

Acceptable

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

PRINTED: 02/12/2014
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 01/29/2014
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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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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY#00021244 was initiated on 01/28/14 and concluded on 01/29/14. KY#00021244 was unsubstantiated with unrelated deficiencies cited.

F 242 SS=D

483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

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 ensure each resident had the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; and make choices about aspects of his or her life in the facility that were significant to the resident for one (1) of three (3) sampled residents (Resident #1). The facility failed to ensure Resident #1 had the right to choose when his/her personal care would be received on 01/15/14.

The findings include:

Review of the facility's "Bill of Resident Rights" dated 07/01/09, revealed residents had the right to refuse treatment. Review revealed residents had the right to receive care from the facility in a

F 000

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.

F 242

1. Resident #1 was provided with reassurance and extra attention at the time of the incident which has continued. Staff counseled at time of incident to prevent further occurrences.
2. All Residents will be interviewed by Administrative Nursing Staff (DON, ADON, EDT, Unit Managers) and Social Services to determine if any incidents of denying a resident right to choose activities, schedules, or healthcare have occurred. This will be completed by 2/28/14.
3. Re-education conducted by DON/EDT on 3/3/14 and 3/4/14 with completion by 3/7/14 related to resident's self-determination guidelines for all staff. Interviews of residents will be conducted (10% sample) of residents with a BIMs score of 8 and higher by Administrative Nursing Staff starting the week of 3/10/14 daily for one week, then three times a week for 1 week; then once weekly for 30 days. Interview question will include how they are treated.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/23/14
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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 242. Continued From page 1

manner and in an environment that promoted, maintained, or enhanced the resident's dignity and respect in full recognition of the resident's individuality. Continued review revealed residents had the right to choose activities, schedules, and health care consistent with the resident's interests, assessments, and plans of care. Further review revealed residents had the right to make choices about aspects of their life in the facility that were significant to each resident.

Review of the facility's "Care of the Cognitively Impaired", a computer generated educational module provided by the facility to all Certified Nursing Assistants (CNAs), revealed a care provider was not to argue with a Dementia resident. Continued review revealed the care provider was to be patient, understanding, and caring when working with or around residents with Dementia. Further review revealed the care provider was to do something to distract the resident with Dementia who was upset; and to respond to abusive or aggressive behaviors in a soft and gentle way.

Review of the facility's "Individual Completed Education" record for CNA #1 revealed she completed the facility's training module, "Care of the Cognitively Impaired" on 09/22/13. Further review revealed CNA #1 completed the module "Resident Rights" on 01/23/13 and 01/14/14.

Review of the facility's "Individual Completed Education" record for CNA #2 revealed she completed the facility's training module, "Care of the Cognitively Impaired" on 8/12/13. Further review revealed CNA #2 completed the module "Resident Rights" on 08/07/13 and 01/06/14.

F 242. *This Plan of Correction is the center's credible allegation of compliance.*
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- and do they get to make choices.
- 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:

3/15/14

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F 242	Continued From page 2 Record review revealed Resident #1 was admitted by the facility on 11/03/11 and re-admitted on 12/09/13, with diagnoses which included Dementia with Behavior Disturbance, Depressive Disorder, Atypical Psychosis, Anxiety, Mood Disorder and a history of a Stroke. Review of the Re-Entry Minimum Data Set (MDS), dated 12/16/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating Resident #1 was cognitively intact. Review of the facility's "Incident Investigation", dated 01/15/14, revealed Resident #1 was upset related to an article of clothing and became agitated and combative during care. Further review revealed Resident #1's right arm was held to prevent the resident from scratching the CNA. Interview with Resident #1, on 01/29/14 at 10:41 AM, revealed staff came into his/her room to provide care. Resident stated he/she was upset because staff could not find his/her brown sweater. Continued interview revealed Resident #1 told staff to get out of his/her room. Resident #1 stated staff did not leave the room as requested; however continued to dress and assist him/her into the wheel chair. Further interview revealed his/her arm was held down while staff completed the Hoyer lift transfer. In addition, Resident #1 denied staff had "hurt" him/her. Interview with CNA #1, on 01/28/14 at 1:43 PM, revealed on 01/15/14, CNA #1 and CNA #2 were providing care for Resident #1. CNA #1 stated Resident #1 became upset with staff when staff were unable to locate his/her brown sweater. Further interview revealed Resident #1 started screaming at staff; however staff continued to	F 242		
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F 242 Continued From page 3

provide care to the resident while he/she was screaming them. CNA #1 stated Resident #1 was in a Hoyer lift (transfer assistive device) when the resident started swinging his/her arms. According to CNA #1, CNA #2 held Resident #1's arm to the resident's chest to keep him/her from hitting staff or injuring himself/herself on the Hoyer lift. CNA #1 indicated she was not told by the resident to stop. The CNA stated she should not have continued to give care when Resident #1 became upset, as residents do have the right to refuse care or treatment. Further interview revealed she should have given Resident #1 time to calm down by exiting the room and re-attempting care at a later time.

