

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

PRINTED: 02/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 02/02/2015
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Based on implementation of the acceptable POC, the facility was deemed to have corrected the deficiencies on 01/22/15, as alleged.	{F 000}		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING OFFICE INSPECTOR GENERAL B. WING	(X3) DATE SURVEY COMPLETED C 01/12/2015
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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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F 000	INITIAL COMMENTS AMENDED An Abbreviated Survey Investigating #KY22628 was conducted on 01/07/15 through 01/12/15 to determine the facility's compliance with Federal requirements. #KY22628 was unsubstantiated with unrelated deficiencies cited at a scope and severity of a "D".	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the physician reviewed the resident's total program of care for two (2) of fourteen (14) sampled residents (Resident #1 and #2). There was no evidence Resident #1 and Resident #2 total plan of care had been reviewed by the physician from August-December 2014 . The findings include: Interview with the Director of Nursing (DON), on 01/09/15 at 11:20 AM, revealed the facility does	F 386	1.) Resident #1 and Resident #2 were both seen by facility Medical	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>U. Edward Foley</i>	TITLE <i>Director Administrator</i>	(X6) DATE 02/02/15
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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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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 NORTH ELM ST. HENDERSON, KY 42420		
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F 386	<p>Continued From page 1</p> <p>not have a specific policy regarding physician visits but they use the Federal Regulations as a guidance.</p> <p>1. Record review revealed the facility admitted Resident #1 on 08/04/14 with diagnoses which included Encephalopathy, Mental Disorder and Morbid Obesity. Review of a quarterly Minimum Data Set (MDS) assessment, dated 12/26/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of nine (9) which indicated the resident was interviewable.</p> <p>Further review of the record revealed there was no documented evidence the physician had reviewed the residents' total program of care from 08/2014 through 12/2014.</p> <p>An attempt at Interviewing Resident #1, on 01/09/15 at 12:15 PM, was unsuccessful because he/she was agitated and yelling out.</p> <p>2. Record review revealed the facility admitted Resident #2 on 02/10/12 with diagnoses which included Chronic Airway Obstruction, Rheumatoid Arthritis and Vascular Dementia. Review of the quarterly MDS assessment, dated 10/03/14, revealed the facility assessed Resident #2's cognition as cognitively intact with a BIMS score of "15" indicating the resident was interviewable.</p> <p>Further review of the record revealed there was no documented evidence the physician had reviewed the residents' total program of care from 08/2014 through 12/2014.</p> <p>Interview with Resident #2, on 01/09/15 at 11:35</p>	F 386	<p>Director on January 10, 2015. During this visit, the total program of care, including medications and treatments were reviewed. Progress notes were written signed and dated as well. Any changes made per Physician as a result of this review of total program of care were completed.</p> <p>2.) On January 8, 2015, a review of Physician visits of all current residents was conducted per Medical Records Director. On January 10, 2015, facility Medical Director saw all current residents that were due or past due for a Physician visit, and signed and dated all physician orders as well as progress notes.</p> <p>3.) Facility Director of nursing in-serviced Medical Records Director on January 12, 2015 regarding the federal requirements on Physician visits, as well as maintaining a current Physician visit log , validating that Physician has signed and dated both the Physician orders and a progress note, upon each visit. In addition facility has added the topic of Physician visits to the daily stand up meeting agenda. Any concerns noted regarding these visits will be addressed at that time.</p> <p>4.) Administrator or Director of Nursing will review the Physician</p>		

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F 386	<p>Continued From page 2</p> <p>AM, revealed he/she has been seen by the physician but was unable to pinpoint the time.</p> <p>Interview with Resident #1's and Resident #2's physician, on 01/09/15 at 12:08 PM, revealed he had not visited the facility to review the resident's program of care. He stated he thought the APRN was seeing the resident; however, he stated the APRN had not worked for him since August. He revealed the facility staff would call if they needed any orders.</p> <p>Interview with the Medical Records Director, on 01/09/15 at 11:53 AM, revealed she uses a spreadsheet to track the timing of required physician visits. She stated if the physician or APRN have not seen a resident, she sends a letter reminding them of the visit requirements. She revealed the letters were usually hand delivered to the physician's office. She stated letters were sent to Resident #1 & Resident #2's physician on 09/05/14, 09/22/14, 10/05/14, 10/22/14, 11/05/14, 11/19/14 and 12/10/14. She further revealed she had made the former Administrator aware Resident #1 and #2's physician had not been seen by their physician.</p> <p>Interview with the former Administrator, on 01/11/15 at 1:17 PM, revealed he was not aware there were residents that had not been seen by a physician. He stated the Director of Nursing (DON) might have known but if so, it wasn't communicated to him. He also revealed the topic of physician visits was never brought up in Quality Assurance (QA) meetings.</p> <p>Interview with the current Administrator, on 01/09/15 at 12:01 PM, revealed he had only been at the facility for two (2) weeks. He reported he</p>	F 386	<p>visit log monthly for at least three (3) months, ensuring that the Physician has signed and dated both the physician orders as well progress note upon each visit, and visits are timely. The progress note being signed and dated is listed upon the Physician visit log as an item to be completed. The results of these reviews will be reviewed by the quality assurance committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services manager, MDS Coordinator, and the Social Service Director with the Medical Director attending at least quarterly.</p>	01/22/15	

