

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

PRINTED: 04/13/2011
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 03/30/2011 C
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			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	F 000			
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide services in accordance with the plan of care for one resident (#2) in a selected sample of four. Resident #2 was care planned to have assistance of one staff with his/her activities of daily living (ADL's). On 03/03/11 a Certified Nurse Aide (CNA) left the resident unsupervised in the shower room. The CNA did not follow the resident's care plan by providing supervision during the entire ADL.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on 03/20/09 with diagnoses to include Congestive Heart Failure, Anemia, Asthma, and Coronary Artery Disease.</p> <p>An interview with the Director of Nursing on 03/29/11 revealed there was no policy and procedure in existence regarding staff following resident care plans.</p>	F 282			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Denise Juppelt

TITLE

Administrator

(X6) DATE

4/18/11

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.

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

PRINTED: 04/13/2011
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 C 03/30/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			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 282	<p>Continued From page 1</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/24/11, revealed a Brief Interview for Mental Status (BIMS) score of "10" indicating the resident was moderately impaired in his/her decision making and supervision was required. The resident was totally dependent on the assistance of one staff member for bathing and required extensive assistance of one staff with his/her personal hygiene.</p> <p>A review of the comprehensive care plan entitled "ADL/Mobility, dated 02/21/11, revealed Resident #2 required the assistance of one staff for showers and/or bed bath. Resident #2 required assistance with dressing/undressing, combing his/her hair, and shaving. The Nursing Assistant Assignment Worksheet, updated 03/29/11, revealed the resident required the assistance of staff for ADL's.</p> <p>An interview with Resident #2, on 03/28/11 at 11:15 AM, revealed he/she was left in the shower room on the shower chair alone around three weeks ago. The resident stated the CNA gave him/her a washcloth and soap, but never turned on the water. A therapist came in to get some towels and questioned him/her about being left unsupervised. Resident #2 revealed he/she did not know how long he/she was in the shower room, but the therapist returned with the aide. The aide was aware the resident could not perform a shower without the staff's assistance. The resident revealed their had been other times staff had left him/her alone in the shower room to get towels, washcloths and a shower chair. Resident #2 stated "I always feel unsafe in the shower by myself". Resident #2 revealed he/she informed his/her family about the incident and the</p>	F 282	<p>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.</p> <p>F282 COMPREHENSIVE CARE PLANS</p> <ol style="list-style-type: none"> 1. Resident #2 is receiving assistance of one staff with her ADL's per plan of care and supervision is being provided by staff during the entire ADL. 2. All alert residents interviewed by Director of Nursing and/or Unit Manager to ensure they are provided supervision during the entire ADL of showering per resident's plan of care. Observation conducted on all non-alert residents by Director of Nursing and/or Unit Manager to ensure 	

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

PRINTED: 04/13/2011
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 C 03/30/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			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 282	Continued From page 2 family member talked with the Administrator about the incident. An interview, on 03/29/11 at 11:21 AM, with CNA #1 revealed she had left the resident unattended in the shower room on 03/03/11. The resident was alert and oriented and required assistance with his/her ADL's. CNA #1 revealed aides provided care to the resident according to their CNA care guide. She revealed she explained to the resident where she was going and thought the resident was all right with her leaving him/her for those few minutes. An interview, on 03/30/11 at 9:15 AM, with Licensed Practical Nurse (LPN) #1, revealed she was unaware of Resident #2 being left alone in the shower room. She stated the incident was something she would be expected to be informed about from the aide providing care and the care should be carried out per the resident's plan of care. An interview, on 03/30/11 at 9:32 AM, with the Director of Nursing (DON) revealed the resident's daughter informed her about the shower issue on 03/07/11. She revealed she pulled up the care tracker (computer program for ADL's) to see who completed the shower and saw it was CNA #1. She talked to CNA #1 regarding the incident and was informed by the CNA that she had left the resident for a few minutes to obtain an item from the resident's room. The resident's plan of care revealed he/she required the assistance of one staff for his/her ADL's. She stated the resident required supervision at all times during the ADL's.	F 282	supervision is provided during the entire ADL of showering per resident's plan of care. 3. All nursing staff in-serviced by Education and Training Director and/or Director of Nursing by 5/2/11 on requirement to provide appropriate level of assistance/supervision during resident's showers per resident's plan of care and Nursing Assistant Assignment Worksheet. 4. Random showers will be monitored by DON or designee to ensure appropriate level of supervision/assistance is provided during the ADL 5x's/week for 2 weeks then 3x's/week for 2 weeks then weekly for 2 weeks and then monthly until consistent compliance is met. Results of monitoring will be reported in monthly QA meeting by DON or designee for review and further recommendations.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		5/2/11 05/03/11 DHLT	

