

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(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	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 ten (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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT Is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care in a manner which maintained or enhanced a resident's dignity and respect for one resident (#10), in the selected sample of nineteen residents, related to not pulling the privacy curtain during provision of care. Findings include: A review of the facility's policy/procedure, "Privacy Curtain Policy," dated 2005, from Lippincott Williams and Wilkins, revealed the privacy curtain should be closed during provision of care for a resident. A record review revealed the facility admitted Resident #10 on 01/14/10 with diagnoses to include Morbid Obesity, Type II Diabetes,	F 241	1. Resident #10 was assessed by the Director of Nursing on 3/29/12 to ensure that the resident did not experience any psychosocial implications related to privacy curtain not being pulled around her during care. The Director of Nursing has made random observation of care being provided to Resident #10 and has not identified any issues with the privacy curtain not being pulled.	4/23/12

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

Mandy [Signature]

TITLE

Administrator

(X6) DATE

4/2/12

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: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 241	Continued From page 1 Amputation of the Right Leg and Peripheral Vascular Disease. Observation of a skin assessment, on 03/07/12 at 9:00 AM, revealed Licensed Practical Nurse (LPN) #1 did not provide privacy as evidenced by not pulling the privacy curtain all the way around the resident's bed. During provision of care for Resident #10, the door was opened twice which exposed the resident. An interview with LPN #1, on 03/07/12 at 10:20 AM, revealed she did not pull the privacy curtain during provision of care for Resident #10. No further explanation was provided. An interview with Resident #10, on 03/07/12 at 10:35 AM, revealed not having the privacy curtain pulled made him/her feel "awkward," and he/she tried several times to pull his/her gown down to keep himself/herself covered during provision of care.	F 241	2. On 3/29/12, the Social Service Director interviewed all interviewable residents' to ensure that were no other residents who had issues with staff providing privacy. In addition, the Director of Nursing, Assistant Director of Nursing and Unit Managers have made observations on 3/31/2012 throughout the facility with no issues identified related to privacy curtains being pulled. 3. On 3/7/12, LPN #1 was re-educated by the Director of Nursing regarding providing privacy for the resident by pulling the privacy curtain all the way around the resident. All nursing staff will be re-educated by the Education and Training Director and/or the Director of Nursing by 4/21/12 on ensuring that the privacy curtain is closed during the provision of care for a resident. 4. The Director of Nursing, Assistant Director of Nursing and Unit Managers will conduct daily rounds for two (2) weeks, then rounds daily Monday through Friday for four (4) weeks, then weekly for six (6) weeks to ensure that all privacy curtains are being pulled all the way around residents during the provision of care. The results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly		
F 314 SS=D	An Interview with Registered Nurse (RN) #1, on 03/07/12 at 11:00 AM, revealed privacy curtains should always be pulled when providing care for a resident. An interview with the Assistant Director of Nursing (ADON), and the Director of Nursing (DON), on 03/07/12 at 11:05 AM and at 11:35 AM, respectively, revealed they expected the nurse to pull the curtain all the way around the resident during provision of care. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(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 314	<p>Continued From page 2</p> <p>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 services to promote healing, prevent infection and prevent new sores from developing.</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 a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for one Resident (#10), in the selected sample of nineteen residents. Observation of Resident #10's wound care, on 03/07/12, revealed the nurse used the same measuring device to measure multiple wounds.</p> <p>Findings to include:</p> <p>A review of the facility's policy/procedure, "Procedure for Wound Prevention and Treatment," dated April 2009, and a review of the facility's policy/procedure, "Procedure for Measuring/Describing a Wound," dated April 2009, revealed no indications on how to properly use a wound measuring device or when to dispose of the wound measuring device.</p> <p>A record review revealed the facility admitted Resident #10 on 01/14/10 with diagnoses to include Peripheral Vascular Disease, Type II Diabetes, Amputation of the Right Leg and</p>	F 314	<ol style="list-style-type: none"> 1. On 3/25/12, the Director of Nursing observed Resident #10 wound measurements being taken and noted that a new measuring device was used when measuring each individual wound. 2. On 04/02/12, the Director of Nursing observed measurements being done on all residents with wounds in the facility to ensure that a new measuring device was used when measuring each individual wound. No concerns were identified. 3. All licensed nurses will be re-educated by the Education and Training Director by 4/21/12 regarding wound prevention and ensuring that a new measuring device is used when measuring multiple wounds on same resident. 4. The Director of Nursing and/or the Assistant Director of Nursing will observe wound measurement on three (3) residents weekly for twelve (12) weeks to ensure that proper techniques for measuring wounds are being used to include using a new measuring device for each wound. The results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. 	4/23/12

