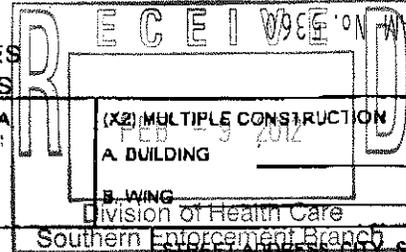


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391



Received Time: Feb. 9, 2012 11:47 AM No. 5366

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED  C 01/10/2012
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NAME OF PROVIDER OR SUPPLIER  
**NIM HENSON GERIATRIC CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**420 JETT DRIVE  
JACKSON, KY 41339**

(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:  An abbreviated standard survey (KY17620) was initiated on 01/09/12 and concluded on 01/10/12. The complaint was substantiated and deficient practice was identified at "D" level.	F 000	THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES CITED. HOWEVER, SUBMISSION OF THE PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAWS.	
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility to ensure the federally required Minimum Data Set (MDS) quarterly review instrument was utilized to assess one of sampled residents (Resident #1). Documentation revealed facility staff had completed a quarterly Minimum Data Set (MDS) assessment, with a reference date of 07/05/11, for Resident #1 and would have been required to complete the next quarterly assessment during the month of October 2011. However, based on documentation, the facility completed the assessment on 12/13/11, approximately five months from the assessment completed in July 2011.  The findings include:  An interview conducted with the Director of Nursing on 01/10/12, at 5:00 PM, revealed the facility did not have a policy related to the timely	F 276	Resident #1 had a MDS assessment completed on 12/31/11 with an updated care plan. He will be assessed on 03/12/12 and continue to be assessed timely in the future.  As of 01/20/12 100% of all residents were reviewed by MDS staff to ensure all Quarterly Assessments were completed timely.  NIIGC software vendor Accu-Med will conduct a training session on assessment requirements on 02/06/12. The DON, House Supervisor, Restorative Supervisor and MDS staff will attend. A new policy on timely MDS assessment has been adopted and a copy is attached (Attachment A). MDS staff will print a monthly schedule of assessments due. This schedule will be listed on a bulletin board in MDS office with due date and type of assessment. A copy of this calendar will be given to DON and Administrator. A daily MDS completion log will be kept by each MDS worker and a copy given to DON and Administrator weekly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Phillips Hittner* TITLE: *Administrator* (X6) DATE: *02-07-12*

Deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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NAME OF PROVIDER OR SUPPLIER  IM HENSON GERIATRIC CENTER	SINGLE ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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F 276	Continued From page 1 completion of the MDS assessment.  A review of MDS assessments completed for Resident #1 revealed the facility completed a quarterly MDS assessment with an assessment reference date of 07/05/11 for Resident #1, and did not complete another required quarterly assessment until 12/13/11.  An interview conducted with the MDS Coordinator revealed the MDS Coordinator was not aware of the requirement to complete a federally required quarterly MDS assessment when the resident was having Medicare assessments completed. The MDS Coordinator reportedly thought residents were not required to have a quarterly MDS assessment completed until they were no longer under Medicare.	F 276	The daily MDS completion log will be reviewed weekly by DON for timely assessment completion and any problems discussed with the administrator.  The care plan committee will meet weekly and review all resident assessments due for timely and accurate completion. The monthly printed report from the MDS will ensure that 100% of the residents ARD dates are maintained. Once weekly all care plans that are due based on the ARD dates are reviewed and revised by a qualified committee. The QA committee will be notified of any continued problems.	02/06/12
280 S=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	Resident #1 was assessed by MDS staff on 12/31/11 with updated care plan and wanderguard applied. Assessment and care plan for resident #1 completed timely in the future.  All residents were reassessed by MDS staff by 01/05/12 and elopement scores updated.	