Interview with CNA #2 on 01/29/14 at 3:37 PM, revealed she was assisting CNA #1 to provide care for Resident #1 on 01/15/14. CNA #2 stated Resident #1 became upset when staff were unable to find his/her brown sweater. The CNA stated Resident #1 told staff he/she did not want to get up out of bed at that time. Continued interview revealed CNA #1 and CNA #2 proceeded in getting Resident #1 up after being told he/she didn't want to get up. CNA #2 stated Resident #1 became combative while in the Hoyer lift and began swinging his/her arms. According to CNA #2, she held Resident #1's hand/arm against his/her chest in an attempt to keep the resident and staff safe until he/she could be released from the Hoyer lift. Further interview revealed the CNAs should have stopped the care when Resident #1 told them he/she did not want to get up.

Interview with the Director of Nursing on 01/28/14 at 5:30 PM, revealed the investigation of the incident revealed the CNA#1's and CNA #2's

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F 242	Continued From page 4 used poor judgement. The DON stated CNA #1 and CNA #2 were task oriented and focused on their task and not on Resident #1 as they should have been. Continued interview on 01/29/14 at 3:01 PM, with the DON revealed the facility did not have a policy related to care provided to the cognitively impaired resident; however the CNA's were given education regarding care of the cognitively impaired resident. The DON stated all CNA's were provided education on Resident Rights. She stated her expectation were for staff to observe resident's rights. Additionally, she stated her expectations were if a resident become agitated, combative or said no, she expected her staff to make sure the resident was safe, walk away and notify the nurse.	F 242	<i>This Plan of Correction is the center's credible allegation of compliance.</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.	
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 review of the facility's guidelines, it was determined the facility failed to ensure services were provided by the facility by qualified persons in accordance with each resident's written plan of care for one (1) of three (3) sampled residents (Resident #1). The facility failed to ensure Resident #1's care plan related to refusal of care was followed on 01/15/14 when Certified Nursing Assistants (CNA) were providing care.	F 282	F282 1. Resident #1 care plan reviewed with caretakers at time of incident. 2. Care plans for all residents will be audited for accuracy, implementation, and thoroughness by Administrative Nursing Staff (DON, ADON, EDT, Unit Managers) for accuracy completed by 2/28/14. Audit includes observational rounds. 3. Re-education related to the use of care plans will take place on 3/3/14 and 3/4/14 by DON/EDT with completion by 3/7/14. Rounds using the developed QA Audit Tool and the Care Plans to indicate compliance will be conducted daily starting the week of 3/10/14 for one week, then three times a week for one week, then once a week for two weeks. These rounds will be conducted by the Administrative Nursing Staff to ensure adherence to the resident's individual care plans. 4. All monitoring findings will be reviewed at monthly QA meeting for compliance and or the need to	

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F 282	Continued From page 5 The findings include: Interview with the Director of Nursing, on 01/29/14 at 3:01 PM, revealed the facility did not have a policy related to implementation of the care plan. Further interview revealed the facility utilized guidelines set by Lippincott the Ninth Edition. Review of Lippincott, Ninth Edition, revealed the nursing process was a deliberate, problem-solving approach to meet the health care and nursing needs of patients (residents). Continued review revealed implementation of the care plan was actualization of the care plan through nursing interventions or supervision of others to do the same. Further review revealed implementation of the care plan involved the following: coordinating activities of patients (residents), family, significant others, nursing team members, and other health team members; delegating specific nursing interventions to other members of the nursing team as appropriate; and recording the patient's (resident's) responses to the nursing interventions precisely and concisely. Review of the facility's "Bill of Resident Rights" dated 07/01/09, revealed residents had the right to refuse treatment. Continued review revealed residents had the right to receive care from the facility in a manner and in an environment that promoted, maintained, or enhanced residents' dignity and respect in full recognition of residents' individuality. Further review revealed residents had the right to choose activities, schedules, and health care consistent with residents' interests, assessments, and plans of care. Additionally, review revealed residents had the right to make choices about aspects of the resident's life in the	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</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. update plan to reach 100% compliance. 5. Date of Compliance:	3/15/14	