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 314	Continued From page 3 Morbid Obesity. Observation of a skin assessment, on 03/07/12 at 9:00 AM, revealed Licensed Practical Nurse (LPN) #1 did not provide proper infection technique while measuring an area on the resident's coccyx, an area on the left inner buttock, two areas behind the resident's left knee, and an area where the 4th toe of the left foot had been removed. Further observation revealed LPN #1 utilized the same measuring device to measure several areas prior to obtaining a new measuring device. She then laid the used measuring device on Resident #10's bed linen. An interview with LPN #1, on 03/07/12 at 10:20 AM, revealed she normally used a new device for every wound, but stated she was "nervous." An interview with Registered Nurse (RN) #1, on 03/07/12 at 11:00 AM, revealed "I would use a new measuring device every time."	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER An interview with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), on 03/07/12 at 11:05 AM, and on 03/09/12 at 3:15 PM, respectively, revealed they expected the nurse to use a new measuring device for each wound every time. Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	1. On 3/25/12, the Director of Nursing observed incontinence care, including the separation of the resident's legs and cleaning of the vaginal area and vulva being provided to Resident #1 by CNA #1 with no concerns identified.	4/23/12	

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 315	Continued From page 4 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the professional standards used by the facility from the "Lippincott's Textbook for Nursing Assistants: a humanistic approach to caregiving," it was determined the facility failed to ensure one resident (#1), in the selected sample of nineteen residents, received appropriate treatment and services to prevent urinary tract infections (UTI) and to restore as much normal bladder function as possible. An observation, on 03/07/12, revealed a Certified Nurse Aide (CNA) #1 provided incontinent care for Resident #1 and failed to clean the vaginal area.	F 315	2. On 3/29/12, the Director of Nursing, Assistant Director of Nursing and Unit Managers observed incontinence care, including the separation of resident's legs and cleaning of the vaginal area and vulva with no infractions noted. 3. All licensed nurses and all certified nursing assistants will be re-educated by 4/21/12 by the Education and Training Director, the Director of Nursing or the Assistant Director of Nursing regarding facility policy on the providing incontinence care including the separation of resident's legs and cleaning of the vaginal area and vulva. CNA #1 was re-educated by the Education and Training Director on 3/29/12 regarding incontinence care including the separation of resident's legs and cleaning of the vaginal area and vulva. 4. The Education Training and Director and/or the Unit Managers will observe pericare on five (5) residents three (3) times per week and then five (5) residents weekly to ensure that peri-care is being provided per policy including the separation of resident's legs and cleaning of the vaginal area and vulva. Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly		
	Findings include: A review of the "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving," revealed the importance of "making sure that the perineum, the vulva (in women), and the penis (in men) is clean" have two reasons. Reason number one (1) is the "Prevention of infection. Because the perineum is close to the vulva (in women) and the penis (in man), these microbes can easily enter the vagina or urethra, causing infection." The second reason is "Prevention of skin breakdown and odor. Feces, urine, and other body fluids, such as menstrual blood, can become trapped in the folds, leading to skin irritation and odor if they are not properly				