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NAME OF PROVIDER OR SUPPLIER  MIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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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
F 280	<p>Continued From page 2 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and a review of facility policy, the facility failed to ensure the plan of care was reviewed and revised by a team of qualified persons after each assessment for one of five sampled residents (Resident #1). A review of Resident #1's medical record revealed the resident was confused and attempted to leave the facility on 07/20/11, and a wanderguard device was implemented at that time. Documentation revealed Resident #1 had not exhibited any additional elopement behaviors and the wanderguard device was discontinued from use on 09/15/11. However, there was no evidence the facility conducted an assessment related to the discontinuation of the wanderguard device and, based on documentation, the resident exited the facility without staff knowledge on 12/31/11.</p> <p>The findings include: A review of the facility policy entitled Elopement Policy and Procedure (with a revision date of 04/15/08) revealed all residents were assessed upon admission and quarterly, annually, and when a significant change occurs. According to the policy, residents identified as an elopement risk would have a wanderguard device placed on their person to alert staff if the resident attempted to leave the facility. The policy did not address the removal of the wanderguard device from the</p>	F 280	<p>The elopement/reduction policy has been updated to include the removal of wanderguard. See Attachment B. All nurses will be inserviced on this policy by 02/06/12 MDS Staff, DON, Nurse Supervisor and Restorative Nurse will be trained on required assessments and care plans by NIIGC software vendor. Accu-Med on 02/06/12. 100% of all resident assessments due based on Assessment Reference Date from Monthly schedule will have their care plan reviewed and revised by the care plan committee weekly.</p> <p>The care plan committee will monitor all due assessments weekly for timely completion and the development of a comprehensive care plan. The DON/Designee will do a monthly audit for compliance. QA committee will be consulted for input when necessary.</p>	02/06/12

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NAME OF PROVIDER OR SUPPLIER  W HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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F 280	<p>Continued From page 3</p> <p>resident's person if the resident was no longer identified as an elopement risk.</p> <p>A review of the record for Resident #1 revealed the facility admitted the resident on 04/23/10, with diagnoses that included Depression, Anxiety, and Late Cardiovascular Accident. Additional review of the record revealed the resident was confused and attempted to leave the facility on 07/20/11. According to the record a wanderguard device was place on the resident at that time. However, documentation revealed Resident #1 had not exhibited any elopement behaviors since application of the device and the wanderguard device was discontinued from use on 09/15/11.</p> <p>A review of a facility incident/accident report for Resident #1 dated 12/31/11, revealed a family member of another resident had reported to facility staff that an elderly gentleman was on the road in front of the facility with a wheelchair.</p> <p>An interview conducted with Resident #1 on 01/09/12, at 12:30 PM, confirmed the resident had made an attempt to leave the facility "a couple of weeks ago." According to the resident, facility staff found the resident outside in the parking lot and had taken him/her back into the facility.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 01/09/12, at 1:10 PM, revealed the RN was notified by a family member of another resident on 12/31/11, during the noon meal that a resident was on the road in front of the facility. The RN stated she went outside, found Resident #1 walking on the road in front of the facility, and assisted the resident back inside the facility.</p>	F 280		

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F 280	<p>Continued From page 4</p> <p>According to RN #1 the resident was in no distress and stated that he/she was going home.</p> <p>A review of video surveillance revealed that on 12/31/11, at 12:27 PM, Resident #1 dressed in a coat and hat and exited the back door of the facility and was returned to his/her room by facility staff at 12:49 PM.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 01/09/12, at 2:45 PM, revealed LPN #1 had called Resident #1's physician on 09/15/11, and informed the physician that Resident #1 had not continued to exhibit wandering behaviors and the physician had requested the use of the wanderguard device to be discontinued. Further interview with the LPN revealed Resident #1 only exhibited exit-seeking behaviors when the resident had confusion related to an illness, had not exhibited wandering behavior since 07/20/11, and the LPN had informed the physician and discontinued the device without the completion of an assessment. According to LPN #1, a care plan update to discontinue the wanderguard device was completed by the LPN on 09/15/11, and the care plan had not been revised to reflect the needs of the resident related to supervision or monitoring.</p> <p>An interview conducted with the MDS Coordinator on 01/09/12, at 4:20 PM, revealed the facility did not have specific assessment guidelines related to the discontinuation of a wanderguard device nor was aware of any specific assessment criteria for the discontinuation of a wanderguard device. Further interview revealed the resident's care plan was not revised to include interventions to ensure monitoring of the resident after the</p>	F 280		

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NAME OF PROVIDER OR SUPPLIER  NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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F 280	Continued From page 5 wanderguard was discontinued.	F 280		

## MDS ASSESSMENT POLICY

The goal of Nirm Henson Geriatric Center is to provide excellent care for all residents. All resident assessments will be completed per the RAI manual. Both OBRA and PPS guidelines will be followed to ensure timely assessments.

ATTACHMENT A

## Wanderguard Reduction Policy

In the event it is determined by the care plan committee and physician that a resident no longer needs the wanderguard device the following measures will take place. The device will remain in place until the elopement assessment is updated to see if the resident is an appropriate candidate for reduction, the seven day reduction form is completed to determine if still appropriate, the elopement assessment is completed again in 30 days after the seven day reduction to assure that reduction is still appropriate and then discussed once again with the care plan committee to ensure the device can be reduced.

ATTACHMENT B