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

PRINTED: 03/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185224		02/24/2011

NAME OF PROVIDER OR SUPPLIER
MEDCO CENTER OF BOWLING GREEN

STREET ADDRESS, CITY, STATE, ZIP CODE
1561 NEWTON AVE.
BOWLING GREEN, KY 42104

(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	F 000		
	The annual standard skilled survey for recertification was conducted on 02/21-24/11 in conjunction with an abbreviated complaint survey KY15746, KY15688, and KY15459. The facility was found to not meet the minimum regulatory requirements and a statement of deficiencies was issued with the highest S/S at a "G" level. The LSC Survey was conducted on 02/24/11.		F 151- Right to Exercise Rights	4/5/11
	KY #15459 regarding quality of care was unsubstantiated. KY# 15688 was substantiated for Quality of Care and Physical Environment and a statement of deficiencies was issued. KY#15746 regarding Neglect was substantiated and a statement of deficiencies was issued.		1. Residents' #17, #18 and #19 will be interviewed by the Life Enrichment Director by 4/5/11 and added to the list of residents who wish to vote.	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	F 151	2. A 100% audit of residents will be completed by the Life Enrichment Director by 4/5/11 to identify any who wish to vote. Those identified will be added to the voting list.	
	The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure three (3) of nineteen (19) sampled residents exercised his/her rights as a resident of the facility and as a citizen of the United States. Residents #17, #18 and #19 were not given the opportunity to vote by the facility after the requests were provided to the facility.		3. The Life Enrichment Director will be re-educated by the Administrator by 4/5/11 on providing all residents with the opportunity to vote. The Life Enrichment Director will notify all residents upon admission of their right to vote. A running list of residents who have expressed interest in voting will be kept by the Life Enrichment Director and updated with new admissions and discharges. 4. The Administrator will review with new admissions for the month their	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 3/18/11

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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F 151	Continued From page 1 The findings include: Record review of the facility's Bill of Resident Rights (undated) on 02/22/11 revealed the facility will protect and promote each of the resident rights: 1. You have the right to exercise your rights as a resident of the facility and as a citizen or a resident of the United States. Group interview on 02/22/11 at 3:00PM revealed Residents #17, #18 and #19 expressed to the activities director the desire to vote during the general elections, but never heard anything back from her. Residents #17, #18 and #19 reported they had all been active voters prior to living at this facility. Residents #17 and #19 reported each had lived at the facility for approximately three (3) years and never had the opportunity to vote since living there. Resident #18 has lived at the facility for approximately five (5) years and had not voted while living there. Residents #17, #18 and #19 expressed the desire to vote in the elections. Interview with the Administrator on 02/24/11 at 11:45AM revealed all residents should have the opportunity to vote if they choose to vote. He reported it is the resident's right to be able to vote. The Administrator reported he was not aware the residents' voting rights had not been completed upon their request.	F 151	wishes to vote and compare to the voting list monthly for 3 months. Results of the audit will be reviewed by the Quality Assurance Committee monthly for 3 months to ensure all residents have been notified of their right to vote and are on the resident voting list if desired. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	F253- Housekeeping & Maintenance Services 1. The hot water boiler was repaired by an outside vendor on 2/24/11. 2. Water temperatures were checked multiple times during survey and on-going for the next week to ensure they were the appropriate temperature. The	4/5/11