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 315	<p>Continued From page 5</p> <p>removed." The step by step procedure in Procedure 17-4, Item number 15, described female perineal care as "Using the other hand, separate the labia. Clean the vulva by placing your washcloth-covered hand at the top of the vulva and stroking downward to the anus. First clean one side, then the other side, and finally the middle, using a different part of the washcloth each time, until the area is clean."</p> <p>An interview with the Director of Nursing (DON), on 03/08/12 at 11:30 AM, revealed the facility used the "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving" as a guide and procedural manual for incontinent care. She revealed the facility followed the standard of practice for incontinent care.</p> <p>A record review revealed the facility admitted Resident #1 on 04/18/11 with diagnoses to include Chronic Kidney Disease, Type II Diabetes, Mental Disorder, Acute Coronary Syndrome.</p> <p>An observation of incontinent care for Resident #1, on 03/07/12 at 9:19 AM, revealed CNA #1 removed the resident's soiled brief while he/she was in the side-lying position on the bed. Registered Nurse (RN) #2 assisted CNA #1 by holding the resident in the side-lying position. CNA #1 used a washcloth to wipe the resident's anal area and did not separate Resident #1's legs to clean the vaginal/vulva area.</p> <p>An interview with CNA #1, on 03/09/12 at 5:30 PM, revealed she provided incontinent care for Resident #1 on 03/07/12. She stated she cleaned the resident while he/she was in the side-lying</p>	F 315			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 315	Continued From page 6 position and cleaned from front to back, and thought she cleaned the vaginal area; however, she did not separate the resident's legs. CNA #1 stated to complete catheter care for a female resident, she was suppose to start at the labia and go out. CNA #1 revealed she should wipe between the resident's legs front to back, separate his/her legs, and then wipe downward. She stated she did not do this because she knew the nurse was coming in to remove the foley catheter. An interview with RN #2, on 03/09/12 at 5:10 PM, revealed she told the CNA "to check the front" after the resident was rolled onto his/her back. She stated she was distracted by another nurse entering the room with a specimen cup, a syringe, and a needle to obtain a urine specimen. She stated CNA #1 wiped the front but she was not sure if his/her legs were separated or not. RN #2 stated, as the licensed person it was her responsibility to ensure the incontinent care was completed correctly. She stated, due to the foley and due to the feces in the brief, the legs should have been separated to properly clean the resident. Interview with CNA #2 and CNA #3, on 03/09/12 at 8:55 AM and 9:05 AM, respectively, revealed incontinent care should begin with the resident lying on his/her back, separate the legs, and wipe from front to back using a different washcloth for each swipe. Then, the resident should be placed in a side-lying position to clean the anal area. CNA #2 and CNA #3 stated a second person would be needed to assist with positioning and to hold the legs open.	F 315			
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 334 SS=D	Continued From page 7 IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 334	1. Resident #17 no longer resides at facility. 2. A 100% audit was completed by the Unit Managers on April 2, 2012 to ensure that all residents had been educated and offered the influenza and pneumococcal vaccine upon admission. All documentation was present and no issues were identified. 3. All licensed nursing staff will be re-educated by 4/21/12 by the Education and Training Director and/or the Director of Nursing on the importance of providing education and offering the influenza and pneumococcal vaccine upon admission into the facility as well as the documentation of vaccinations. 4. The Director of Nursing, the Assistant Director of Nursing and/or the Unit Managers will provide a chart review weekly on three (3) new admissions per week for twelve (12) weeks if available to ensure that they are offered the influenza and pneumococcal vaccine upon admission and that the vaccinations are documented. Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	4/23/12	

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PAUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 334	Continued From page 8 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.	F 334			
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the documentation of education regarding benefits and potential side effects of vaccines, as well as dates that immunizations were last given, were offered to one resident (#17), in the selected sample of nineteen residents. Findings include:				

