

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

PRINTED: 05/29/2015
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 05/14/2015
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NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3878 TURKEYFOOT ROAD ELSMERE, KY 41018
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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
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#00023177 was initiated on 05/11/15 and concluded on 05/14/15. KY#00023177 was substantiated with deficiencies cited with the highest Scope/Severity (S/S) cited at an "E".	F 000	Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. 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 prompts efforts by the facility to resolve grievances for three (3) of (4) sampled residents and five (5) unsampled residents. Residents #2, #3, #4, and Unsampled Residents A, B, C, D and E expressed concerns with staff not answering their call lights which caused them to hold their urine for long periods of time or wet themselves while waiting on staff for assistance. The findings include: Review of the facility's policy, titled "Grievances and Complaints", dated 10/02/12, revealed the facility would help residents, their representatives, other interested family members or resident advocates file grievances and/or complaints when such requests were made. Further review of the policy revealed it was their protocol to respond to Grievances and/or complaints which may be	F 166	1. Residents 2, 3, 4 and A, B, C, D, E were contacted by Social Services regarding grievances that had not been resolved per their statements. Each grievance was addressed and resolved to each Residents satisfaction with validation by interview. Daily Monday through Friday follow up interviews starting on 5/15/2015 through 6/12/15. Although there were during this time expressed issues none of the residents interviewed expressed the same issue on the following day. When residents were not in their room for Social Service interview, the Social Worker pulled the call light and noted no delay in the answering of the call light by a staff member. 2. All Residents have the potential to be affected by this alleged deficient practice. 3. Review of the protocols for Grievances and for the handling of Resident Council Minutes were reviewed by the IDT. The determination was made that Grievances and issues raised in Resident Council Meetings should not be handled in the same manner as previously. The protocol for the handling of the Resident Council issues was revised to reflect that each	6/18/2015

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6/17/2015
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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 166	<p>Continued From page 1</p> <p>submitted orally or in writing. Written grievances or complaints were to be signed by the resident or the person filing the grievance or complaint on behalf of the Resident. The Administrator would delegate the responsibility of the grievance and/or complaint investigation to the Director of Social Services (DSS). Further review of the policy revealed that upon receipt, the grievance or complaint would be investigated and reported to the Administrator immediately. A written report of the findings would be submitted to the Administrator within three (3) days of receiving the grievance and/or complaint. The Administrator would review the findings and determine if further actions needed to be taken. Continued review revealed the resident, or the person filing the grievance and/or complaint on behalf of the resident, would be informed of the findings and any action would be taken to correct the identified issues. The grievance and/or complaint would be entered on the grievance log and filed appropriately in the Social Service Office and a review of grievances and/or complaints would be presented to the daily Individualized Treatment (IDT) team meeting and the monthly Quality Assurance (QA) meeting my the DSS.</p> <p>1. Review of Resident #2's "Resident Concern Report", which was the facility's grievance form, dated 05/08/15, revealed the resident expressed he/she had to wait a long time for staff to answer the call light. Continued review of the grievance form revealed the resident was asked on 05/06/15, 05/07/15, and 05/08/15 by the Social Service Director if he/she continued to have any concerns and the resident expressed he/she did not.</p> <p>Interview with Resident #2, on 05/12/15 at 5:20</p>	F 166	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>department head would be responsible for addressing any issues related to their departments, in writing, raised in the meeting within three (3) working days and submitted to the Administrator for review and approval of the resolution(s).</p> <p>The Director of Nursing educated Facility Staff on 6/12/2015 on the grievance process.</p> <p>4. Each Department Head will monitor compliance of the resolution to each grievance one time weekly for four weeks. The results will be presented to the IDT at the monthly QA meeting for review and determination if additional follow-up is required.</p> <p>The Social Service Director and/or the Administrator will conduct 5 random interviews of any resident not attending Resident Council Meeting and will contact the Responsible Party of 5 residents unable to communicate, both on a monthly basis to inquire about any grievances.</p>