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F 253	Continued From page 2 This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a comfortable environment. The hot water temperatures varied from 48 degrees to 96 degrees. Two (2) of nineteen (19) sampled residents (Resident's #3 and #11) expressed discomfort with the water temperatures during grooming. The findings include: The hot water temperature logs provided by the facility dated 01/03/11 - 02/22/11 revealed temperatures had been recorded within a range between 101-110 degrees Fahrenheit. Interview with Resident #3 on 02/21/11 on initial tour at 6:30pm revealed the water temperature in the resident's room as well as the shower had been so cold he/she could not shave or take a shower. The resident stated he/she would not take a shower again until the cold water was fixed in the shower room. Observations of water temperatures on 02/22/11, between 8:42am and 9:30am, revealed a range of hot water temperatures between 48 and 96 degrees Fahrenheit in resident rooms (2, 4, 6, 7, 9, 11,15, 17, 23, 28, 32, and 34). The "A" hall shower reached a maximum temperature of 90 degrees when checked. Temperatures taken in Resident #3 ' s room (3B) on 02/22/11 at 9:45am was 96 degrees.	F 253	water temperature was 106 degrees on 2/24/11 as noted by the Administrator. 3. The Maintenance Supervisor was re-educated on 2/25/11 by the Administrator on the policy and procedures related to water temperatures. Water temperatures will be checked daily to ensure continued compliance. Any temperatures above or below the acceptable range of 100 – 110 degrees will be addressed immediately. 4. The Quality Assurance Committee will review the water temperature logs monthly for 3 months for further recommendations as needed. If at any time concerns are identified a Quality Assurance meeting will be held to address concerns and implement further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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F 253	Continued From page 3 Interview on 02/22/11 at 9:03am with LPN #3 revealed water in the resident rooms does not get very hot. Interview on 02/22/11 at 9:30am with Resident #11 revealed the water does not get hot enough to shave comfortably. A recheck of water temperatures on 02/22/11, beginning at 12:45pm with the Maintenance Supervisor, revealed a range of water temperatures from 85 degrees to 110 degrees. The 85 degree temperature was the maximum temperature obtained in room 34 after running the water for six (6) minutes. Interview with the Maintenance Supervisor on 02/23/11 at approximately 3:00pm revealed the water coming from the boiler is about 95-100 degrees Fahrenheit. He stated the water then goes through a mixing value where it is mixed with more cold water. Interview with the Administrator on 02/24/11 at 11:00am revealed the water temperatures are checked on Tuesdays and they had not identified a problem in the past. The administrator stated the maintenance director was trained upon hire regarding proper temperatures, what to do if the temperatures are not within those parameters, and on the ability to make those adjustments. The administrator also stated that daily temperatures are checked if there are issues. In addition, the administrator revealed that a repairman had been called and would be checking out the problem.	F 253		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F279- Develop Comprehensive Care Plans	4/5/11

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F 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation, it was determined the facility failed to develop a comprehensive plan of care for two (2) of nineteen (19) sampled residents (#8 and #10). The facility failed to implement care plan interventions for Resident #8. Bowel movements documented on the Care Tracker were not monitored. The failure to monitor the bowel movements resulted in the facility not implementing the intervention of providing medication to the resident to aid in bowel elimination. This failure resulted in the hospitalization of Resident #8 with a fecal impaction, pain and fever. The facility further	F 279	1. Resident #8's bowel elimination care plan interventions are in place as of 3/16/11 as confirmed by the Director of Nursing. Resident #10's care plan has been updated by the Director of Nursing on 2/25/11 to identify the treatment for head lice. 2. A 100% audit of all resident care plans will be completed by the interdisciplinary team by 4/5/11 to ensure that interventions are appropriate for each individual and that interventions are in place. Any identified concerns will be immediately corrected. 3. The licensed nursing staff and interdisciplinary team will be re-educated by the Education and Training Director on the policy and procedures related to the care planning process and following the residents plan of care by 4/5/11. 4. The Director of Nursing will audit 5 charts per week for 12 weeks to assure care plans are up to date, risk factors are identified and interventions are in place and being followed. Results of the auditing will be reviewed with the Quality Assurance Committee monthly for 3 months and according to Quality Assurance Committee recommendations thereafter. If at anytime a concern is identified a Quality Assurance Committee meeting will be held for further recommendations. The Quality	

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F 279	Continued From page 5 failed to include the treatments for head lice ordered on Resident #10 into the care plan. The findings include: 1. The facility policy on Plan of Care (Revised October 2008) revealed a complete care plan includes realistic and measurable resident goals. It will include specific individualized interventions. It is further revealed, the care plan may include pre-printed pages with goals listed which require being checked off (place a check in a pre-printed box) to constitute an active goal. Interview on 02/24/11 at 9:27am with the Clinical Reimbursement Coordinator revealed only the items checked on the pre-printed care plan forms are active goals for the resident. Hand written goals may be included. Resident #8's care plan had no written goals. Resident #8 did have listed as interventions "Monitor bowel elimination using Care Tracker" and "Provide medication as ordered to aid in elimination". Resident #8 was originally admitted on 11/02/06 to the facility with a diagnoses of Alzheimer's, dementia, diabetes, hyperlipidemia, atrial fibrillation and osteopenia. Review of the last annual Minimum Data Set (MDS) ,Version 2.0 dated 06/04/10, revealed the resident has severe cognition impairment, requires extensive assistance with toileting and extensive assistance to eat and drink. The resident is on the medication Lasix and aspirin. There is also a history of constipation. Review of the care plan dated 02/07/11 for Resident #8 revealed Alteration in Bowel Elimination as being identified as a problem.	F 279	Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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F 279	Continued From page 6 Noted on the care plan the identifying factors which make bowel elimination a problem are: history of constipation and incontinence, the medications lasix and aspirin, a diagnosis of Alzheimer's, dementia and diabetes, and being a dependent transfer. Interventions included monitor bowel elimination using Care Tracker and provide medication as ordered to aid in elimination. Review of the Care Tracker revealed the facility failed to monitor the bowel movement results for Resident #8. The resident had no bowel movement or only a small bowel movement on December 9, 10, 11, 12, 13, 23, 24, 25, 26, 27, 28, 29, 30, 31/2010. In January 2011, on the following dates, there were no bowel movements: 1, 4, 5, 6, 7, 8, 9, 16, 17, 18, 22, 23, 24, 25 and through second shift on January 26, when the resident was transported by ambulance to the Emergency Room . Review of the Medication Administration Record (MAR) for January 2011 revealed the resident had an order for MOM (milk of magnesia) 30cc to be given as needed (for constipation). However, the medication was never administered on any of the days the resident did not have a documented bowel movement as was an intervention on the care plan. On 01/26/11 at 1:10pm record review revealed documented in the nurses notes, Resident #8 was restless, abdomen distended and bowel sounds sluggish. The resident had facial grimace upon palpitation of the abdomen. The resident was transported to the Emergency Room. 01/26/11 at 1:30pm the emergency record	F 279		

