

MAY 31 2011

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

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES
PRINTED: 05/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HARDINSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143	
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F 000	INITIAL COMMENTS	F 000	Disclaimer: This plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Medco Center of Hardinsburg does not admit that the deficiencies listed on the HCFA 2567 exist, nor does Medco Center of Hardinsburg, admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts, and conclusions that form the basis for the deficiency.	
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, review of the facility's policy and procedure, employee training, in-servicing, and interview, it was determined the facility failed to enhance a resident's dignity for one (1) sampled (Resident #6) and two (2) unsampled residents of sixteen (16) sampled residents. During meal service four (4) staff members were observed standing up while feeding residents, and a staff member referred to an unsampled resident as a "feeder". The findings include: Review of the facility policy for feeding a resident revealed the facility utilizes the reference resource of Lippincott Standards of Practice regarding feeding of a dependent person. The Lippincontt Standards of Practlce states the caregiver should be at the residents level before assistance is provided.	F 241	F241 It is the policy of Medco Center of Hardinsburg to promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality. 1. An observation of the Restorative Dining Room was completed on May 8, 2011, by the Nursing Home Administrator, with no concerns identified concerning the feeding of dependent residents, the appropriate positioning of staff while feeding dependent residents, and/or the preservation of resident rights and dignity during meals. 2. An observation of the Restorative Dining Room was completed on May 8, 2011, by the Nursing Home Administrator, with no concerns identified concerning the feeding of dependent residents, the appropriate	

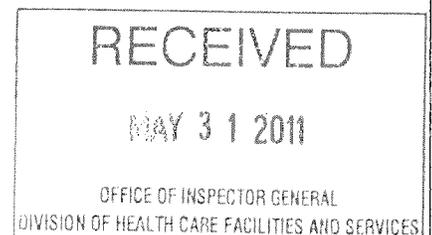
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mary Nell Bouvier* TITLE *Administrator* (X8) DATE *5/26/11*

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.

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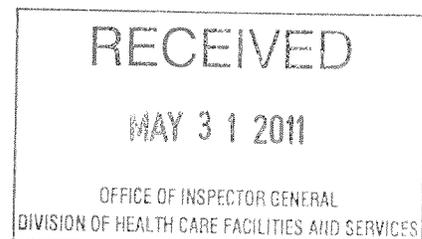
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F 241	Continued From page 1 Review of the facility's employee training and in-service records for dining and feeding did not include the appropriate positioning of the staff while feeding dependent residents. Observation on 05/03/11 at 11:35am of the Restorative Dining area revealed Registered Nurse (RN) #2 and a Licensed Practical Nurse (LPN), who was in orientation with RN #2, were standing while feeding Resident #6 his/her meal. Both staff members remained standing throughout the entire meal service. Observation on 05/04/11 at 7:30am of the Restorative Dining area revealed Certified Nursing Assistant (CNA) #2 standing while feeding an unsampled resident. Further observation revealed, the Activities Director standing in the middle of the restorative dining area calling out to a CNA across the room to ask if an unsampled resident is a "feeder". The Activities Director then proceeded to stand and feed the unsampled resident their meal. Interview on 05/05/11 at 7:22am with LPN #1 revealed staff are trained to sit down and feed the residents. She further revealed staff are trained not to call out a residents name and refer to them as feeders. LPN #1 stated, staff are trained during orientation and are corrected if observed standing while feeding the residents. Interview on 05/05/11 at 8:00am with CNA #2 revealed she was aware she was standing while feeding a resident. CNA #2 stated she was standing to feed an unsampled resident in hopes of getting he/she to start eating on their own. She	F 241	positioning of staff while feeding dependent residents, and/or the preservation of resident rights and dignity during meals. 3. All Nursing staff and Department Heads will be re-educated by June 17, 2011 by the Education and Training Director, the Director of Nursing, the Assistant Director of Nursing, or the Unit Manager, on feeding dependent residents, the appropriate positioning of staff while feeding dependent residents, and ensuring that resident rights and dignity are maintained during meals. 4. The Education Training Director the Assistant Director of Nursing or the Unit Manager will monitor the Restorative Dining Room three (3) times per week for twelve(12)weeks to observe for proper feeding of dependent residents, appropriate positioning of staff while feeding dependent residents, and to ensure resident rights and dignity are preserved during meals. The results of the audit will be presented to the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance committee will convene to review and make recommendations as appropriate. If at the end of the three (3) month period no concerns are identified, the facility will conduct random observations of meal service to assure ongoing	



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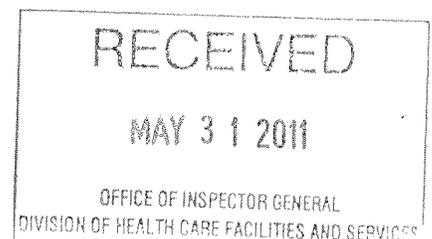
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F 241	<p>Continued From page 2</p> <p>also revealed feeding the residents while standing could make them feel belittled. CNA #2 revealed that training and in-servicing on appropriate feeding techniques is provided yearly.</p> <p>Interview on 05/05/11 at 8:05am with the Director of Education revealed staff are trained on the appropriate feeding techniques to a dependent resident on a yearly basis, whenever there is a problem, and upon hire. However, she did not know when the last in-service had occurred. The Director of Education stated she monitors how trays are distributed and how residents are being fed. She further revealed staff should be at the residents level when feeding. The Director of Education confirmed she did not monitor the restorative dining area.</p> <p>Further interview with the Director of Education revealed she was not aware that the in-service did not include staff positioning. She further revealed that the in-services were provided by the facility. She stated standing over a resident could make them feel hovered over, rushed, and less important. She confirmed the current system in place for training is not effective and monitoring of the restorative dining area should be implemented.</p> <p>Interview with Activities Director on 05/05/11 at 8:05am revealed she was a Certified Nursing Assistant(CNA) before she was the Activities Director. She stated, staff should sit down when feeding the resident. She stated, she was standing because she was just going to try to get the resident to feed themselves, but realized that the resident was not going to and then she retrieved a chair. The Activities Director</p>	F 241	<p>compliance. The Quality Assurance Committee will consist of at minimum the Nursing Home Administrator, the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, the Nutrition Services Manager, with the Medical Director attending at least quarterly and as needed, and will make further recommendations if additional concerns are identified regarding the feeding of dependent residents, or appropriate positioning of staff while feeding dependent residents, or if the preservation of resident rights or dignity is compromised during meal service.</p> <p>5. Completion date: June 17, 2011</p>	