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PM and on 05/14/15 at 10:15 AM , revealed his/her call light had been on for over an hour. The resident reported he/she knew it was over an hour because there was a clock in his/her room and could often refer to it. Resident #2 reported he/she had problems with his/her kidneys and could not "hold water". The resident reported this was a concern that continued and stated he/she had to wait for long periods of time everyday. Resident #2 reported staff would respond to the call light at times, but when they did come, they would tell him/her that they would come back to assist him/her and they would not return for an hour. The resident reported he/she had voided while waiting on staff to assist him/her with toileting and it made him/her feel terrible. An additional interview revealed she was a two (2) person assist and often had to wait for staff to assist him/her with toileting.

2. Review of Resident #3's "Resident Concern Report", dated 03/06/15, revealed the resident reported he/she pulled the call light at 8:30 PM and the nurse aide didn't come to answer it until 11:30 PM. Resident #3 further reported he/she was not changed the whole night. The response to Resident's #3 grievance form was addressed by the SSD in which she told the resident she, "informed the Director of Nursing (DON) and explained sometimes it took some time when they (staff) were passing trays or a new shift was coming on".

Interview with Resident #3, on 05/12/15 at 5:30 PM and 05/14/15 at 11:01 AM, revealed that when staff made his/her bed, the call light was behind the bed and the resident reported he/she could not reach it. The resident reported he/she could not go to the bathroom on his/her own and

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F 166	Continued From page 3 needed the assistance of staff. An additional interview with Resident #3 revealed he/she had waited for staff to assist him/her with his/her call light. Resident #3 reported it took staff about an hour or two (2) hours to respond to his/her call light. The resident stated he/she told staff to change him/her when they responded to the call light and it would take staff awhile to respond. Resident #3 reported this was still a concern. 3. Interview with Resident #4, on 05/13/15 at 11:45 AM, revealed he/she had urinated on him/herself while waiting on staff to respond to his/her call light. Resident #4 was not certain how long he/she had to wait for staff to respond to the call light, but noted it took awhile for staff to respond, often being told they were short staffed. 4. Interview with Unsampled Resident A, on 05/14/15 at 9:52 AM, revealed that when he/she pressed the call light, he/she would have to go to the bathroom. Unsampled Resident A reported he/she has had to wait over ten (10) minutes for staff to respond to his/ her call light. The resident reported he/she had reported this concern to staff, but nothing came from it. Additionally, Unsampled Resident A stated, "I have to go so bad that when I do go, I can't". 5. Interview with Unsampled Resident B, on 05/14/15 at 11:25 AM, revealed the call bells not being answered was worse on the weekends. The resident reported he/she had asked for a bedpan and had to wait for over a half an hour for someone to assist him/her. Unsampled Resident B stated, "when I have to go, I have to go, I don't want to wait". Unsampled Resident B reported this made him feel terrible, adding he/she spent more time holding his/her urine than going to the	F 166			