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F 279	Continued From page 7 revealed "abdominal distention" (swelling), pain and fever. Resident #8 was admitted with a fecal impaction. Hospital documentation further revealed it required several days to provide significant results and relief to the resident. Hospital documentation dated 01/30/11revealed the impaction was resolved; five (5) days after the resident was initially admitted. Interview on 02/22/11 at 3:05pm with the daughter of the resident revealed the resident is "total care", is not involved in any activities and is bed ridden. Interview on 02/24/11 at 7:50am with RN#3 revealed the purpose of the care plan is to know how to take care of the residents and what interventions the staff needs to put in place. Interview with the Assistant Director of Nursing on 02/24/11 at 8:55am revealed the purpose of the care plan is to identify potential problems, set a reachable goal, and have interventions in place to prevent the problem from occurring. 2. Record review of Resident #10 revealed an admission on 07/20/06 with the diagnosis of Hypertension, Chronic Airway Obstruction Disease, Advanced Dementia with Agitated Behaviors and Adult Failure to Thrive. The facility assessed the resident as cogitively impaired on the quarterly minimal data set dated 12/31/10. Record review of the physician orders for Resident #10 dated 02/13/11 revealed orders to	F 279		

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F 279	Continued From page 8 apply RID (lice treatment) to scalp and hair until entirely wet. Record review of physician orders dated 02/18/11 revealed an order for lice treatment to scalp now and again in one week. However, new physician orders dated 02/22/11 for repeat lice treatment in the morning and in seven (7) days, and may use the electric nit comb daily for the next eight (8) days. Record review of Resident #10's resident care plan (RCP), revised 02/21/11, revealed the resident's treatment plan did not address head lice treatments in the RCP, nor was the RCP updated anytime between 02/21/11 through 02/24/11 to reflect the treatment plan. Observation on 02/23/11 at 6:50am revealed a treatment cart placed at the entrance of Resident #10's door with a container labeled for this resident's treatment of lice. Interview with LPN #3 on 02/23/11 at 7:15am revealed the nursing staff does take off the physician orders to update the medication administration record and care plans with the new orders. Interview with the Clinical Reimbursement Coordinator (CRC), on 02/24/11 at 9:25am, revealed she is responsible to complete a comprehensive care plan for each resident. She reported the nurses taking off any new orders are to care plan the orders at the time the order is received, and she would review to ensure each of the triggers were care planned as well as any orders when she does her reviews, if they are not already care planned.	F 279		

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F 279	Continued From page 9 Interview with the Director of Nursing (DON) on 02/24/11 at 9:50am revealed the nurses are to update the resident care plan when the physician orders are transcribed and the Clinical Reimbursement Coordinator (CRC) updates the care plans at the time of her reviews and with any triggers identified. She reported there is not a tracking tool or audits in place to ensure the care plans are updated when the orders are transcribed.	F 279		
F 280 SS=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 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to revise the care	F 280	F280- Right To Participate Planning Care 1. Resident #4's care plan was updated on 3/14/11 by the Director of Nursing to reflect residents' wishes regarding securing of her catheter. A meeting will be held with Hospice Services by 4/5/11 to integrate care plans on resident #10. 2. Catheter care plans for all residents with catheters will be reviewed and updated as necessary by the interdisciplinary team by 4/5/11 to ensure accuracy. As of 3/14/11 there are no other hospice residents at this time. 3. Nursing staff will be re-educated by the Education and Training Director by 4/5/11 on securing Foley catheters as directed by assignment sheet and proper procedures for resident refusals. The Interdisciplinary Team will be re-educated by the Director of Nursing by 4/5/11 on the policy and procedures	4/5/11