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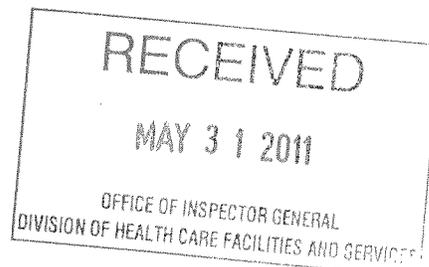
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F 241	Continued From page 3 acknowledged that she had called out over the dining room to ask other staff if the unsampled resident was a "feeder". She stated she should have walked over to another staff member to ask the question. She stated, I can see where that is a Dignity, Privacy and Confidentiality issue. Interview on 05/05/11 at 8:15am with RN #2 revealed staff members should not stand to feed the residents. She stated sitting down while feeding the residents makes them feel more comfortable and allows the staff to monitor the resident more closely. She further revealed standing over a resident would make them feel inferior. RN #2 stated she did not realize she was standing while feeding the resident; therefore, did not think to correct the LPN in orientation. She further stated she did not remember having an in-service or facility training on the proper positioning while providing assistance to dependent residents during meal service.	F 241		
F 309 SS=E	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 resident record review, review of the facility Policy and Procedures on Admission Orders, facility Policy and Procedures on	F 309	F309 It is the policy of Medco Center of Hardinsburg that 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. 1. Resident #1 was assessed by the Unit Manager on May 3, 2011 and found no abnormal findings. The resident's family and physician were notified on May 3, 2011 by Unit Manager. No further recommendations by the physician were ordered. A record	



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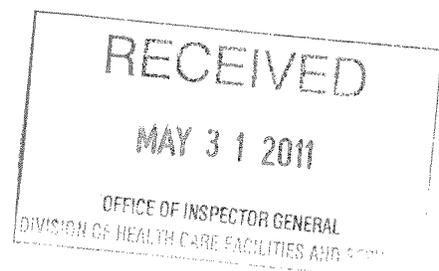
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F 309	<p>Continued From page 4</p> <p>Documentation, and interviews, the facility failed to follow the physician admission orders for one (1) of sixteen (16) sampled residents (Resident #1). Resident #1's vital signs were not obtained on nine (9) of twelve (12) possible days following admission, as ordered by the physician.</p> <p>The findings include:</p> <p>The facility Clinical Administrative Manual Policy and Procedure on Admission Orders (Revised October 2002) revealed to contact the attending physician immediately upon admit to confirm orders. It is also stated to transcribe the approved transfer orders onto the Physician's Order Sheet.</p> <p>A review of the medical record for Resident #1 revealed an admission date of 04/22/11 with a diagnoses including urinary tract infection(UTI), cerebral vascular accident (CVA), trans-ischemic attack (TIA), Hypertension, weakness and recent falls. Review of the Physician Admission Orders revealed an order for daily vital signs. Only three (3) vital sign entries were present on Resident #1's chart: 04/28/11, 05/01/11 and 05/02/11, out of twelve (12) opportunities.</p> <p>Interview on 05/03/11 at 2:35pm with the Unit Manager revealed when a physician orders daily vital signs on a resident, they are obtained daily and are charted on the flow sheet located in front of the Nurses Notes in the chart. The Unit Manager acknowledged daily vital signs were not obtained or charted on Resident #1.</p> <p>Interview on 05/05/11 at 7:22am with the Unit Manager revealed if daily vital signs are ordered,</p>	F 309	<p>review by the Director of Nursing on May 10, 2011 for resident # 1 was completed to assure all physician orders were being followed. No concerns were identified.</p> <p>2. A record view of current residents admitted since April 1, 2011 will be completed prior to June 17,2011 by the Director of Nursing, the Assistant Director of Nursing, the Education and Training Director, or the Unit Manager, to assure all physician admission orders are present and have been or are being followed. Any discrepancies will be reviewed with the physician for further direction.</p> <p>3. All Licensed staff will be re-educated on the facility Clinical Administrative Manual Policy and Procedure on Admission Orders (Revised October 2002) by either the Director of Nursing, the Assistant Director of Nursing, the Education Training Director or the Unit Manager by June 17, 2011. Admission orders for new admissions, or return admissions, will be reviewed by the Interdisciplinary Team during the next scheduled Daily Clinical Review meeting to assure all physician orders are transcribed correctly and are in place. The Interdisciplinary Team will consist of the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, the Life Enrichment Director and the Nutrition Services Manager. Education was provided to</p>		



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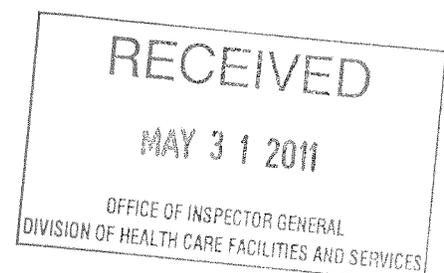
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F 309	Continued From page 5 they should be done daily. It was revealed orders for vital signs are monitored by "the nurses". Interview on 05/05/11 at 7:40am with the Director of Education and Training revealed admission orders are verified with the physician. The orders are then placed on the different forms needed to be carried out by the staff. It was further revealed orders are monitored by the Director of Nursing, the Assistant Director of Nursing, the Educator and the Unit Manager to verify they are being followed.	F 309	the Interdisciplinary Team on this process by the Director of Nursing on June 1, 2011.	
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	F 441	4. All medical records of new admissions or return admissions will be reviewed by the Director of Nursing, the Assistant Director of Nursing, the Education and Training Director, or the Unit Manager weekly for twelve (12) weeks to assure that the physician admission orders have been correctly transcribed, confirmed by the attending physician, and are being followed by nursing staff per physician orders. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months, after which time the Interdisciplinary Team will continue to review admission orders in Daily Clinical Review and will present concerns to the Quality Assurance Committee if concerns are identified. The Quality Assurance Committee will consist of at minimum, the Nursing Home Administrator, the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, the Nutrition Services Manager, with the Medical Director attending at least quarterly and as needed. If at anytime concerns are identified, the Quality Assurance Committee will convene and make further recommendations as appropriate. 5. Completion date: June 17, 2011	