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 334	Continued From page 9 An interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), on 03/09/12 at 4:00 PM, revealed the facility's policy was to offer and provide education and the influenza and pneumococcal vaccines upon admission. The influenza vaccine was offered between November and March each year, and the pneumococcal vaccine was offered all year round. The ADON revealed the documentation should include a Pneumococcal and Annual Influenza Vaccine Information and Request form and Immunization Record. The DON revealed the facility tracked the residents who received the vaccines. The DON and ADON revealed there were no known contraindications to the vaccines for this resident. A record review revealed the facility admitted Resident #17 on 12/15/11 with diagnosis to include a Femur Fracture. Further review revealed no known allergies or no known contraindications to the vaccines. A review of the Pneumococcal and Annual Influenza Vaccine Information and Request revealed only the center's name and the resident's name. There was no documented evidence the vaccines were offered and/or refused. A review of the Immunization Record revealed only the resident's name, a medical record number, and the date of the resident's admission to the facility. Further review of the Immunization Record revealed there was no documented evidence the vaccines were administered.	F 334			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(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 334	Continued From page 10 A review of the facility's vaccine tracking log revealed the resident was not listed. Further interview with the ADON revealed the Unit Manager admitted Resident #17 to the facility; however, she was no longer employed by the facility. A phone call was made, by the ADON, to Resident #17's daughter, who revealed the resident refused the pneumococcal vaccine. He/she had received the influenza vaccine, on 11/11/11, prior to admission to the facility.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	The doors on the refrigerator and freezer door handles, seals, hinges and plate warmer were cleaned on 3/7/12 as observed by Nutrition Service Manager. The seals on the refrigerator door were replaced on 3/7/12 and the floor is no longer wet from moisture as observed by Nutrition Service Manager on 3/7/12. The baseboard ledge located behind the pan rack was cleaned on 3/8/12 as observed by Nutrition Service Manager. The brown discoloration and mouse droppings has been cleaned from the racks of bowls date and as observed Nutrition Service Manager 03/30/2012. The seals floor and baseboard adjacent to the freezer and refrigerator were cleaned on 3/8/12 as observed by Nutrition Service Manager. No mice have been seen in the kitchen and no mouse droppings have been identified in the kitchen as observed by the Nutrition Service manager on 3/30/2012.	4/23/12
	This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observation, on the Initial tour and during a tray preparation, revealed areas in the kitchen with a build-up of grime. Additionally, observations, on three consecutive days of the survey, revealed mouse droppings present in the kitchen where the clean dishes were stored. The facility census was ninety-six (96) with four (4) residents who received tube feedings.			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 371	<p>Continued From page 11</p> <p>Findings include:</p> <p>Observation of the facility kitchen, on 03/06/12 at 10:45 AM, revealed a build-up of a black grimy substance on the refrigerator and freezer door handles, hinges and seals. The floor and base board adjacent to the freezer and refrigerator had a build-up of debris and grime. The floor was wet from moisture dripping from the bottom seal of the refrigerator, which was in disrepair. The plate warmer was observed to have a build-up of gray grimo on the perimeter of the lid and hinges, and debris was around the inside of the of the warmer.</p> <p>Observation of the facility kitchen, on 03/06/12 at 12:00 PM, on 03/07/12 at 11:40 AM, and on 03/08/12 at 8:45 AM, revealed a baseboard ledge located behind the clean pan rack. Further observation revealed there were racks of bowls with numerous mouse droppings, and irregular brownish-colored discolorations along the entire length of the baseboard. The metal pan rack was next to the baseboard and was full of clean pots, pans and lids. A pan lid was observed off the edge of the rack and touched the baseboard with the mouse droppings and brownish stains.</p> <p>An interview with the Dietary Manager, on 03/07/12 at 11:40 AM, revealed not all areas of the kitchen were on a cleaning schedule; however, the kitchen staff should have cleaned the surface areas.</p> <p>An interview with Kitchen Staff #1, on 03/07/12 at 11:55 AM, revealed she observed mice in the kitchen on several occasions. She was</p>	F 371	<p>Pest control continues to service the facility at least twice per week. The pest control company continues to service the facility on a minimum of two (2) times per week and are also available as needed on a 24 hour basis. Additional areas that mice may have entered facility have been identified and repaired/closed. The cleaning schedule has been updated to include baseboards, outsides of refrigerator and freezer, plate warmer and floors of walk-in freezer and cooler. . All dietary staff have been re-educated on cleaning procedures and on completing maintenance request for pest control concerns by Nutrition Service Manager on 03/30/2012 . Sanitation inspections will be completed five (5) days per week by the Nutrition Service manager for six (6) weeks then weekly for six (6) weeks as well as by the Nursing Home Administrator for weekly for twelve (12) weeks. Inspections will include cleanliness of the kitchen and inspection for any indication of mice.</p> <p>Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(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 371	<p>Continued From page 12</p> <p>frightened of mice, so she asked Kitchen Steff #2 to enter the kitchen first. An interview with Kitchen Staff #2 revealed she entered the kitchen first because Kitchen Staff #1 was afraid whenever mice were visible in the kitchen. Mice were seen in areas of the kitchen for a couple of months. She revealed she did not see mice as frequently, as she did in the past, but observed a mouse in the kitchen about two days ago.</p> <p>An interview with the Registered Dietician, on 03/08/12 at 8:45 AM, revealed mice were a problem in the facility, especially in the kitchen. The pest control company was working to eradicate them and was doing the "routine stuff" such as putting traps outside and inside the facility. He revealed that holes in the wall of the kitchen were filled by maintenance last December. The pest control technician was in the facility on Tuesday (03/06/12), and a total of six mice were found, so they "vamped up the baits." The Dietician revealed there was a risk for illness due to the infestation of mice.</p> <p>An interview with the Maintenance Director, on 03/07/12 at 4:45 PM, and on 03/08/12 at 6:30 PM, revealed he was first aware of the problem regarding mice, in December, and felt it was still a problem. He revealed he saw mice in the traps and the kitchen staff reported sightings of mice to him. The pest control company was notified at that time. He had the holes filled in the kitchen wall in December, and the pest control technician recently filled holes in the foundation of the building. He stated he was unaware if the pest control was effective; however, he was not seeing "as many." He stated, "we are paying them [pest control company], they should be getting it under</p>	F 371		