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F 166	<p>Continued From page 4 bathroom.</p> <p>6. Interview with Unsampld Resident C, on 05/14/15 at 11:19 AM, revealed he/she had voiced concerns about staff not answering his/her call light to the facility. Unsampld Resident C reported this would occur mostly during first (1st) shift. The resident reported he/she has had to wait for over thirty (30) minutes or so. The resident reported he/she needed assistance with going to the bathroom. Unsampld Resident C reported he/she had urinated in his/her bed while waiting for staff to answer his/her call light. Additionally, Unsampld Resident C reported it made him/her mad when he had to wait for staff.</p> <p>7. Interview with Unsampld Resident D, on 05/14/15 at 4:00 PM, revealed he/she had waited "too long" for staff to respond to the call light. The resident reported he/she had stated to staff he/she would take him/herself to the bathroom because, "when you got to go, you got to go". Unsampld Resident D reported he/she had urinated on him/herself waiting for staff to respond to his/her call light. Unsampld Resident D reported this made him/her feel "helpless".</p> <p>8. Interview with Unsampld Resident E, on 05/14/15 at 10:06 AM, revealed the resident was lying in bed with his/her call light at the foot of the bed, under his/her sheet covers. Resident reported staff very seldom checked on him/her. The resident reported he/she would pull his/her call light, but could not reach it.</p> <p>Interview with Housekeeper #1, on 05/13/15 at 9:51 AM, revealed she had heard residents complain about the time it took staff to respond to their call lights. Further interview with</p>	F 166		
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F 166	<p>Continued From page 5</p> <p>Housekeeper #1 revealed she did not know the residents by name, but knew it was the residents from the South Unit, since that was the unit she often worked. The South Unit included rooms from 120-132, which was where Residents #2 and #3 resided.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 05/13/15 at 2:43 PM, revealed it took a long time to respond to call lights, when they were short of staff. She reported she had been short of staff lately and stated Resident # 4 and Unsampld Resident A have often complained to her on how long it took for staff to respond to their call lights. She reported the residents did not tell her how long they had waited, but would often tell her they were waiting to go to the bathroom. She reported these residents needed assistance from staff to assist them with toileting. Continued interview with CNA #2 revealed Resident #4 soiled him/herself while waiting on staff to answer his/her call light. She reported this happened about three (3) days ago. She reported she reported the residents complaint to her supervisor, but was not certain what happened after she reported it.</p> <p>Interview with CNA #6, on 05/14/15 at 10:20 AM, revealed residents had complained to him about staff taking a long time to answer their lights. He reported most of the residents on his wing were two (2) assist and there was not enough staff to meet the needs of those residents, especially when they needed assistance to go to the bathroom because he had to find staff to assist with taking the residents. Continued interview with CNA #6 revealed that some staff were good at getting the call lights when they went off; however, others would let the call light ring. CNA</p>	F 166	

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#6 reported he went to lunch one day to come back and find that all of his call lights, for his assigned resident's, were going off. He reported he did not know how long the lights were going off, adding "the other assigned aides were no were to be found". CNA #6 reported it took teamwork to care for the residents, but some staff would only care for their assigned residents and would tell other staff members they were not responsible for the residents that were not assigned to them. CNA #6 reported he did not have names of residents specifically who complained, but added it was mostly all of the South Unit.

Interview with CNA #7, on 05/14/15 at 10:34 AM, revealed some residents have made complaints to her about staff taking a long time to respond to their call lights, however, she did not know the residents by name. Continued interview with CNA #7 revealed that it was important to assist the residents when they needed it because they could hurt themselves.

Interview with Registered Nurse (RN) #2, on 05/13/15 at 6:40 PM, revealed some residents had complained to her about how long they had to wait for someone to respond to their call light. She reported staff should respond to the resident's call light in a "timely manner". She stated Resident #3, and Unsampld Residents B and D, had reported the call light concern to her. She stated Unsampld Resident D even stated, "I was going to get up and go by myself". Continued interview with RN #2 revealed Resident #2 complained a lot about needing assistance with going to the bathroom and stated the resident was often soiled when they responded to him/her. She stated Resident #2