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F 441	Continued From page 6 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. (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 facility policy, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection. Ten (10) unsampled residents and one (1) sampled resident, (Resident #5) had disposable respiratory equipment that was not properly stored or dated. In addition, staff were observed placing a dirty tray back on the food cart with the trays still being distributed to the other residents. The findings include: Review of the facility policy for Disposable Equipment Change related to Respiratory Practice revised October 2008 revealed respiratory supplies are routinely changed and cleaned to prevent nosocomial infection. Section 1. K stated Medication/nebulizer storage bags	F 441	F441 It is the policy of Medco Center of Hardinsburg 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. 1. Observation by the Director of Nursing on May 10, 2011 noted oxygen tubing/nebulizers to be dated and stored appropriately. An observation of tray pass by the Director of Nursing on May 10, 2011 noted staff were following appropriate infection control practices. 2. Observation by the Director of Nursing on May 10, 2011 noted oxygen tubing/nebulizers to be dated and stored appropriately. An observation of tray pass by the Director of Nursing on May 10, 2011 noted staff were following appropriate infection control practices. 3. All Licensed Nursing staff will be re-educated prior to June 17, 2011 by the Education Training Director, the Director of Nursing, the Assistant Director of Nursing or the Unit Manager, on the facility policy for Disposable Equipment Change related to Respiratory Practice (revised October 2008) to ensure respiratory supplies are routinely changed and cleaned to prevent nosocomial infection to include that	



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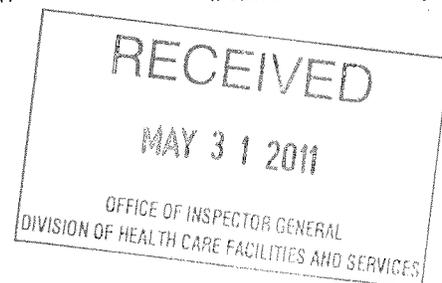
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F 441	<p>Continued From page 7</p> <p>and nebulizer set-up are changed weekly and as needed. Section 2. stated, to date all disposable supplies upon opening including oxygen tubing.</p> <p>Observation on 05/03/11 during initial tour of the West Unit of the facility revealed five (5) residents with mini-neb equipment not properly stored in plastic bags. One (1) resident had a mini-neb mask that was on the floor. Further observation revealed during initial tour of the West Hall revealed two (2) unsampled residents with mini-neb equipment not properly stored in a plastic bag.</p> <p>Observation on 05/03/11 at 8:55am, during the initial tour of the facility, revealed in Room 12, an oxygen nasal cannula not covered or dated. A humidifier bottle attached to the concentrator was empty and undated.</p> <p>Observation on 05/03/11 at 11:10am in Room 4 Bed One (1) was oxygen tubing on the floor with no label or date. Bed two (2) had oxygen tubing on the floor with no date or label. The cannula nose piece was hanging over a garbage can next to the oxygen concentrator which was on with no resident present.</p> <p>Observation on 05/03/11 at 11:11am was an unidentified resident walking in the hall outside Room 10 with an oxygen tank in tow, no date or label on the oxygen tubing.</p> <p>Observation on 05/03/11 at 11:15am revealed a tray taken to the resident in Room 7, then the resident requesting assistance on a bed pan. The tray was then removed from the room and placed back on the cart with the trays being</p>	F 441	<p>Medication/nebulizer are in storage bags and nebulizer set-up are changed weekly, and as needed, and that all disposable supplies are dated upon opening, including oxygen tubing. All nursing staff will be re-educated by the Education Training Director, the Director of Nursing, the Assistant Director of Nursing, or the Unit Manager, related to the storage of disposable respiratory equipment that is in use and infection control practices during meal tray pass. This re-education will be completed by June 17, 2011.</p> <p>4. The Director of Nursing, the Assistant Director of Nursing, the Education Training Director, or the Unit Manager will complete audits of disposable respiratory equipment to include appropriate storage, dating and replacement, weekly for twelve (12) weeks to ensure facility policies are being followed. The Director of Nursing, the Assistant Director of Nursing, the Education Training Director, or the Unit Manager, will observe meal tray pass three (3) times per week for twelve (12) weeks to assure that appropriate infection control standards are maintained. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months, after which time the Education and Training Director will continue to complete random observations to</p>	



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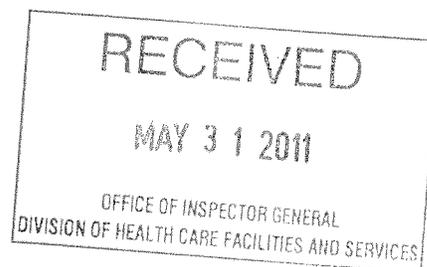
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F 441	<p>Continued From page 8 distributed to the other residents. In the same room, a urinal was open sitting on a night stand.</p> <p>Observation on 05/04/11 at 1:20pm revealed one (1) unsampled resident resident on the West Hall with mini-neb equipment not stored properly in a plastic bag.</p> <p>Observation on 05/05/11 at 7:30am revealed one (1) unsampled resident with mini-neb equipment that was not dated.</p> <p>Interview on 05/05/11 at 7:22am with the Unit Manager revealed oxygen tubing is to be stored in a bag connected to the oxygen concentrator when not in use. She acknowledged that disposable oxygen supplies should be dated and labeled.</p> <p>Continued interview with the Unit Manager revealed, once trays have been removed from the meal cart, they are not to be placed back on the cart with the trays currently being served.</p> <p>Interview with the Director of Education on 05/05/11 at 7:30am revealed min-neb equipment is to be stored in a bag. She stated that all staff are responsible to ensure equipment is properly stored and dated. The Director of Education stated the mini-neb disposable equipment and oxygen tubing is changed and dated once a week on third shift. She stated the purpose of changing and dating disposable respiratory equipment is to prevent them from being there to long and prevent infection.</p> <p>Interview on 05/05/11 at 7:30am with the Director of Education and Training revealed oxygen tubing</p>	F 441	<p>assure ongoing compliance and will present concerns to the Quality Assurance Committee if concerns are identified. The Quality Assurance Committee will consist of at minimum the Nursing Home Administrator, the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, the Nutrition Services Manager, with the Medical Director attending at least quarterly and as needed. If at anytime concerns are identified the quality Assurance Committee will convene and make further recommendations as appropriate.</p> <p>5. Completion date: June 17, 2011</p>	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HARDINSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143	
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F 441	<p>Continued From page 9</p> <p>not in use is to be stored in a plastic bag. In addition, tubing is to be dated as is the concentrator humidifier bottle and the equalizer mask. The Director of Education stated she was unsure who would be accountable to assure tubing was changed and dated. Continued interview revealed, the night nursing staff is responsible to change the tubing, a day is designated, but that day was not known. It was revealed there is no documentation for the changing of the oxygen tubing.</p> <p>Interview with Certified Nursing Assistant (CNA) #4 on 05/05/11 at 7:45am revealed she was aware that mini-neb equipment should be stored in a bag. She stated if the min-neb equipment is not changed or stored in bags the residents could get sick.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 05/05/11 at 7:55am revealed she was aware the mini-neb equipment should be stored in bags. She stated if the equipment is not changed or stored properly the residents could breath in microbes and cause an infection.</p> <p>Interview on 05/05/11 at 8:22am with Licensed Practical Nurse(LPN) #3 revealed oxygen tubing is to be changed by the night shift on Tuesdays, and it should be dated. LPN #3 stated she was unsure if there is a place to document on the tubing changes.</p> <p>Interview on 05/05/11 at 8:35am with LPN #4 revealed the oxygen tubing is changed once a week by the night staff on Tuesdays. LPN #4 stated the tubing should be dated and initialed when change.</p>	F 441		



