

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>An Abbreviated Survey investigating ARO#KY00016513 and ARO#KY00016515 was conducted 06/08/11 through 06/10/11. ARO #KY00016515 was substantiated with no deficiencies. ARO #KY00016513 was substantiated with an unrelated deficiency cited at a Scope and Severity of a "D".</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services were provided in accordance with the Comprehensive Plan of Care for one (1) of eight (8) sampled residents (Resident #6). Observation of Resident #6 on 06/08/11 revealed the resident was positioned improperly in the bed and a skin assessment completed on 06/09/11 revealed the resident had two (2) Unidentified Abrasions to the left of the lumbar spine.</p> <p>The findings include: Review of Resident #6's clinical record revealed the facility admitted the resident on 03/16/10 with diagnoses which included Adult Failure to Thrive, Palliative Care, and a Fracture of the Right Femur/Status-Post Hemiarthroplasty 05/30/11. Review of the Quarterly Minimum Data Set</p>	F 282	<p>Bluegrass Care and Rehabilitation does not believe and does not admit that any deficiencies exist before, during and after the survey. Bluegrass Care and Rehab reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Bluegrass Care and Rehab reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potential applicable Peer Review. Quality Assurance or self critical examination privileges, which Bluegrass Care and Rehab offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	

RECEIVED
JUN 29 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nikki Schley, MHA</i>	TITLE Administrator	(X6) DATE 6-29-11
---	------------------------	----------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 1</p> <p>(MDS) Assessment dated 04/27/11 revealed the facility assessed the resident as oriented and requiring limited assistance with transfers and extensive assistance with ambulation.</p> <p>Review of the Comprehensive Plan of Care dated 01/31/11, last revised on 06/04/11 revealed the resident was identified to be at risk for developing pressure ulcers due to immobility and incontinence. The interventions included assisting as needed to reposition, minimize pressure over boney prominences, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, and position with pillows to maintain proper body alignment.</p> <p>Observation of the resident on 06/08/11 at 6:30 PM revealed the resident was in bed lying on her/his back with the head of the bed up thirty (30) degrees and the resident was positioned low in the bed, and needed to be pulled up towards the head of the bed. Observation revealed no pillows to maintain proper body alignment.</p> <p>Observation of Resident #6 on 06/08/11 at 7:45 PM and at 8:45 PM revealed the resident was lying on her/his back and was scooted down in the bed. During the observation at 8:45 PM Resident #6 stated repeatedly, "my tail hurts". The surveyor notified the Unit Manager and two (2) nurses went in to reposition the resident.</p> <p>Observation of a Skin Assessment on 06/09/11 at 12:00 PM completed by the Wound Nurse revealed the resident had two (2) areas described by the Wound Nurse as old abrasions to the left of the lumber spine. Interview with the Wound</p>	F 282	<p>F282 483.20(k) (3) (ii) Services by qualified persons/per care plan</p> <p>Corrective Action for Residents Affected:</p> <p>(1.) The physician/ARNP and POA were notified on 6-09-11 regarding the findings from the skin assessment. Protective dressing treatment ordered and applied. Resident also repositioned often, with use of wedge cushion/pillows, and care plan updated 6-09-11 per interventions.</p> <p>Identification of Residents with potential to be affected:</p> <p>(1). All residents have potential to be affected per the alleged deficient practice. All residents were assessed by wound care nurses, ADONs, MDS Coordinators, Restorative nurse to ensure no other residents found with unnoted skin impairments. No new areas identified and no new positioning issues identified.</p> <p>Measures or systems changes to prevent recurrence:</p> <p>(1.) Weekly skin assessments, conducted by licensed nursing staff and/or wound certified nurse, to be completed on all residents. Weekly skin assessments to be reviewed in AM clinical meeting to ensure new skin issues identified have proper intervention and treatment.</p>	6-28-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 2</p> <p>Nurse at that time revealed she would attempt to find the triangle wedge which was used for positioning in an attempt to keep the resident on her/his side.</p> <p>Interview on 06/09/11 at 12:00 PM with Certified Nursing Assistant (CNA) #1 revealed he was assigned to the resident and was unaware of the resident having any areas on the skin and he turned and repositioned the resident every two (2) hours. However, the resident would often remove the pillow he positioned behind her/his back and turn on to her/his back. He stated the resident used to have a triangle wedge which was used for positioning which was more effective in keeping the resident on her/his side; however, he could not locate it in the room and was using pillows instead. Continued interview revealed the resident was pulled up in the bed with a draw sheet and received incontinence care every two hours.</p> <p>Continued observation of the resident on 06/09/11 at 2:30 PM revealed the Physical Therapist was working with the resident in bed and positioned a triangle wedge behind the resident's back as well as a pillow between the resident's legs and pillows under the resident's arms after bedside therapy. Further observation revealed the resident was observed to have eyes closed and to stay on the left side in the bed.</p> <p>Review of the Physician's Order dated 06/09/11 after the skin assessment revealed orders to apply Optifoam to the lower back for protection only, change every three days and as needed.</p> <p>Continued interview with the Wound Nurse on</p>	F 282	<p>(2.) MDS reviewed current resident care plans to ensure appropriate interventions in place. Care plans updated to reflect any new skin issues identified, to include interventions.</p> <p>(3.) Licensed Nursing staff and direct care staff were in-serviced by the Wound care nurses/SDC on conducting a skin assessment, proper documentation, reporting new skin issues and appropriate interventions, to include following care plans and proper positioning. In-service completed by 6-26-11.</p> <p>(4.) A 10% audit of weekly skin assessments, to include visual assessment and care plan review, will be completed weekly by the wound care nurse, DON and/or ADON's to ensure proper identification and interventions in place.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Findings of the weekly audits will be reviewed by the QA committee meeting monthly for 3 months and then at the discretion of the QA committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2011
---	---	--	--