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F 166	<p>Continued From page 7</p> <p>could not hold his/her bladder very well, adding "his/her bladder wasn't very good and he/she can't hold it". Further interview with RN #2 revealed Unsampld Resident C reported to her that he/she pressed his/her call light to be assisted to the bedpan. RN #2 reported CNA #9 responded to the light, stated she would come back to assist the resident, but never returned, adding the CNA went on break. She stated that when she talked to CNA #9 about the situation she told her, "she forgot". RN #2 stated she ended up assisting Unsampld Resident C with toileting. RN #2 stated Unsampld Resident C was upset. RN #9 stated she told CNA #9 to care for the residents before she went on break and stated she had not told her supervisor about the situation, but would. Additionally, she reported that when the residents had a complaint/grievance, she told her supervisor.</p> <p>Interview with CNA #9, on 05/14/15 at 12:56 AM, revealed she had some complaints from the residents, during the change of shift, at 6:45 AM and she would not be able to assist the residents until 7:05 AM. Continued interview with CNA #9 revealed Unsampld Resident B had made a complaint about his/her call light, adding "he/she complains about everything". Further interview with CNA #9 revealed she recalled the incident with Unsampld Resident C. CNA #9 reported she told Unsampld Resident C she would assist him/her with his/her bedpan. CNA #9 stated she was going to assist the resident, but forgot about the resident's request and went to lunch. CNA #9 stated she was working by herself that day and a lot of the residents were two (2) person assist. She reported she did not initially leave the resident, just forgot about the resident's request.</p>	F 166		

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F 166	<p>Continued From page 8</p> <p>Interview with RN #3, on 05/13/15 at 7:22 PM, revealed there was not enough staff available to answer the resident's call lights timely. She reported she would sometimes have to leave her cart, from administering medications to the residents, to answer call lights. RN #3 reported Unsamped Resident B had complained to her that it took staff a long time to respond to his/her call light. She reported Unsamped Resident B had stated multiple times, "Oh my gosh, it takes you so long". RN #3 reported Unsamped Resident E often "screamed" out for assistance. Further interview with RN #3 revealed it was difficult to meet the needs of the residents when they required Hoyer lift and two (2) person assist with transfers due to limited staff.</p> <p>Interview with the Activity Director, on 05/14/15 at 11:49 AM, revealed the residents' grievances/complaints should have been addressed because it was the residents' right to have their concern and situation addressed. She stated, she informed the Director of Nursing (DON) about the residents' concerns, but did not know what the DON did to follow up on the residents' concerns. Continued interview with the Activity Director revealed she did not recall the concern of the residents being addressed in resident council.</p> <p>Interview with the Social Service Director (SSD), on 05/14/15 at 3:03 PM, revealed the process of reporting a grievance would be to fill out the "Resident Concern Report" which would then go to her or the DON. Further interview with the SSD revealed she was aware of Resident #2's and #3's, concerns, but was not aware of the other residents concerns regarding their call lights, but should have been. She reported she</p>	F 166		

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would inform the Administrator and the DON of any follow-ups with the resident that she may have had. Continued interview with the SSD revealed she did not know how the DON addressed the concern for the call lights. The SSD revealed she was not aware of Resident #3's initial complaint because the form was given to her late. She reported the follow up she had given the resident did not address the resident's concern. Continued interview with the SSD revealed the resident's concerns were not brought before the Interdisciplinary Team (IDT) nor was there a Quality Assurance (QA) meeting to develop a solution for the call lights, but should have been.

Interview with the Director of Nursing (DON), on 05/14/15 at 4:40 PM, revealed she was aware of Resident #2's and Resident #3's concerns, but should have been notified about the other residents' concerns regarding their call lights. Continued interview with the DON revealed that by alerting her of the residents' concerns, that would be how they communicated to the staff that they needed help. She stated it was important that the residents' call lights were answered quickly. The DON reported it would be her expectation to accommodate the needs of the residents by answering the residents call lights and by acknowledging that they need assistance.

Interview with the Administrator, on 05/14/15 at 5:45 PM, revealed it was the responsibility of all staff to answer the residents' grievances were addressed. He stated there were some things the residents requested that any staff member could assist with. Continued interview with the Administrator revealed it was his expectation that the policy would be followed.