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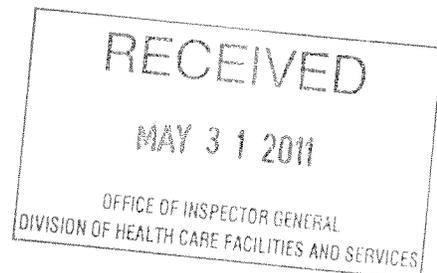
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F 441	Continued From page 10	F 441		
F 514 SS=E	<p>Interview with LPN #1, who is the Unit Manager, on 05/05/11 at 10:15am, revealed mini-neb equipment should be changed once a week and properly stored in a bag and oxygen tubing should be changed once a week. She stated that if this is not done there is an increase risk of infection for the residents.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, facility policy of Clinical Programs Manual Policy and Procedure, and interview, the facility failed to maintain clinical records on three (3) of sixteen (16) sampled residents (Resident's #1, #4, and #8). The facility failed to document the reason medication were not administered on the Medication Administration Record (MAR) and failed to document the monitoring of an Intravenous Infiltrate in the medical record for Resident #1.</p>	F 514	<p>F 514 It is the policy of Medco Center of Hardinsburg that the facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <ol style="list-style-type: none"> 1. Resident #1's physician was notified of the alleged deficient practice of missed observations for monitoring of the bruising and swelling to the left hand on May 3, 2011; the bruising and swelling of the left hand was resolved on May 3, 2011. Resident # 4's physician was notified on May 5, 2011 of the alleged missed documentation of medication administration on the Medication Administration Record . Resident #8's physician was notified of weekly blood sugar results on May 4, 2011. No further recommendations were made. 2. A one-time review of Medication Administration Records and Treatment Administration Records of all current residents will be completed prior to June 17, 2011 by the Director of Nursing, the Assistant Director of Nursing, the Education Training 	



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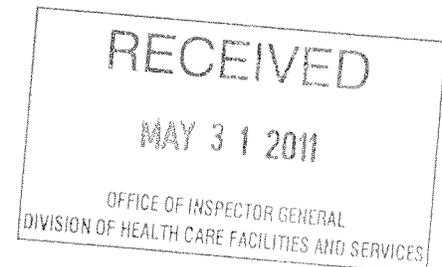
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F 514	<p>Continued From page 11</p> <p>The facility failed to document medication administration and treatment administration of multiple medications and treatments on multiple days for Resident #4. The facility failed to properly document reporting of weekly blood sugars to the physician for Resident #8.</p> <p>The findings include:</p> <p>The facility Clinical Programs Manual (Effective January 2004) Policy and Procedure on Documentation revealed ongoing documentation of the resident's health status will be provided to include observations, assessments, interventions and clinical outcomes. "Documentation is designed to demonstrate the clinical picture of the resident and to ensure the appropriate information is available to all interdisciplinary team members regarding treatment interventions and responses". The policy revealed nursing documentation includes vital signs, medications and treatments, plans of care and assessments.</p> <p>1. Record review of the medication orders for Resident #1 revealed the resident was to receive the medication Alprazolam 0.25 mg at bedtime, but was circled seven (7) out of eight (8) times on the Medication Administration Record (MAR) in April 2011. There was no documentation on the MAR that indicated the reason the medication was circled.</p> <p>Interview on 05/05/11 at 7:22am with the Unit Manager regarding the reason the medication was circled on the MAR revealed, Resident #1 did not receive the ordered Alprazolam 0.25 mg as ordered because the resident refused the medication.</p>	F 514	<p>Director, or the Unit Manager, to assure that documentation is complete for Medications and Treatments. Any identified concerns will have physician notification for further direction.</p> <p>3. All Licensed staff will be re-educated by the Director of Nursing, the Assistant Director of Nursing, the Education Training Director, or the Unit Manager, prior to June 17, 2011 on facility policy and procedure for Documentation to include vital signs, medications and treatments, plans of care and assessments.</p> <p>4. The Director of Nursing, the Assistant Director of Nursing, the Unit Manager, or the Education Training Director, will audit all Medication Administration Records and Treatment Administration Records three (3) times per week for six (6) weeks followed by weekly for six (6) weeks to ensure that documentation for Medications and Treatment Administration records are maintained in accordance with accepted professional standards and practices. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months, after which time the Education and Training Director will continue to complete random observations to assure ongoing compliance and will present concerns to the Quality Assurance Committee if</p>	