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F 282	Continued From page 6 facility that were significant to a resident. Record review revealed the facility admitted Resident #1 on 11/03/11 and re-admitted the resident on 12/09/13, with diagnoses which included Dementia with Behavior Disturbance, Depressive Disorder, Atypical Psychosis, Anxiety, Mood Disorder and a history of a Stroke. Review of the Re-Entry Minimum Data Set (MDS), dated 12/16/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) of fifteen (15), indicating Resident #1 was cognitively intact. Review of Resident #1's Comprehensive Care Plan related to potential for alteration in psychosocial wellbeing related to the diagnosis of Anxiety, with dated 10/01/13, revealed staff were to honor Resident #1's right to refuse. Review of the Comprehensive Care Plan related to history of refusing care, dated 10/01/13, revealed Resident #1 had a known history of agitation. Interventions included staff encouraging Resident #1 to perform independent Activities of Daily Living (ADL's); and encourage decisions concerning timing of care, clothes to wear and what activities to attend. Further review revealed staff were to stop providing care when Resident #1 became upset and to attempt care again when Resident #1 was calm. Review of the facility's "Incident Investigation", dated 01/15/14, revealed Resident #1 was upset related to an article of clothing and became agitated and combative during care. Further review revealed Resident #1's right arm was held to his/her chest by a CNA to prevent the resident from scratching the CNA.	F 282			

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F 282	<p>Continued From page 7</p> <p>Interview with Resident #1 on 01/29/14 at 10:41 AM, revealed staff came into his/her room to provide care; he/she became upset because staff could not locate his/her brown sweater and told staff to get leave the room. Resident #1 stated staff did not leave room, continued to assist him/her in dressing and into his/her wheel chair. According to Resident #1 staff held his/her arm down while transferring him/her with the Hoyer lift. Resident #1 indicated he/she was not injured however during the transfer.</p> <p>Interview with CNA #1 on 01/28/14 at 1:43 PM, revealed she and CNA #2 were caring for Resident #1 on 01/15/14 when the resident became upset because they could not find his/her brown sweater. CNA #1 stated the resident started screaming at her and CNA #2; however they continued to provide care and were transferring Resident #1 with the Hoyer lift (device used to assist with transfers) when he/she began to swing his/her arms. According to CNA #1, CNA #2 held Resident #1's arms to his/her chest to keep the resident from hitting staff or hurting himself/herself on the lift. She stated Resident #1 had not told them to stop; but they should have stopped when he/she became upset. CNA #1 stated residents had rights and this included the right to refuse care or treatment. Continued interview revealed CNA #1 was not sure if Resident #1 was care planned for refusing care. However, she indicated she should have allowed time for Resident #1 to calm down and re-attempted care at a later time.</p> <p>Interview with CNA #2 on 01/29/14 at 3:37 PM, revealed she and CNA #1 were providing care for Resident #1 on 01/15/14 when he/she became upset because they could not find his/her brown</p>	F 282		

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F 282	Continued From page 8 sweater. CNA #2 stated Resident #1 had told them she did not want to get up out of bed; however they continued to get the resident up anyway. She stated Resident #1 became increasingly agitated and combative during the Hoyer lift transfer, and started swinging his/her arms. CNA #2 stated she held Resident #1's hand/arm against his/her chest in an attempt to keep the resident and staff safe until completion of the transfer. The CNA stated staff should not have continued providing care after Resident #1 told them he/she did not want to get up. She stated she did not know if Resident #1 was care planned for refusing care; however indicated she knew they should have stopped when the resident became upset. Interview with the Director of Nursing (DON) on 01/28/14 at 5:30 PM, revealed during the investigation of this it was determined the CNA's involved used poor judgement. She stated CNA #1 and CNA #2 were focused on performing their task; however should have been focused on Resident #1. An additional interview on 01/29/14 at 3:01 PM with the DON, revealed the facility did not have a policy related to implementing the interventions on the Comprehensive Care Plan; stating it was common knowledge. The DON stated the facility had an educational process to teach all aspects of the care plan. She stated her expectations were staff would implement and follow residents' care plans. The DON indicated the care plan guided the care of residents as it is based on each resident's individual needs.	F 282			