

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

PRINTED: 02/04/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185392	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/03/2016
NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101	
(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)
{F 000}	INITIAL COMMENTS An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 12/31/15 as alleged.	{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.

*Angelika
2/11/16
OK*

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165392	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2015
NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101		
(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 Recertification Survey was initiated on 12/08/15 and concluded on 12/10/15, with deficiencies cited at the highest Scope and Severity of an "D".	F 000	Woodland Oaks does not believe and does not admit that any deficiencies existed, either before, during or after the survey. Woodland Oaks reserves the right to contest this survey findings through informal dispute resolution, formal legislative appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position. Woodland Oaks reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver or any potentially applicable peer review, quality assurance or self-critical examination privileges which Woodland Oaks does not waive, and reserves the right to assert any administrative, civil or criminal claim, action or proceeding. Woodland Oaks offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to our residents.		
F 441 SS=D	483.66 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. (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.	F 441	1) Resident # 14 and Unsampled Resident A did not have any adverse effects from the alleged improper perineal care i.e. no reports of fever, abdominal pain or any of signs or symptoms of a urinary tract infection. 2) All RN's, LPN's and SRNA's, including SRNA # 2 and SRNA #3, were in-serviced on proper		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Amber B. Naeve

Administrator

1/21/16

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NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101	
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F 441	Continued From page 1 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of twenty-two (22) sampled residents (Resident #14) and one (1) unsampled resident (Unsampled Resident #A).	F 441	perineal care techniques and proper hand washing on December 16, 2015 by the Director of CQI. An assessment of each resident was completed on December 17, 2015 by staff RN's/LPN's for any signs or symptom of infection as evidenced by abdominal pain and fever. 3) SRNA's will be educated during orientation regarding proper perineal care and proper handwashing techniques by the Director of CQI. All nursing staff will be inserviced annually and upon hire on perineal care and hand washing techniques by the Director of CQI. 4) The CQI Director will conduct a direct observation audit of at least 10% of resident population on a monthly basis for proper pericare and handwashing techniques for a period of 6 months. If any concerns are identified the Director of CQI will perform	
	Observation revealed staff failed to use appropriate hand hygiene during and after performing perineal/incontinence care. The findings include: 1. Review of Resident #14's medical record revealed the facility admitted the resident on 10/16/14 with diagnoses which included Dementia and Urinary Retention. Review of Resident #14's Minimum Data Set (MDS) Assessment dated 10/22/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) indicating severe cognitive impairment.		immediate education with the staff involved in the observed audit. This will be included in the monthly Quality Assurance review. The monthly Quality Assurance meeting is attended by nursing, infection control, housekeeping, activities, and administration, as well as the facility Medical Director. 5) December 18, 2015	12/18/15

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NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101		
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F 441	Continued From page 2 Observation of Resident #14's perineal care, on 12/10/15 at 1:50 PM, revealed State Registered Nursing Assistant (SRNA) #2 provided perineal care, removed the soiled gloves, and failed to wash her hands prior to donning new gloves. After donning new gloves, SRNA #2 assisted the resident to roll to his/her side and cleansed the resident's buttocks and anal area. Further observation revealed SRNA #2 failed to remove the soiled gloves or wash her hands after cleaning the resident's buttocks and anal area and prior to touching the resident's bed linens. 2. Observation of perineal care for Unsampled Resident A on 12/10/15 at 2:20 PM, revealed after performing perineal care, SRNA #3 failed to remove her soiled gloves before touching the resident's bed linens. Further observation revealed after pulling up the resident's bed linens with the soiled gloves, SRNA #3 removed her soiled gloves, but failed to wash her hands prior to touching the resident's bed controls and call light. Interview with SRNA #3, on 12/10/15 at 4:30 PM, revealed she had been educated on the correct procedure for perineal care and handwashing at the facility. Further interview, revealed she should have washed her hands prior to touching environmental surfaces such as the resident's bed linens, bed controls and call light after providing perineal/incontinence care. Interview, with CQI (Continuous Quality Improvement) /Infection Control Registered Nurse on 12/10/15 at 3:10 PM, revealed staff was educated on the correct procedures for hand washing and perineal care. Further interview revealed staff should wash their hands anytime	F 441			

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NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101
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F 441	Continued From page 3 gloves were removed and before touching environmental surfaces. Interview, on 12/10/15 at 3:30 PM, with the Director of Nursing (DON), revealed staff was trained on the correct procedures for hand washing and perineal care upon hire, annually and when there was identified issues in the facility. Continued interview, revealed staff was to wash their hands anytime gloves were removed and before reapplying gloves, when going from dirty to clean, when finished with care, and before leaving a resident's room.	F 441		
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NAME OF PROVIDER OR SUPPLIER WOODLAND OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 1820 OAKVIEW ROAD ASHLAND, KY 41101
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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: 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 1992. Fuel source is Natural Gas.</p> <p>A Life Safety Code Survey was conducted on 12/08/2015. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kimberly B. Noel* TITLE *Administrator* (X8) DATE *1/5/16*

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