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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 05/14/2015
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 282 SS=D	<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 Unsamped Resident E's care plan was followed. Unsamped Resident E's call light was observed at the foot of the resident's bed and the care plan documented his/her call light would be within reach.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) revealed the facility did not have a written policy regarding care plans. Per the DON, the facility utilized the Resident Assessment Instrument (RAI) process for residents' Comprehensive Care Plans.</p> <p>Review of the RAI User Manual Version 3.0, May 2011, revealed the Interdisciplinary Team (IDT) was to develop the Comprehensive Care Plan based on the results of the comprehensive assessment. Review revealed the IDT and resident and/or resident's representative determined the areas requiring care plan interventions for development, revision or continuance of the individualized care plan. Further review revealed the care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent</p>	F 282	<p>Disclaimer: Preparation and/or execution of the 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 the provisions of federal and state law require it. The provider maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit the facilities capability to render adequate care.</p> <p>F282</p> <p>1. Resident E's call light cord was placed within her reach.</p> <p>2. All Residents have the potential to be affected by this alleged deficient practice.</p> <p>3. All nursing staff (licensed and State Tested) were re-educated by the Director of Nursing starting 5/14/15 through 5/23/15 to the facility protocol of placement of call lights for Resident use and the necessity of appropriate placement for each Resident as indicated on the Resident Care Plan.</p> <p>4. The Director of Nursing, Unit Managers, Shift Supervisors and/or the Staff Development Coordinator began rounds on 5/15/2015 checking each resident to assure their call light is within reach and/or available for their use each shift twice per week for one week, once on each shift every 2 weeks for one month and spot checks thereafter. The Administrator will present results to the IDT and at the monthly QA meeting for review and determination if additional follow up is required.</p>	6/18/2015	

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F 282	<p>Continued From page 11 with each resident's written plan of care.</p> <p>Review of Unsampled Resident E's record revealed the resident was admitted by the facility on 04/24/15 with diagnoses which included a Fracture to Upper End Tibia, Depressive Disorder, and Macular Degeneration. Review of the resident's Admissions Minimum Data Sheet (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) score of six (6), which was indicative of severe cognitive impairment. Review of Unsampled Resident E's care plan, dated 05/07/15, revealed the resident was care planned for potential for falls. Continued review of the care plan revealed the resident's call light would be within reach and answered promptly.</p> <p>Observation and interview with Unsampled Resident E, on 05/14/15 at 10:06 AM, revealed the resident was lying in bed with his/her call light at the foot of the bed, under his/her sheet covers. Unsampled Resident E reported staff very seldom checked on him/her. The resident reported he/she would pull his/her call light, but could not reach it.</p> <p>Observation and interview with Certified Nursing Assistant (CNA) #5, on 05/14/15 at 10:09 AM and at 1:32 PM, revealed CNA #5 walked into Unsampled Resident E's room and pulled his/her call light from under the sheet near his/her feet. Continued interview with CNA #5 revealed the resident's call light should have been in reach for the resident. She reported it was important to have the resident's call light in reach so that staff could get to the resident if there were any emergencies.</p> <p>Interview with CNA #9, on 05/14/15 at 12:56 PM,</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>revealed Unsamped Resident E should have had his/her call light in reach. Continued interview with CNA #9 revealed it was important to follow the resident's care plans because Unsamped Resident E could need help and had no way of calling for it.</p> <p>Interview with Registered Nurse (RN) #4, on 05/14/15 at 1:31 PM, revealed Unsamped Resident E's call light should have been in reach and his/her care plan should have been followed.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 05/14/15 at 2:30 PM, revealed she completed the full assessments and care plans for the residents. She reported she would update the care plans on a daily basis and as needed. Continued interview with the MDS Coordinator revealed it would be her expectation that the care plans would be followed.</p> <p>Interview with the Director of Nursing (DON), on 05/14/15 at 4:40 PM, revealed it would be her expectation that Unsamped Resident E's call light would be were he/she could reach it. She reported the resident's care plan should have been followed adding the care plan directs the care of the residents after an assessments and it informs the staff of how to care for the resident.</p> <p>Interview with the Administrator on 05/14/15 at 5:45 PM, revealed it would be his expectation that Unsamped Resident E's care planned would have been followed.</p>	F 282		
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