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(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 371	Continued From page 13 control." An interview with the Administrator, on 03/07/12 at 5:20 PM, revealed the problem with the mice started last May, after there was flooding in the area. She revealed she observed a mouse in the kitchen in October, whenever she was there during a deep cleaning. She said she observed a mouse in a trap and residents reported seeing mice on Wing 2. Maintenance was well aware of the problem, and sealed holes in the kitchen wall and placed new door sweeps on some of the doors. Additionally, she stated the mice in the kitchen could be a potential health risk.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	1. On 3/29/12 RN #3 was re-educated on the facility's policy on Enteral Tubes and ensuring that clean gloves are used throughout procedure. The Director of Nursing observed RN #3 receive enteral medications on 03/29/12 and no issues with infection control were identified. 2. On 3/30/12, the Director of Nursing, the Assistant Director of Nursing, and the Unit Managers observed all residents with g-tubes receiving medication per Enteral Tubes and noted that the policy was being followed with licensed staff using clean gloves during administration of medications. 3. All licensed staff will be re-educated by the Education and Training Director and/or the Director of Nursing by 4/21/12 on the Enteral Tubes policy and ensuring that clean gloves are used when providing care for resident's who have g-tube placement.	4/23/12

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 441	<p>Continued From page 14</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to maintain an infection control program to help prevent the development and transmission of disease and infection. Observation during a medication pass, on 03/06/12, revealed Registered Nurse (RN) #3 contaminated her hands during administration of a medication via a gastronomy tube (G-Tube) and did not wash her hands or reglove before continuing administration of the medication via the G-tube.</p> <p>Findings include: A review of the facility's policy/procedure, "Enteral Tubes," dated October 2002, revealed standard precautions would be observed throughout the procedure which included clean gloves.</p>	F 441	<p>4. The Director of Nursing, the Assistant Director of Nursing and/or Unit Managers will observe administration of medication to three (3) g-tube resident three (3) times a week on random shifts for two (2) weeks and then one (1) resident weekly for ten (10) weeks to ensure that clean gloves are being used prior to the administration of medications. Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly</p>		