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F 280	Continued From page 10 plan for two (2) of nineteen (19) sampled residents (#4 and #10) to address the anchoring of an indwelling catheter and the integration of the Hospice care plan. The findings include: Review of the facility's procedure guidelines from Mosby 8th Edition, General Procedures and Treatment Modalities, Management of the patient with an indwelling catheter and a closed drainage system revealed 2. To secure the indwelling catheter to the patient's thigh using tape, strap, adhesive anchor, or other securement device. 1. Record review of Resident #4 revealed an admission to the facility on 07/21/10. The diagnosis included Congestive Heart Failure, Chronic Kidney Disease, Depression, Diabetes Mellitus, Urinary Tract Infection and Pressure Sore to low back. The facility assessed the resident as cognitatively intact during the Quarterly Minimum Data Set (MDS) dated 12/24/10. Observation of indwelling catheter care on 02/23/11 at 9:40AM revealed the catheter was not secured to the resident's thigh prior to catheter care, nor was the catheter anchored to the resident's thigh post catheter care. Interview with Resident #4 on 02/24/11 at 7:40AM revealed the catheter did not bother him/her when it was loose. The resident reported the leg band that was on his/her leg was tight, so it felt better off. Interview with Certified Nurse Assistant (CNA) #3 on 02/24/11 at 7:50AM revealed Resident #4	F 280	related to the care planning process and following the residents plan of care and integration of care plans with hospice services. 4. All catheter care plans and all hospice care plans will be reviewed monthly for 3 months for continued compliance by the interdisciplinary team. Monitoring will be presented to the Quality Assurance Committee for further recommendations. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185224		02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 280	Continued From page 11 really did not like the leg band on because the band was tight on the resident's leg; therefore, the band was removed. CNA #3 reported the indwelling catheters are not routinely secured to the resident's leg and are left loose. CNA #3 reported indwelling catheters were painful if tugged on. Interview with the Director of Nursing (DON) on 02/23/11 at 3:25PM revealed the only policy the facility used for indwelling catheter care was the Mosby's procedures and treatment modalities. She reported the guidelines are what staff are suppose to be using when giving care to residents. 2. Record review of the agreement for Hospice services dated effective 07/20/10 revealed section 4.2 The Nursing Facility plan of care in accordance with applicable federal and state laws and regulations, the Nursing Facility shall revise it Nursing Facility Plan of Care with the Hospice Plan of Care for each Residential Hospice Patient and will furnish Hospice with a copy. The nursing facility will consult with Hospice, as reasonable necessary, with respect to any modification of the Nursing Facility Plan of Care for the Residential Hospice patient. The Nursing Facility agrees that the Nursing Facility Plan of Care will be consistent with the Hospice Plan of Care for a Residential Hospice patient and will coordinate care and services provided to the Residential Hospice patient with in Hospice. Record review of Resident #10 revealed an admission to the facility on 07/20/06. The diagnosis included Hypertension, Chronic Airway Obstruction Disease, Advanced Dementia with Agitated Behaviors and Adult Failure to Thrive.	F 280		

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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BOWLING GREEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104	

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F 280	Continued From page 12 The facility assessed the resident as cogitatively impaired at a level three (3) on the quarterly Minimum Data Set (MDS) dated 12/31/10. Interview with the Clinical Reimbursement Coordinator (CRC), on 02/24/11 at 9:25AM, revealed she is responsible to complete a comprehensive care plan for each resident. The CRC reported Resident #10 has been a patient of Hospice since 08/09/10 as evidenced by the Hospice care plan. She reported the nurses taking off any new orders are to care plan the orders at the time the order is received. She would review to ensure each of the triggers were care planned as well as any orders when she did her reviews if they were not already care planned. She reported Hospice was identified on the MDS, but had not integrated the facility and the Hospice care plan. Interview with the Director of Nursing (DON) on 02/24/11 at 9:50AM revealed the nurses are to update the resident care plan when the physician orders are transcribed and the Clinical Reimbursement Coordinator (CRC) updates the care plans at the time of her reviews with any triggers identified. The DON reported she was not familiar with the details of the Hospice contract. The DON was unable to provide evidence of an integrated nursing facility care plan to show what services were provided for each entity providing services. The DON was unable to define the services and the frequency of the services provided by Hospice. She reported there is not a tracking tool or audits in place to ensure the care plans are updated when the orders are transcribed.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	F282- Services By Qualified Persons/Per Care Plan	4/5/11