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F 386	Continued From page 3 had already spoken to the Medical Records Director regarding the issue and would be speaking with the Medical Director as well. Interview with the Medical Director, on 01/09/15 at 12:34 PM, revealed he was not aware Resident #1 and Resident #2 had not been seen by a physician since August 2014. He stated he expected residents to be seen by a physician or a APRN per the regulatory guidelines. He revealed he also expected the facility to notify him if a resident had not been seen and he would see the resident as needed.	F 386	F 387		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on Interview and record review it was determined the facility failed to ensure a resident was seen by a physician once every thirty (30) days for the first ninety (90) days after admission and once every sixty (60) days thereafter for two (2) of fourteen (14) sampled residents (Resident #1 and #2). The findings include:	F 387	1.) Resident #1 and Resident #2 were both seen by facility Medical Director on January 10, 2015. During this visit, the total program of care, including medications and treatments were reviewed. Progress notes were written signed and dated as well. Any changes made per Physician as a result of this review of total program of care were completed. 2.) On January 8, 2015, a review of Physician visits of all current residents was conducted per Medical Records Director. On January 10, 2015, facility Medical Director saw all current residents that were due or past due for a Physician visit, and signed and dated all physician orders as well as progress notes. 3.) Facility Director of nursing in-serviced Medical Records Director on January 12, 2015 regarding the federal requirements on Physician visits, as well as maintaining a current Physician visit log, validating that Physician has signed and dated both the Physician orders		

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F 387	<p>Continued From page 4</p> <p>Interview with the Director of Nursing (DON), on 01/09/15 at 11:20 AM, revealed the facility does not have a specific policy regarding physician visits as they use the Federal Regulations as a guidance.</p> <p>1. Record review revealed the facility admitted Resident #1 on 08/04/14 with diagnoses which included Encephalopathy, Mental Disorder and Morbid Obesity. Review of a quarterly Minimum Data Set (MDS) assessment, dated 12/26/14, revealed the facility assessed Resident #1's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of nine (9) which indicated the resident was interviewable.</p> <p>Further review of Resident #1's record revealed there was no documented evidence the resident's physician had seen the resident every thirty (30) days since admission on 08/04/14.</p> <p>2. Record review revealed Resident #2 was admitted to the facility on 02/10/12 with diagnoses which included Chronic Airway Obstruction, Rheumatoid Arthritis and Vascular Dementia. Review of quarterly MDS assessment dated 10/03/14, revealed the facility assessed Resident #2 as cognitively intact with a BIMS score of 15 indicating the resident was interviewable.</p> <p>Review of the Physician's Progress Notes for Resident #2 revealed the resident had not been seen by the physician every sixty (60) days. The resident was last seen by the APRN on 08/18/14; however, there was no evidence the resident was seen from 08/2014-12/2015 by the physician or the APRN.</p>	F 387	<p>and a progress note, upon each visit. In addition facility has added the topic of Physician visits to the daily stand up meeting agenda. Any concerns noted regarding these visits will be addressed at that time.</p> <p>4.) <u>Administrator or Director of Nursing will review the Physician</u></p> <p>visit log monthly for at least three (3) months, ensuring that the Physician has signed and dated both the physician orders as well progress note upon each visit, and visits are timely. The progress note being signed and dated is listed upon the Physician visit log as an item to be completed. The results of these reviews will be reviewed by the quality assurance committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Services manager, MDS Coordinator, and the Social Service Director with the Medical Director attending at least quarterly.</p>	01/22/15	

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F 387	<p>Continued From page 5</p> <p>Interview with Resident #1 and #2's physician, on 01/09/15 at 12:06 PM, revealed he thought the Advanced Practice Registered Nurse (APRN) was seeing the resident but stated the APRN had not worked for him since August 2014.</p> <p>Interview with the Medical Records Director, on 01/09/15 at 11:53 AM, revealed she used a spreadsheet to track the timing of required physician visits. She stated she sends a letter to the physician when the physician has not seen the resident to remind the physician of the visit requirements. She revealed the letters were usually hand delivered to the physician's office as well as any other documents such as physician orders that need to be signed. She stated letters were sent to Resident #1's and Resident #2's physician on 09/05/14, 09/22/14, 10/05/14, 10/22/14, 11/05/14, 11/19/14 and 12/10/14. She revealed the former Administrator was aware of the physician not seeing the residents.</p> <p>Interview with the former Administrator, on 01/11/15 at 1:17 PM, revealed he was not aware there were resident's that had not been seen by a physician. He reported the DON might have known, but if so, it wasn't communicated to him. The topic of physician visits was never brought up in Quality Assurance (QA) meetings.</p> <p>Interview with the Administrator, on 01/09/15 at 12:01 PM, revealed he has worked at the facility for two (2) weeks. He stated he had already talked with the Medical Records Director regarding the issue and would be speaking with the Medical Director as well.</p> <p>Interview with the Medical Director, on 01/09/15 at 12:34 PM, revealed he was not aware that</p>	F 387			

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F 387	Continued From page 6 Resident #1 And Resident #2 had not had the required physician visits. He stated he expected residents would be seen by a physician as outlined in the regulations. He revealed he also expected the facility to notify him if a resident had not been seen and he would see the resident as needed.	F 387			