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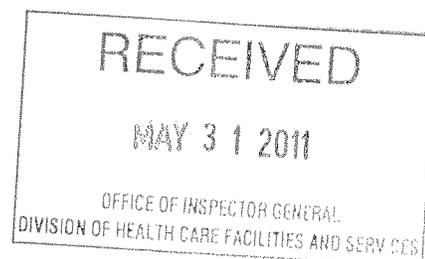
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F 514	Continued From page 12 Interview on 05/05/11 at 8:22am with Licensed Practical Nurse (LPM) #3 revealed she was the nurse that circled the initials on the MAR for Resident #1's Alprazolam 0.25 mg. She stated the medication was not refused by the resident but was unavailable to administer. She further revealed the physician was to be notified of three (3) missed doses of a medication. LPN #3 stated did not know who was responsible to monitor the MAR's. Record review of the Physician treatment order for Resident #1 revealed monitoring of bruising and swelling of the left hand every shift till healed related to intravenous infiltration was only documented three (3) times out of fifteen (15) opportunities on the treatment record. 2. Record review of the MAR for Resident #4 revealed, in the month of April 2011, the following medications were not signed off as given: Ferrex 10 capsule was not signed off twelve (12) times out of fifty-eight (58) opportunities; Keppra 500mg tablet was not signed off twelve (12) out of fifty-eight (58) opportunities; Lopressor 25mg tablet was not signed off twelve (12) out of fifty-eight (58) opportunities; Pantanol 0.1% eye drops was not signed off twelve (12) out of fifty-eight (58) opportunities; Hydrocodone-APAP 10-325mg was not signed off twenty-three (23) out of one-hundred sixteen (116) opportunities; Lantus 100 units/ml Insulin not signed off three (3) out of sixty (60) opportunities. Record review of the MAR for Resident #4	F 514	concerns are identified. The Quality Assurance Committee will consist of at minimum, the Nursing Home Administrator, the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, the Nutrition Services Manager, with the Medical Director attending at least quarterly and as needed. If at anytime concerns are identified, the Quality Assurance Committee will convene and make further recommendations as appropriate. 5. Completion date: June 17, 2011	



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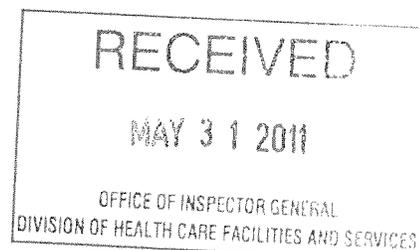
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F 514	<p>Continued From page 13</p> <p>revealed no documentation for the ordered "Glucerna 1.2 45ml/hr continous feed, except 2 hours from 2200 to 2400".</p> <p>Interview on 05/04/11 at 1:45pm with the Regional Nurse Consultant revealed the expectation of the nurse is to document on the MAR when a medication is administered.</p> <p>Interview on 05/05/11 at 7:22am with the Unit Manager revealed the Director of Education was responsible to monitor the MAR's and TAR's. New staff is trained on the MAR's by the nurses working the floor.</p> <p>Interview on 05/05/11 at 7:30am with the Director of Education and Training revealed the Director of Nursing, the Assistant Director of Nursing, the Unit Manager and she, monitors the MAR's for discrepancies. Medical Records monitors the previous months MAR's. It was further stated the new nurse employees are taught in orientation to document on the MAR.</p> <p>Interview on 05/05/11 at 7:35 with Medical Records revealed the role of Medical Records was to put records in the chart and file, not to audit or follow up on nursing documentation.</p> <p>Interview on 05/05/11 at 7:40am with the Regional Nurse Consultant revealed random audits were done of the charts and their documentation. This was to be done by the Director of Education. It was further revealed Medical Records does not audit the charts.</p> <p>Interview on 05/05/11 at 8:35am with LPN #4 revealed the Director of Education was</p>	F 514		



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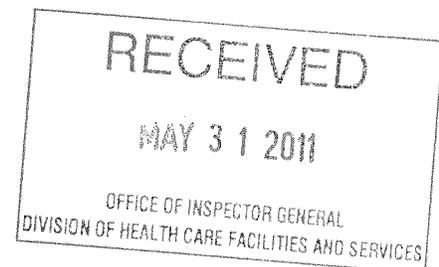
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F 514	<p>Continued From page 14 responsible to monitor the holes in the MAR's.</p> <p>3. Record review of the medical record for Resident #8 revealed a Physician Order to notify M.D. of finger stick blood sugar results weekly on Monday on 7-3.</p> <p>Record review of the Diabetic Care Flow Sheet for Resident #8 revealed documentation that the M.D. was notified four (4) out of twelve (12) opportunities for the months of February 2011, March 2011, and April 2011.</p> <p>Interview on 05/05/11 at 8:30am with Medical Records Supply Clerk (MRSC) revealed Diabetic Flow Sheets are normally taken to the medical doctor (MD)'s office for review and signatures two (2) to three (3) times weekly.</p> <p>Interview on 05/05/11 at 8:40am with the Unit Manager, LPN #1, revealed the MD reviews the copy of the Diabetic Flow Sheet and writes new orders on the copy of the Diabetic Flow Sheet. The new orders were then transcribed on a Physician Order Sheet and the MD comes in a few days later and signs the new orders. The copy of the Diabetic Flow Sheet that the MD wrote orders on is then placed in the shredder. Unit Manager, LPN #1 said she was not aware that the Diabetic Flow Sheet with orders written by the MD should be placed in the medical record. Unit Manager, LPN #1 stated she was aware that only a nurse can take a verbal or telephone order from a MD.</p> <p>Intevieiw on 05/05/11 at 10:10am with the MD revealed he requested to be notified of blood sugar results weekly on Monday because</p>	F 514			



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F 514	Continued From page 15 Resident #8 is a Diabetic. The MD said he was not aware that his hand written orders were being shredded and they should be maintained as part of the resident's medical record.	F 514		



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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OFFICE OF INSPECTOR GENERAL

DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/04/2011
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K 000

INITIAL COMMENTS

A Life Safety Code Survey was initiated and concluded on 05/04/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".

K 000

K 018
SS=E

NFPA 101 LIFE SAFETY CODE STANDARD

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

K 018

K018 It is the policy of the Medco Center of Hardinsburg to ensure there are no impediments to the closing of doors.

1. The roller catch on the laundry room door was removed on 5/4/11. The trash can holding the resident room door open was immediately removed by the Maintenance Director on 5/4/11.
2. All doors in the facility were inspected by the Maintenance Director on 5/4/11 and impediments, if any, were removed.
3. The Nursing Home Administrator re-educated the Maintenance Director on 5/4/11 regarding the CMS standard prohibiting roller catches and what constitutes an impediment to closing a door.
4. The Maintenance Director or Housekeeping Supervisor will inspect the facility for impediments to the closing of doors weekly for twelve (12) weeks. The Nursing Home Administrator will review door audits weekly for twelve (12) weeks. The

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors according to NFPA standards. The deficiency

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mary Nell Bauman* TITLE *Administrative* (X6) DATE *5/26/11*

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.