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F 282	Continued From page 13 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement care plan interventions for one (1) resident (Resident #11) out of nineteen (19) sampled residents. The facility failed to monitor the bowel elimination of Resident #11 and further failed to provide physician ordered medication to aid in elimination. The findings include: The facility provided policy on Plan of Care (Revised October 2008) revealed specific individualized interventions will be listed on the care plan and will include the discipline responsible to provide the intervention. Review of the care plan for Resident #11 revealed the interventions: Monitor bowel elimination using CareTracker (the facility system of documentation for bowel movements), and provide medication as ordered to aid in elimination. Review of the Bowel and Bladder Chart Detail Report revealed Resident #11 had no bowel movements documented January 2, 3, 4, 5 and 6. No documented bowel movements January 11, 12, 13 and 14 and none documented on January 25, 26, 27, 28. Further review of records revealed no bowel movements documented on February 4,	F 282	1. Resident #11 is being monitored for bowel elimination and interventions are being implemented per the bowel elimination plan of care as noted by the Director of Nursing on 3/18/11. 2. A 100% audit of all resident care plans will be completed by the interdisciplinary team by 4/5/11 to assure interventions are in place. 3. Licensed nursing staff will be re-educated by the Education and Training Director on 4/5/11 on following the care plan interventions. 4. The Director of Nursing will audit 5 resident records per week for 12 weeks to assure interventions are in place. Results of the audits will be reviewed with the Quality Assurance Committee monthly for 3 months and according to Quality Assurance Committee recommendations thereafter. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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F 282	Continued From page 14 5, 6, 7 and 8. In addition, no bowel movements documented February 11, 12, 13 and first shift on the 14th. Review of the Medication Administration Record (MAR) for Resident #11 revealed in the month of January 2011 the medication ordered as needed for constipation was administered only once. Review of the MAR for February 2011 revealed the resident was started on a prescription of Miralax, 17grams, to be taken in eight ounces of water at 7am each morning, beginning February 10, 2011. However, the facility failed to follow the intervention of tracking the bowel movements of Resident #11, which lead to a complaint of constipation on 02/14/11. Review of the resident's chart revealed a nurses note entry on 02/14/11 at 9:55am where the resident complained of constipation. Interview on 02/24/11 at 7:40am with RN #3 revealed a bowel protocol is to be followed when the resident had no bowel movement or a small bowel movement in the last three (3) days or nine (9) shifts. The protocol called for either Milk of Magnesia to be given, if there is a standing order, and if not, the physician is to be notified. Interview on 02/24/11 at 8:20am with the Assistant Director of Nurses revealed every morning a bowel sheet is printed to indicate which residents did not have a bowel movement in three (3) days. If the resident did not have a bowel movement in three (3) days, the bowel protocol would be initiated.	F 282		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	F 283	F283- Anticipate Discharge: Recap Stay/Final Status	4/5/11

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F 283	Continued From page 15 When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to have a discharge summary that included a recapitulation (summary) of the resident's stay for one (Resident #14) of three (3) sampled resident closed records reviewed. Resident #14 was discharged from the nursing facility on 01/18/11 without an interdisciplinary discharge note that would include education material, medication list and instructions, follow-up physician appointments, and any supplies/equipment needed after discharge. The findings include: Review of Resident #14's closed clinical record revealed the resident was discharged from the nursing facility to home without any discharge instructions or a discharge summary completed that would recapitulate (summarize) the resident's stay. The record revealed no interdisciplinary discharge note that would include medication instructions, education, community referrals, and supplies/equipment needed after discharge. In addition, the record revealed there was no physician order to discharge the resident until two	F 283	1. Resident #14 is no longer in facility. 2. A 100% audit of residents with planned discharges in the last 30 days will be completed by the Social Services Director by 4/5/11 to determine if any required a discharge summary and/or recapitulation of stay that didn't receive one. If any are identified as not having a discharge summary the Social Services Director will complete and review with the resident or family by 4/5/11. Any resident identified as not having a recapitulation of stay will have one completed and placed in their medical record by the Social Services Director by 4/5/11. 3. The licensed nursing staff and interdisciplinary team will be re-educated by the Education and Training Director by 4/5/11 on the policies and procedures related to completion of discharge summary and/or recapitulation of stay. 4. Director of Nursing and/or Medical Records Clerk will audit all planned discharges weekly for 12 weeks to ensure summary/recapitulation of stay was appropriate. Monitoring results will be presented to the Quality Assurance Committee for review and further recommendations. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations	

