but not be limited to methods of prevention. The findings include: Review of the Checklist for Compliance with KRS 214.620(4) HIV/AIDS Patient Information revealed information provided by each facility	F 492	F492 1. No identified resident listed. Center will edit current "Important Information About HIV and AIDS" form to included methods of prevention. 2. 100% of all residents in house will be educated on prevention methods and signatures obtained on updated form. 3. Education of admissions team on the updates to the "Important Information About HIV and AIDS" form with methods of prevention. Audit will be completed by Administrator on all new admissions for 3 months to ensure updated form is in use. All monitoring findings will be reviewed at monthly QA meeting for compliance and or the need to update plan to reach 100% compliance. 4. Date of Compliance: 1/13/2013	1/13/2013	

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F 492	Continued From page 19 must include methods of prevention. Review of the facility's form "Important Information About HIV and AIDS" revealed no documented evidence the form included methods of prevention. Interview with the Director of Nursing (DON), on 11/28/12 at 9:30 AM, revealed the form needed to be revised to meet statutory requirements.	F 492			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185445	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 11/27/2012
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3876 TURKEYFOOT ROAD ELSMERE, KY 41018		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1998</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two stories, Type II (111) Unprotected</p> <p>SMOKE COMPARTMENTS: Four smoke compartments</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY and Wet SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel Generator</p> <p>A life safety code survey was initiated and concluded on 11-27-2012 for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility 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 the survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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