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3676 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 3 06/10/11 at 5:45 PM revealed she was wound certified and the abrasions on the resident's lower back were scabbed and were probably caused by friction and shearing. Further interview revealed she had brought in extra pillows and positioned the resident properly in an attempt to keep the resident comfortable and on her/his side. She further stated she educated staff on interventions to prevent skin breakdown and she needed to ensure there was an inservice related to positioning.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents were provided the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the Comprehensive Plan of Care for one (1) of eight (8) sampled residents (Resident #6). Observation of a skin assessment for Resident #6 on 06/09/11 revealed the resident had two (2) Unidentified Abrasions measuring 0.3 centimeters x 0.3 centimeters and 0.1 centimeter x 0.1 centimeter to the left of the lumber spine. In addition, the facility failed to ensure the resident	F 309	F309 483.25 Provide Care/Services for Highest Well Being Corrective Action for Residents Affected: (1.) The physician/ARNP and POA were notified on 6-09-11 regarding the findings from the skin assessment. Protective dressing treatment ordered and applied. Resident also repositioned often, with use of wedge cushion/pillows, and care plan updated 6-09-11 per interventions. Identification of Residents with potential to be affected: (1). All residents have potential to be affected per the alleged deficient practice. All residents were assessed by wound care nurses, ADONs, MDS Coordinators, Restorative nurse to ensure no other residents found with unnoted skin impairments. No new areas identified and no new positioning issues identified.	6-28-11