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F 283	Continued From page 16 (2) days later (01/20/11). The physician order stated "ok that resident was discharged." Interview with the Medical Record Director on 02/24/11 at approximately 10:00am revealed a search of the records did not find a discharge summary for Resident #14. She stated nursing was responsible for that task. Interview with the Director of Nursing on 02/24/11 at 10:20am revealed she was not aware a discharge summary and discharge instructions were not given to the resident upon discharge. She revealed she was not working at the facility when the resident was discharged; however, it was the facility's practice that discharge instructions would be given prior to discharging a resident. A discharge summary should have been completed.	F 283	as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
F 309 SS=G	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 interview and record review, it was determined the facility failed to fully implement the bowel and bladder program to include the bowel protocol. The facility failed to monitor resident bowel movements and address with interventions those residents care needs per the protocol for	F 309	F309- Provide Care/Services for Highest Well Being 1. Resident's #1, #8, #11 and #12 are being monitored for bowel elimination and interventions are being implemented as care planned as noted by the Director of Nursing on 3/16/11. On 3/16/11 a review of resident #1, #8, #11, #12 bowel elimination records by the Director of Nursing noted that residents #1, #8, #11 and #12 were having regular bowel movements and care plan interventions were in place. 2. A review of all residents bowel elimination records will be conducted by	4/5/11

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F 309	Continued From page 17 four (4) of nineteen (19) sampled residents (Resident #1, #8, #11 and #12). On 01/26/11 the facility assessed Resident #8 as restless, having abdomen distention, bowel sounds diminished, and noted the resident grimaced upon palpitation of the abdomen. The facility transferred Resident #8 to the hospital and was subsequently admitted with a diagnosis of fecal impaction. The facility assessed Resident #11at risk for constipation, however, failed to implememt the bowel protocol to prevent constipation. On 02/14/11 Resident #11 complained of constipation after having no bowel movement since 02/10/11 and the facility taking no action. Resident #11 was noted to complain of constipation prior to any intervention. The findings include: Review of the Bowel and Bladder Program Procedure (Revised January 2009) provided by the nursing facility included the following points to be addressed to manage constipation: include resident goals and interventions on the Alteration in Bowel Elimination/Plan of Care, Initiate/Update the Alteration in Bowel Elimination/Plan of Care on all residents identified with constipation, and document elimination results using the Care Tracker. Further review of the program revealed the facility did not include a process to monitor the results of the Care Tracker data/information; therefore, the nursing staff did not have access to a system of notification when residents did not have a bowel movement for three (3) days. The nursing staff would not know when to initiate or implement an intervention(s). A bowel protocol	F 309	the Director of Nursing by 4/5/11 to assure all residents were having regular bowel movements and that any resident who was not having regular bowel movements were receiving interventions per the plan of care. 3. Licensed nursing staff have been re-educated by the Education and Training Director on 2/24/11 on pulling and reviewing the bowel elimination caretracker report at a minimum of daily and initiating appropriate interventions as necessary. 4. The Director of Nursing will monitor the pulling of the bowel elimination caretracker report daily, 5 times a week, to ensure continued compliance. Results of the monitoring will be reviewed with the Quality Assurance Committee monthly for 3 months and according to Quality Assurance Committee recommendations thereafter. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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F 309	Continued From page 18 document was not provided. Interview with the Regional Nurse Consultant on 02/23/11 at 1:50pm revealed there had been a problem with the nursing staff documenting residents bowel movements. She stated this problem was identified during the investigation of Resident #8's fecal impaction on 01/26/11. She acknowledged staff were not documenting in the Care Tracker consistently whenever a resident had a bowel movement. She indicated education was provided and the nursing assistants are supposed to record each bowel movement in the Care Tracker system. (The in-service training record provided addressed nursing staff and not the nursing assistants.) The nurse is suppose to pull the Bowel Chart Detail Reports and if a resident has not had a bowel movement within three (3) days, the facility's Bowel Protocol is suppose to be implemented. However, there was no documented evidence the nurses were utilizing the Bowel Detail Reports. The Nurse Consultant stated the sheets the nurses use to determine which resident may need interventions are thrown away after the nurse's shift. Continued interview revealed there was no documentation kept on residents that have been noted in the past to have gone three (3) or more days without a bowel movement. Interview on 02/23/11 at 9:20am with LPN #1 revealed the bowel protocol followed by the facility is to give the resident Milk of Magnesia (MOM) after three (3) days with no bowel movement. If the resident does not have an order for MOM, the physician is called and an order obtained. It was stated there is a system that flags those residents who have not had a bowel movement in three (3) days, which is how the nurses know the bowel	F 309		