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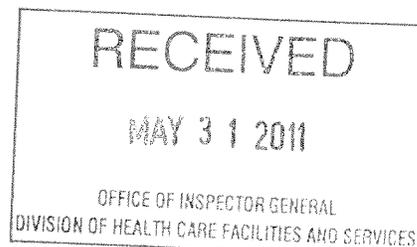
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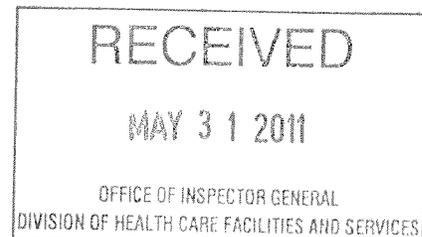
K 018	Continued From page 1 had the potential to affect one (1) of four (4) smoke compartments, approximately twenty (30) residents, staff and visitors within the compartment. The facility has the capacity for sixty-three (63) beds; the census was fifty-seven (57) on the day of the survey. The findings include: Observation on 05/04/2011 at 11:00 AM, with the Administrator and the Maintenance Director, revealed a roller catch installed at the bottom of the door to the laundry room located in the West wing. Further observation at 11:10 AM, revealed a trash can in the resident room 18, was positioned so that it prevented the door from closing. Interview on 05/04/2011 at 11:10 AM, with the Administrator and the Maintenance Director, revealed they were unaware of the trash can being used to hold the door open, and immediately removed it. Further interview at 11:00 AM, revealed they were not aware that roller catches are prohibited for usage per CMS standards. Reference: NFPA 101 (2000 Edition) 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or	K 018	Maintenance Director will report on door audit results to the Quality Assurance Committee monthly for three (3) months as part of the Preventive Maintenance Report. The Quality Assurance Committee, consisting of at minimum, the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) will make further recommendations if additional impediments to the closing of doors are identified. The Quality Assurance process will be ongoing to ensure there are no impediments to the closing of facility doors. 5. Completion Date: June 17, 2011	
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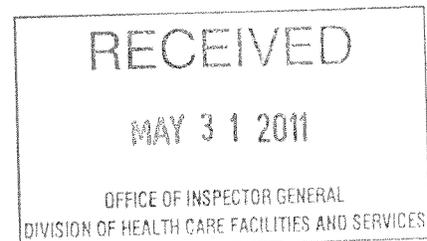
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2 plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The facility has the capacity for sixty three (63) beds and the census was fifty seven (57) on the day of the survey. The deficiency has the potential to affect all four (4) smoke compartments, fifty seven (57) residents, staff and visitors. The findings include: A tour of the facility conducted on 05/04/11 at 11:50 AM revealed that all the smoke partitions located in the attic throughout the facility, were	K 025	K025 It is the policy of the Medco Center of Hardinsburg to maintain smoke barriers that resist the passage of smoke between smoke compartments per NFPA standards. 1. All smoke partitions identified during the survey as located in the attic will be replaced by the Maintenance Director prior to June 17, 2011. 2. An environmental audit will be completed by the Maintenance Director to assure all smoke partitions are NFPA compliant by June 17, 2011. All smoke barriers will meet NFPA standards. 3. The Nursing Home Administrator educated the Maintenance Director on May 24, 2011 regarding smoke barriers that meet NFPA standards. 4. The Maintenance Director will inspect the smoke partitions in the facility attic monthly for three (3) months to ensure compliance with NFPA standards as part of Preventive Maintenance Check list. The Nursing Home Administrator will review the Smoke Partition audits monthly for three (3) months. The Maintenance Director will report on the Smoke	



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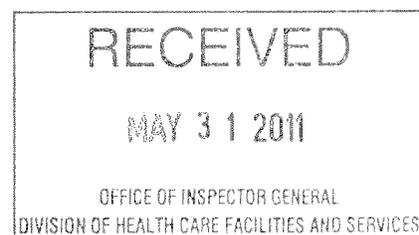
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K 025	Continued From page 3 noted to be penetrated by electrical wiring and non rated homemade doors. An interview with the Maintenance Director 05/04/11 at 11:50 AM revealed he was not aware of the penetrations, and that doors in the attic had to be rated. Reference to: NFPA 101 Life Safety Code 2000 Edition 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. Reference: NFPA 101 (2000 Edition). 8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protective ' s shall be as follows: (3) 1/2-hour fire barrier - 20-minute fire protection rating (1) 2-hour fire barrier - 11/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection	K 025	Barrier audit results to the Quality Assurance Committee monthly for three (3) months as part of the Preventive Maintenance Report. The Quality Assurance Committee, consisting of at minimum, the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager, and Medical Director (quarterly attendant) will make further recommendations if additional issues regarding attic Smoke Barriers are identified. The Quality Assurance process will be ongoing to ensure that the facility maintains smoke barriers that resist the passage of smoke between smoke compartments per NFPA standards. 5. Completion Date: June 17, 2011	



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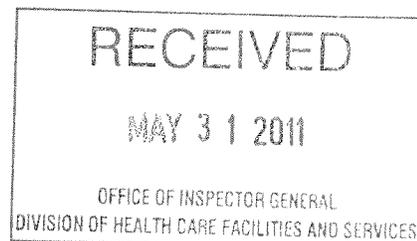
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K 025	Continued From page 4 rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	K 025		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are	K 066	K066 It is the policy of the Medco Center of Hardinsburg to use approved ashtrays in the designated facility smoking area. 1. Un-approved ashtrays will be removed from the designated smoking area and replaced with approved ashtrays prior to June 17, 2011. 2. An audit of all smoke receptacles will be completed to assure all are an approved receptacle. Any un-approved ashtrays will be removed from the designated smoking area and replaced with approved ashtrays prior to June 17, 2011 3. The Nursing Home Administrator educated the Maintenance Director on May 24, 2011 on what constitutes an approved ashtray.	