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2011
--	---	--	--

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 309	<p>Continued From page 4 was positioned properly in bed to prevent skin breakdown.</p> <p>The findings include:</p> <p>Review of Resident #6's medical record revealed diagnoses which included Adult Failure to Thrive, Palliative Care, and a Fracture of the Right Femur/Status-Post Hemiarthroplasty 05/30/11. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 04/27/11 revealed the facility assessed the resident as oriented and requiring limited assistance with transfers and extensive assistance with ambulation.</p> <p>Review of the Nursing Admission Skin Evaluation dated 06/03/11 completed by Registered Nurse (RN) #1 revealed the resident had red blanchable areas of the thoracic and lumbar spine.</p> <p>Review of the Comprehensive Plan of Care dated 01/31/11, last revised on 06/04/11 revealed the resident was identified to be at risk for developing pressure ulcers due to immobility and incontinence. The interventions included assisting as needed to reposition, minimize pressure over bony prominences, notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, or discoloration, and position with pillows to maintain proper body alignment.</p> <p>Observation of the resident on 06/08/11 at 6:30 PM revealed the resident was in bed lying on her/his back and had scooted down in bed.</p> <p>Observation of the resident on 06/08/11 at 7:45 PM and at 8:45 PM revealed the resident was</p>	F 309	<p>Measures or systems changes to prevent recurrence:</p> <p>(1.) Weekly skin assessments, conducted by licensed nursing staff and/or wound certified nurse, to be completed on all residents. Weekly skin assessments to be reviewed in AM clinical meeting to ensure new skin issues identified have proper intervention and treatment.</p> <p>(2.) MDS reviewed current resident care plans to ensure appropriate interventions in place. Care plans updated to reflect any new skin issues identified, to include interventions.</p> <p>(3.) Licensed Nursing staff and direct care staff were in-serviced by the Wound care nurses/SOC on conducting a skin assessment, proper documentation, reporting new skin issues and appropriate interventions, to include following care plans and proper positioning. In-service completed by 6-26-11.</p> <p>(4.) A 10% audit of weekly skin assessments, to include visual assessment and care plan review, will be completed weekly by the wound care nurse, DON and/or ADON's to ensure proper identification and interventions in place.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3578 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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)	(X6) COMPLETION DATE
F 309	<p>Continued From page 5</p> <p>lying on her/his back. During the observation at 8:45 PM the resident stated repeatedly, "my tail hurts". The surveyor notified the Unit Manager and two (2) nurses went in to reposition the resident.</p> <p>Observation of a Skin Assessment on 06/09/11 at 12:00 PM performed by the Wound Nurse revealed the resident had areas described by the Wound Nurse as old abrasions which appeared as scabs and measured 0.3 centimeters x 0.3 centimeters and 0.1 centimeter x 0.1 centimeter to the left of the lumbar spine. Interview with the Wound Nurse at the time of the skin assessment revealed the areas were unidentified and she would notify the Physician for treatment orders. She stated she would attempt to find the triangle wedge which was used for positioning in an attempt to keep the resident on her/his side.</p> <p>Interview on 06/09/11 at 12:00 PM with Certified Nursing Assistant (CNA) #1 revealed he was assigned to the resident and was unaware of the resident having any areas on the skin. He stated the resident's Foley Catheter was discontinued yesterday and the resident wore attends. He further stated he turned and repositioned the resident every two (2) hours and the resident would often remove the pillow he positioned behind the resident's back and turn on to her/his back. He stated the resident used to have a triangle wedge which was used for positioning which was more effective in keeping the resident on her/his side; however, he could not find it in the room and was using pillows. He further stated the resident was pulled up in the bed with a draw sheet and received incontinence care every two hours. Continued interview revealed he</p>	F 309	<p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Findings of the weekly audits will be reviewed by the QA committee meeting monthly for 3 months and then at the discretion of the QA committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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 309	<p>Continued From page 6</p> <p>was to notify the nurse if he found skin breakdown while completing care.</p> <p>Further observation of the resident on 06/09/11 at 2:30 PM revealed the Physical Therapist was working with the resident in bed and positioned a triangle wedge behind the resident's back as well as a pillow between the resident's legs and pillows under the resident's arms after bedside therapy. The resident was further observed to have eyes closed and to stay on the left side in the bed.</p> <p>Interview with RN #1 on 06/10/11 at 5:25 PM, revealed she had completed the skin assessment on the resident's re-admission from the hospital after hip surgery. She stated the resident had red blanchable areas to the spine; however, had no scabs or abrasions on the back.</p> <p>Further interview with the Wound Nurse on 06/10/11 at 5:45 PM revealed she was wound certified and the Abrasions on the resident's lower back were scabbed and were probably caused by friction and shearing which could lead to pressure areas if not caught early. Further interview revealed the areas were not pressure sores because they were not located on a bony prominence. Continued interview revealed she had brought in extra pillows and positioned the resident properly in attempt to keep the resident comfortable and on her/his side. She further stated she educated staff on interventions to prevent skin breakdown and the nurses's received a wound competency training in 11/09. She further stated she needed to ensure there was an inservice related to positioning.</p>	F 309		

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

PRINTED: 06/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
--	--

(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)	(X6) COMPLETION DATE
F 309	<p>Continued From page 7</p> <p>Interview on 06/10/11 at 6:15 PM with Licensed Practical Nurse (LPN) #2 revealed she was assigned to the resident on 06/08/11 and 06/09/11 and was unaware of the resident having abrasions to the back.</p> <p>Review of the Nurse's Notes revealed there was no documented evidence the facility was aware of the Abrasions on the resident's lumbar back.</p> <p>Review of the Physician's Orders dated 06/11 revealed there was no treatment orders related to the areas on the resident's lower back prior to 06/09/11. Review of the Physician's Order dated 06/09/11 revealed orders to apply Optifoam to the lower back for protection only, change every three days and as needed.</p>	F 309		