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F 309	Continued From page 19 status of the residents. However, the facility could provide evidence that this monitoring was completed. Interview on 02/23/11 at 2:20pm with LPN #2 revealed the bowel protocol is charted in the kiosk (computer touch screen located on the wall). If the resident fails to have a bowel movement in three (3) days, MOM or a laxative is given. It was further revealed the nurses print off the list of those residents that have not had a bowel movement or small stool only within three (3) days. However, there was no documented evidence the facility implemented this process with Resident #8 when the resident went 5 days with no bowel movement or had only a small bowel movement prior to the resident's transfer to the hospital with a fecal impaction. Interview on 02/23/11 at 2:25pm, with RN #1 revealed if the nurses did not have the bowel report, someone had failed to print them. It was revealed there is no log or method of documentation to assure the bowel protocol is being followed. Interview on 02/24/11 at 8:10am with CNA #5 revealed the bowel and bladder program for the resident is on their care plan. The care plan is updated daily and as needed. 1. Resident #8 was admitted on 11/02/06 to the facility with a diagnoses of Alzheimer dementia, diabetes, hyperlipidemia, atrial fibrillation and osteopenia. Review of the last annual Minimum Data Set (MDS), dated 06/04/10, revealed the facility assessed Resident #8 with severe cognition impairment, requiring extensive assistance with toileting and extensive assistance	F 309		

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F 309	Continued From page 20 with eating and drinking. Review of the nutritional care plan dated 02/01/11 revealed Resident #8 at risk for constipation. The care plan detailed the resident's history of constipation under the problem list for Alteration in Bowel Elimination. Interventions on the care plan included monitoring bowel elimination with the Care Tracker and provide medication as ordered to aid in elimination. Review of the bowel record for Resident #8 revealed the resident had no bowel movement or only a small bowel movement in 2010 on December 9, 10, 11, 12, 13 with no intervention, December 23, 24, 25 with no intervention, December 26, 27, 28 with no intervention, continuing on December 29, 30, 31 with no intervention. Repeatedly, no action or follow up. In January 2011, on the following dates, there were no bowel movements: 1, 4, 5, 6 with no intervention, 7, 8, 9 with no intervention, 16, 17, 18 with no intervention, 22, 23, 24, 25 and through second shift on January 26, with no intervention until the resident was transported by ambulance to the Emergency Room . Review of the Medication Administration Record (MAR) for January 2011 revealed the resident had an order for MOM (milk of magnesia) 30cc to be given as needed (for constipation). However, there was no documented evidence the facility administered medication on any of the days the resident did not have a documented bowel movement. Review of nurse's notes on 01/26/11 at 1:10pm revealed Resident #8 was restless, the abdomen was distended, bowel sounds were sluggish and	F 309		

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F 309	Continued From page 21 the resident was grimacing. The physician was notified and orders were received to transport the resident to the Emergency Department for evaluation. Review of the Transfer form completed by LPN #3 on 01/26/11 at 12:45pm revealed the reason for the transfer was the resident had no bowel sounds, abdominal distention (swelling) and rebound tenderness (when you press in on the belly then let go it causes pain). Review of The Emergency Physician Record dated 01/26/11 revealed the resident was documented as having pain in the lower mid abdomen, decreased bowel sounds and a fever. A Computerized Tomography (CT) scan dated 01/26/11 revealed a "massive rectal and sigmoid (the part of the colon immediately above the rectum) fecal impaction." The resident was hospitalized from 01/26/11 through 01/31/11. The discharge summary electronically signed by the physician dated 02/14/11 noted the resident was placed on a bowel regimen which required several days to provide significant results. Hospital document dated 01/30/11 shows the impaction resolved. The final diagnoses included: abdominal pain, severe constipation, acute renal failure secondary to severe constipation and urinary retention, secondary to severe constipation. 2. Resident #11 was admitted on 09/09/09 with the diagnoses of muscular atrophy, dysphagia, lack of coordination, abnormal posture and	F 309		