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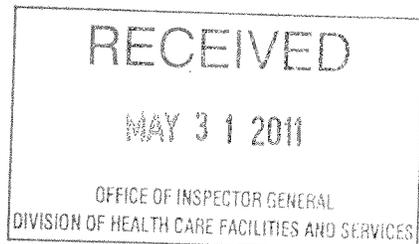
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K 066	<p>Continued From page 5 readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview on 05/04/11 it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area. This deficiency could affect all persons in the designated smoking area. The smoking area is located more than twenty five (25) feet from the building housing residents. The facility is licensed for sixty three (63) beds with a census of fifty seven (57) the day of the survey.</p> <p>The findings include:</p> <p>Observation on 05/04/11, at 12:00 PM revealed an ashtray on a table in the designated smoking area of an unapproved type. This observation was confirmed with the Maintenance Director and the Administrator.</p> <p>Interview on 05/04/11, at 12:00 PM with the Maintenance Director and the Administrator indicated that the ashtray would be removed and an ashtray of the approved type would be provided.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be</p>	K 066	<p>4. The Maintenance Director or the Housekeeping Supervisor will inspect the facility designated smoking area to ensure that approved ashtrays are in use weekly for twelve (12) weeks and then monthly as part of the Preventive Maintenance check list. The Maintenance Director or Housekeeping Supervisor will report on ashtray audits to the Quality Assurance Committee for three (3) months as part of Preventive Maintenance Report. The Quality Assurance Committee, consisting of at minimum, the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager, and Medical Director (quarterly attendant) will make further recommendations if additional concerns are identified regarding the use of approved ashtrays in the facility designated smoking area. The Quality Assurance process will be ongoing to ensure that the facility uses approved ashtrays in the designated facility smoking area.</p> <p>5. Completion date: June 17, 2011</p>



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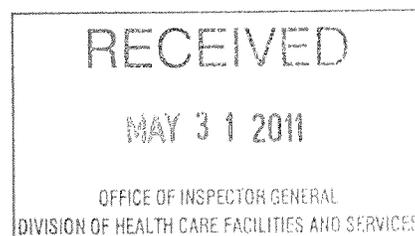
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K 066	Continued From page 6 readily available to all areas where smoking is permitted.	K 066		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure portable space heaters used in the facility were according to NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, approximately twenty (30) residents, staff and visitors within the compartment. The facility has the capacity for sixty-three (63) beds; the census was fifty-seven (57) on the day of the survey. Observation on 05/04/2011 at 9:30 AM, with the Administrator and the Maintenance Director, revealed space heaters being used in both the Physical Therapy Office and the Clinical Reimbursement Office. The observation was confirmed with the Maintenance Director. Interview on 05/04/2011 at 9:30 AM, with the Maintenance Director, revealed he was unaware of the space heaters usage. The facility had no documentation for the heater, listing its temperature range. The space heaters were	K 070	K070 It is the policy of the Medco Center of Hardinsburg that, if portable space heating devices are used, they meet NFPA standards. 1. The portable space heating devices not meeting NFPA standards in the Physical Therapy Office and the Clinical Reimbursement Office were removed on May 4, 2011. 2. The Maintenance Director inspected all areas of the facility on May 4, 2011 for any un-approved portable space heating devices. None were found. 3. Staff have been re-educated by the Maintenance Director, the Housekeeping Supervisor or the Education and Training Director on the requirement for use of only NFPA approved portable space heating devices prior to June 17, 2011. 4. The Maintenance Director or the Housekeeping Supervisor will inspect the facility to ensure portable space heaters, if used, meet NFPA standards, weekly, for two (2) months and then monthly as part of Preventive Maintenance check list. Maintenance Director to report on portable heater audits to Quality Assurance Committee monthly for three (3) months as part of Preventive Maintenance Report. The Quality	



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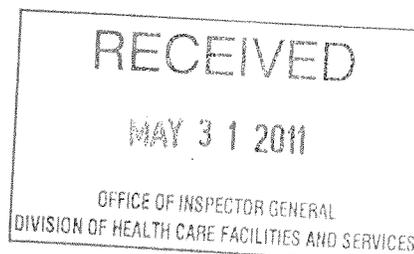
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K 070	Continued From page 7 Immediately removed from the offices. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	Assurance Committee, consisting of at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager, and Medical Director (quarterly attendant) will make further recommendations if additional portable space heater issues are identified. The Quality Assurance process will be ongoing to ensure that only portable space heating devices that meet NFPA standards are used. 5. Completion date: June 17, 2011	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect all four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty-three (63) beds; the census on the day of the survey was fifty-seven (57).	K 072	K072 It is the policy of the Medco Center of Hardinsburg that all facility means of egress are maintained free and clear of obstructions according to NFPA standards. 1. The ice machine is to be relocated to an area that is not a means of egress prior to June 17, 2011. The med carts, linen carts, patient lift, weight scale and snack carts have permanent storage sites identified that are not an impediment to egress and these storage sites will be in use before June 17, 2011. 2. The Maintenance Director inspected the facility on May 5, 2011 to ensure that all means of egress are free and clear of obstructions according to NFPA standards. Any identified concerns were corrected.	



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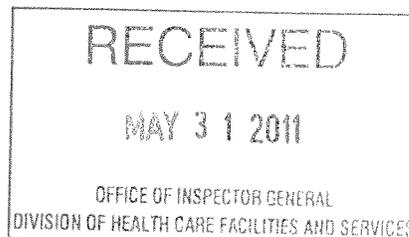
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K 072	Continued From page 8 The findings include: Observation during the Life Safety Code Survey on 05/04/2011 between 9:30 AM and 2:00 PM, with the Administrator and the Maintenance Director, revealed med carts, linen carts, a patient lift, a weight scale, and snack carts located within the resident area corridors. The items observed in the corridors to be stationary for a period of more than thirty (30) minutes. Also observed was an ice machine located in the corridor outside of the kitchen area, near the East exit. Interview with the Administrator and the Maintenance Director, confirmed the items located in the corridors and indicated the facility lacked in storage space. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	3. The Maintenance Director, the Housekeeping Supervisor or the Education Training Director will educate all staff prior to June 17, 2011 on maintaining a means of egress at all times. 4. The Maintenance Director or the Housekeeping Supervisor, will inspect the facility two (2) times per week for three (3) months to ensure the facility means of egress are maintained free and clear of obstructions according to NFPA standards. The Nursing Home Administrator will review the egress audits weekly for three (3) months. The Maintenance Director will report on the egress audits to the Quality Assurance Committee monthly for three (3) months as part of the Preventive Maintenance report. The Quality Assurance Committee, consisting of at minimum, the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) will make further recommendations if additional egress issues are identified. The Quality Assurance process will be ongoing to ensure that the facility means of egress are maintained free and clear of obstructions according to NFPA standards.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than	K 076	5. Completion date: June 17, 2011	