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

PRINTED: 04/13/2011
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 C 03/30/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			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 323	<p>Continued From page 3</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one resident (#2) in the selected sample of four. Resident #2 was assessed as requiring the assist of one staff for showers or baths, however, the resident was left unsupervised on 03/03/11 in the shower room for an undetermined period of time. Resident #2 revealed he/she felt unsafe when left alone in the shower room.</p> <p>Findings include:</p> <p>A review of the policy and procedures entitled "Accidents and Incidents: Reports, Investigating, Follow-up and Final Disposition" dated July 2010 revealed the centers are obligated to provide adequate supervision to prevent accidents. Adequate supervision is defined by the type and frequency of supervision, based on the individual residents assessed needs and identified hazards in the resident environment. The center implements interventions including adequate supervision consistent with resident goals, need, plans of care and standard of practice.</p>	F 323	<p>F323 FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES</p> <ol style="list-style-type: none"> 1. Resident #2 is receiving supervision of one staff while in the shower room. 2. All alert residents interviewed by Director of Nursing and/or Unit Manager to ensure they are provided the appropriate level of supervision during the entire ADL of showering per resident's plan of care. Observation conducted on all non-alert residents by Director of Nursing and/or Unit Manager to ensure supervision is provided during the entire ADL of showering per resident's plan of care. 3. All nursing staff in-serviced by Education and Training Director and/or Director of Nursing by 5/2/11 on requirement to provide adequate supervision during resident's showers per resident's plan of care to prevent accidents. 4. Random showers will be monitored by DON or designee to ensure appropriate level of supervision is provided during the ADL 5x's/week for 2 weeks then 3x's/week for 2 weeks then weekly for 2 weeks and then monthly until consistent compliance is met. Results of monitoring will be reported in monthly QA meeting by DON or designee for review and further recommendations. 	5/2/11 05/03/11 D4/LT

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

PRINTED: 04/13/2011
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 C 03/30/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			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 323	<p>Continued From page 4</p> <p>Resident #2 was admitted to the facility with diagnoses to include Congestive Heart Failure, Anemia, Asthma, and Coronary Artery Disease.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/24/11, revealed a Brief Interview for Mental Status (BIMS) score of "10" indicating the resident was moderately impaired in his/her decision making and supervision was required. The resident was totally dependent on the assistance of one staff member for bathing and required extensive assistance of one staff with his/her personal hygiene.</p> <p>A review of the comprehensive care plan entitled "ADL/Mobility", dated 02/21/11, revealed the resident required the assistance of one staff for showers and/or bed bath. Resident #2 required assistance with dressing/undressing, combing his/her hair, and shaving. The Nursing Assistant Assignment Worksheet, updated 03/29/11, revealed the resident resident required the assistance of staff for ADL's.</p> <p>An interview with Resident #2, on 03/28/11 at 11:15 AM, revealed he/she was left in the shower room on the shower chair alone around three weeks ago. The resident stated the CNA gave him/her a washcloth and soap, but never turned on the water. A therapist entered the shower room to get some towels and questioned him/her about being left unsupervised. Resident #2 revealed he/she did not know how long he/she was in the shower room, but the therapist left and returned with the CNA. The resident revealed there had been other times the staff had left him/her alone in the shower room to get towels, washcloths or the shower chair. Resident #2 stated "I always feel unsafe in the shower by</p>	F 323		

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

PRINTED: 04/13/2011
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 C 03/30/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 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 323	<p>Continued From page 5</p> <p>myself'. Resident #2 revealed he/she informed his/her family about the incident and the family member talked to the Administrator about the incident.</p> <p>An interview with the Physical Therapy Assistant (PTA), on 03/29/11 at 10:35 AM, revealed she recalled the incident of finding Resident #2 in the shower room unattended. She stated she could not recall the exact day of the incident but thought it was 3-4 weeks ago around 10:00 AM. The PTA stated the resident was seated on the shower chair against the wall in a gown in the shower room. She was not sure if she made the nurse covering the area aware of the incident.</p> <p>An interview, on 03/29/11 at 11:21 AM, with CNA #1 revealed she had left the resident unattended in the shower room on 03/03/11. CNA #1 revealed she left the shower area for a few minutes and went two doors down to the resident's room to get an item she had forgotten. CNA #1 stated she also took the bed linens to make the resident's bed, but did not make it up until they were both in the room. She revealed she explained to the resident where she was going and thought the resident was all right with her leaving him/her alone for those few minutes. She stated the resident never said anything to her about the incident and she did not report anything to her nurse that day. CNA #1 revealed nobody had said anything to her about the incident after 03/03/11. She stated "it was not something to report to the nurse".</p> <p>An interview, on 03/30/11 at 9:15 AM, with Licensed Practical Nurse (LPN) #1, revealed she was unaware of Resident #2 being left alone in the shower room. She stated the incident was</p>	F 323		

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

PRINTED: 04/13/2011
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 C 03/30/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			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 323	Continued From page 6 something she expected to be informed about from the CNA providing care. An interview, on 03/30/11 at 9:32 AM, with the Director of Nursing (DON) revealed the resident's daughter informed her about the shower issue on 03/07/11. She revealed she pulled up the care tracker (computer program for ADL's) to see who completed the shower and saw it was CNA #1. The DON stated she talked with CNA #1 about the incident. According to the resident's last MDS he/she was totally dependent on staff for his/her bathing. The resident's care plan revealed he/she required the assistance of one staff for his/her ADL's. The DON stated that meant the staff had to do everything for the resident and it didn't mean the resident could be left by him/herself/ and be okay. The resident required supervision at all times during that particular ADL.	F 323			