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F 309	Continued From page 22 abnormal gait. The current MDS assessment dated 02/01/11 revealed the facility assessed the resident as requiring extensive assistance with toileting. Review of the medical record revealed a physician's order dated 11/27/09 for Colace 100mg capsule to be given once a day as needed for constipation. Review of the Bowel and Bladder Chart Detail Report revealed Resident #11 had no bowel movement in 2011 on January 2, 3, 4, 5 and 6 with no intervention. No bowel movement January 11, 12, 13 and 14 with no intervention and none on January 25, 26, 27, 28 with no intervention. No bowel movement on February 4, 5, 6, 7 and 8 with no intervention. No bowel movement February 11, 12, 13 and first shift on the 14th. Review of the resident's clinical record revealed a nurses' note dated 02/14/11 at 9:55am where the resident complained of constipation. Review of the January 2011 Medication Administration Record (MAR), for Resident #11, revealed the medication was administered once. Review of the MAR for February 2011 revealed due to Resident #11's continued complaints of constipation, the physician ordered another laxative to be given routinely on 02/10/11. The physician ordered Miralax, 17grams, to be taken in eight ounces of water at 7am each morning . This is documented in the MAR as given starting on 02/10/11. However, Resident #11 complained	F 309		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185224		02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 309	Continued From page 23 of constipation on 02/14/11 and review of the bowel records revealed no documented bowel movements on February 11, 12, 13, and first shift of the 14th. 3. Review of Resident #12's clinical record revealed the resident was admitted on 12/31/08 with diagnoses of Pneumonia, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus and past history of Hip Fracture. Review of the 09/01/10 Resident Assessment Protocol Summary (RAPS) revealed the facility identified Resident #12 as having the potential for dehydration. Review of the Bowel Data Assessment dated 01/27/11 revealed the resident was frequently incontinent of bowel and received Calcium channel blockers, antidepressants, diuretics, and NSAIDS. However, review of the current care plan revealed no documented evidence the facility identified the potential for constipation. The care plan had checked for diarrhea. Record review revealed no documented evidence the facility took any action related to Resident #12 having no bowel movement for six (6) days. The Care Tracker on 02/23/11 revealed no bowel movement on 01/16, 01/17, 01/18, 01/19, 01/20, and 01/21/2011. Interview with the Director of Nursing (DON) on 02/14/11 at 10:30am revealed that each nurse should print a daily Care Tracker report and provide the report to the medication nurse. The medication nurse will review the report and give medication for constipation to residents with no bowel movements for three (3) days. The DON	F 309		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BOWLING GREEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104	

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F 309	Continued From page 24 revealed she would take responsibility to ensure the bowel status is monitored, as this had not been done previously. The DON stated she had only been at the facility for two (2) weeks. 4. Review of Resident #1's clinical record revealed the resident was re-admitted to the facility on 11/29/10 with diagnoses of Pneumonia, Chronic Obstructive Pulmonary Disease, Neuropathy, Chronic Back Pain, and Cerebral Palsy.The facility assessed Resident #1 at risk for constipation related to taking pain medications (Lortab 10/325 every 6 hours/as needed and MS 30mg twice a day). The physician ordered a stool softener daily for constipation. The resident was in the hospital 11/18/2010 through 11/29/2010 for wound skin graft. Review of hospital documentation revealed a physician note dated 11/22/10 where the resident experienced a fecal impaction that had to be manually removed. Review of the Resident Assessment Protocol Summary (RAPS) dated 09/24/10 revealed the facility assessed the resident being at risk for dehydration, incontinent of bowel and requiring extensive assist of two persons to toilet. Observation of Resident #1 revealed the resident sat in a wheelchair for extended periods of the day on 02/22/11 and 02/23/11. Review of the bowel record on the Care Tracker revealed Resident #1 had no bowel movement on December (2010) 12, 13, 14, 15, 16, 18, 19,	F 309		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185224		02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 25 20, 21, 26, 27, 28, 29, and 29th. January (2011) 10, 11, 12, 13, 14,16, 17, 18, 19, 20, 21, 22, 24, 25, and 26th. In addition, no bowel movements were documented from January 31-February 8, 2011 (9 days). Review of the care plan revealed the facility was to monitor bowel movements and administer stool softener as ordered. Interview with the Regional Nurse Consultant on 02/23/11 at 1:50pm revealed there had been a problem with the nursing staff documenting residents bowel movements. She acknowledged staff were not documenting in the Care Tracker consistently whenever a resident had a bowel movement. She indicated education was provided and the nursing assistants are suppose to record each bowel movement in the Care Tracker system. The nurse is suppose to pull the Bowel Chart Detail Reports and if a resident has not had a bowel movement within three (3) days, the facility's Bowel Protocol is suppose to be implemented. However, Resident #1's Bowel Chart Detail Reports revealed the resident had no documented bowel movements for nine (9) days from 01/31/11 through 02/08/11. This was after the in-service training provided by the Nurse Consultant in January 26, 2011.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F314- Treatment/Services To Prevent/Heal Pressure Sores 1. Barrier was applied by the Certified Nursing Assistant to resident #1's buttocks after observed incontinent care on 2/24/11 as noted by the Assistant Director of Nursing. 2. Observations by the Director of Nursing on 3/18/11 noted all incontinent residents had moisture barrier applied.	4/5/11

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