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K 076	<p>Continued From page 9 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored according to NFPA standards. This deficiency has the potential to affect all four (4) smoke compartments and residents. The facility has the capacity for sixty-three (63) beds; the census on the day of the survey was fifty-seven (57).</p> <p>The findings include:</p> <p>Observation on 05/04/2011 at 10:55 AM, with the Administrator and the Director of Maintenance, revealed full and empty oxygen cylinders were stored together with no separation, within the oxygen storage room. This observation was confirmed with the Administrator and the Director of Maintenance.</p> <p>Interview on 05/04/2011 at 10:55 AM with the Administrator and the Maintenance Director, indicated that the cylinders would be stored properly.</p> <p>Reference: NFPA 99 (1999 Edition). 4-3.1.1.2</p>	K 076	<p>K076 It is the policy of the Medco Center of Hardinsburg that medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <ol style="list-style-type: none"> 1. The full and empty oxygen cylinders identified during survey were immediately separated on May 4, 2011 and placed in the appropriate storage racks. 2. The Maintenance Director audited the oxygen storage area on May 4, 2011 and found no other inappropriately stored oxygen cylinders. 3. The Maintenance Director or the Education Training Director will re-educate staff on oxygen cylinder storage prior to June 17, 2011. 4. The Maintenance Director or the Housekeeping Supervisor will inspect the oxygen cylinder storage area two(2) times per week for three (3) months to ensure oxygen cylinders are stored in accordance with NFPA standards. The Maintenance Director will report on the oxygen cylinder audits to the Quality Assurance Committee monthly for three (3) months. The Quality Assurance Committee, consisting of at minimum, the Nursing Home Administrator, the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, the Nutrition Services Manager and the Medical Director (quarterly attendant) will



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K 076 Continued From page 10
3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.
8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.

4-3.5.2.2
2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.

4-5.1.1.1
Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.

K 147 SS=E NFPA 101 LIFE SAFETY CODE STANDARD
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2

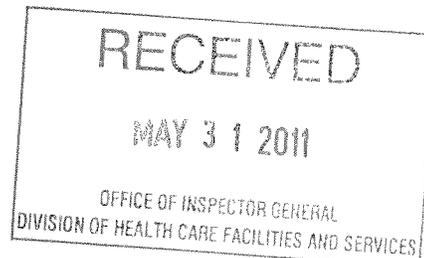
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. This deficient practice affected all smoke compartments, including residents, staff, and visitors. The facility is licensed for sixty three (63) beds with a census of fifty seven (57) the day of the survey.

The findings include:

K 076 make further recommendations if additional oxygen cylinder storage issues are identified. The Quality Assurance process will be ongoing to ensure that the facility storage of oxygen cylinders is in accordance with NFPA standards.
5. Completion date: June 17, 2011

K 147 **K147 It is the policy of the Medco Center of Hardinsburg that electrical wiring is maintained according to NFPA standards.**

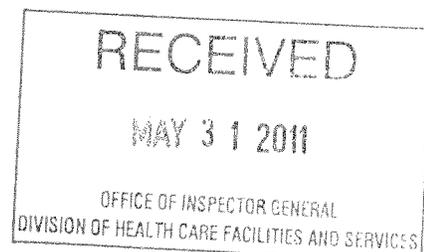
1. The piggy back power strips in Room 4 were discarded on May 4, 2011. The oxygen nebulizer in Room 3 was relocated on May 4, 2011. The open junction boxes in the attic were replaced on May 5, 2011. An electrical receptacle and an exhaust fan were installed in the attic to cool the telephone electrical system on May 9, 2011.
2. The Maintenance Director inspected the facility on May 5, 2011 to ensure that electrical wiring meets NFPA



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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HARDINSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143	
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K 147	<p>Continued From page 11</p> <p>Observations and Interview on 05/04/11, with the Maintenance Director and the Administrator revealed:</p> <p>(1) Observation on 05/04/11 at 10:48 AM revealed piggy backed power strips located in room #4.</p> <p>Interview on 05/04/11 at 10:48 AM with the Maintenance Director revealed that he was unaware of the power strips plugged into each other to form a longer cord.</p> <p>2) Observation on 05/04/11 at 10:50 AM revealed an oxygen nebulizer plugged into a power strip located in room #3.</p> <p>Interview on 05/04/11 at 10:50 AM with the Maintenance Director and the Administrator revealed that they were aware medical equipment could not be plugged into a power strip, and did not know who plugged the nebulizer into the power strip. The nebulizer was relocated at the time of observation and interview.</p> <p>3) Observation on 05/04/11 at 11:50 AM revealed open electrical junction boxes located in the attic.</p> <p>Interview on 05/04/11 at 11:50 AM with the Maintenance Director revealed that he was unaware of the open junction boxes in the attic.</p> <p>4) Observation on 05/04/11 at 11:50 AM revealed an extension cord plugged into a bath fan mounted in a plywood box located in the attic, to draw in air from the room below, to cool</p>	K 147	<p>standards. No further issues were identified.</p> <p>3. The Nursing Home Administrator educated the Maintenance Director on May 25, 2011 regarding the importance of maintaining NFPA standards for electrical wiring.</p> <p>4. The Maintenance Director will inspect the facility two(2) times per week for twelve (12) weeks to ensure that NFPA standards for Electrical wiring are maintained as part of the Preventative Maintenance Checklist. The Maintenance Director will report on the electrical audits to the Quality Assurance Committee monthly for three (3) months as part of the Preventive Maintenance Report. The Quality Assurance Committee, consisting of at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) will make further recommendations if additional electrical issues are identified. The Quality Assurance process will be ongoing to ensure that facility electrical wiring is maintained according to NFPA standards.</p> <p>5. Completion date: June 17, 2011</p>



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/04/2011
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Continued From page 12
telephone electrical equipment.

Interview on 05/04/11 at 11:50 AM with the Maintenance Director revealed that the extension cord and bath fan had been installed by the previous Maintenance Director three years prior to this survey.

Reference: NFPA 99 (1999 edition)

3-3.2.1.2 D

Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.

Reference: NFPA 70 (1999 edition)

370.28(c) Covers.

All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.

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