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 441	Continued From page 15 Observation of a medication pass, on 03/06/12 at 10:50 AM, revealed Resident B was in bed with a tube feeding infusing. The tube feeding was turned off and RN #3 determined the tubing was clogged when she checked for placement. She pulled the bed linens back and touched the tubing, which had fecal matter on it. She asked Resident B if he/she had a bowel movement and he/she shook his/her head "yes." RN #3 then laid the tubing back on the bed, and began to manipulate the enteral tubing and the port, without washing her hands or regloving. An interview with RN #3, on 03/06/12 at 10:55 AM, revealed she "should have changed gloves," but did not. No further explanation was provided. An interview with the Director of Nursing (DON), on 03/08/12 at 10:55 AM, revealed she would have expected RN #3 to clean the contaminated tubing, then wash her hands, reglove, and continue to administer the medication. She stated it was a "major risk factor for complications and infection control."	F 441			
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 469	As of 03/30/2012 no mice or mice droppings have been identified in the kitchen by the Nutrition Service manager or the Nursing Home Administrator. As of 03/30/2012 no mice or mice droppings have been identified in the kitchen by the Nutrition Service manager or the Nursing Home Administrator.	4/23/12	

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 469	<p>Continued From page 16</p> <p>the facility's pest control agreement, it was determined the facility failed to ensure an effective pest control program so that the facility was free of rodents. Observations of the facility's kitchen revealed areas with visible signs of mouse droppings. Resident rooms were observed with sticky traps and reports of observations of mice. Interviews with staff revealed mice were observed by residents, and staff in the kitchen revealed mice were seen frequently in the kitchen.</p> <p>Findings include:</p> <p>A review of the facility's pest control service agreement, dated 09/22/10, revealed specific pests to be controlled included mice, and included all interior areas of the facility structure. The service guarantee section listed "Complete guarantee for control of said pests(s) for life of the agreement." The agreement was signed by the Administrator.</p> <p>A review of the facility's Pest Control Log listed mice as the "pest type" on 09/25/11, 10/24/11, 12/27/11, 01/17/12, 02/08/12, 02/13/12, 02/17/12 and 02/25/12.</p> <p>Observations of the kitchen, on 03/06/12 at 12:00 PM, on 03/07/12 at 11:40 AM, and on 03/08/12 at 8:45 AM, revealed a baseboard ledge in the kitchen, which was behind the racks of clean dishes, had mouse droppings and irregular brownish colored discolorations along the entire length of the baseboard. An observation, on 03/07/12 at 9:45 AM, revealed there was a glue trap, in Room 212, located on the floor by the base of the wall.</p>	F 469	<p>The pest control company continues to service the facility on a minimum of two (2) times per week and are also available as needed on a 24 hour basis. Additional areas that mice may have entered facility have been identified and repaired/closed. Dietary staff were educated on completing maintenance request for pest control concerns on 03/30/2012 by the Nutrition Service manager.</p> <p>Department Heads have been retrained on 03/30/2012 by the Nursing Home Administrator on completing the pest log with identification of where the pests were sighted and contact NHA or Maintenance so that pest control company can be notified immediately of any pests.</p> <p>Facility rounds will be completed five (5) days per for six (6) weeks then three (3) times per week for six (6) weeks by the maintenance staff to identify any signs of pest activity. Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 469	Continued From page 17 An interview with Resident A, on 03/07/12 at 9:45 AM, revealed he/she observed mice in his/her room more than once recently and the facility had "placed a sticky trap in the room yesterday." An interview with Kitchen Staff #1 and #2, on 03/07/12 at 11:55 AM, revealed mice were seen in areas of the kitchen for a couple of months, and as recently as two days ago. An interview with the Registered Dietician, on 03/08/12 at 8:45 AM, revealed mice were a problem in the facility, especially in the kitchen, and the pest control company was working to eradicate them. They had been doing the "routine stuff" like traps inside and outside since December. He revealed there were holes in the wall of the dishroom of the kitchen, and maintenance closed the holes in December. The pest control technician was in the facility, on 03/06/12, and six mice were found so they "vamped up the baits." An interview with the Director of Nursing (DON), on 03/07/12 at 3:40 PM, revealed she was aware that Certified Nurse Aides (CNA) reported seeing mice in the shower rooms about two months ago. The DON revealed she did not speak to the Dietary Manager about the mice. She would have spoken to her supervisor, but as DON, she received reports from the staff and then reported to the Administrator. An interview with the Administrator, on 03/07/12 at 5:20 PM, revealed she felt the problem with the mice started in May after there was flooding in the area and then it became worse. In October, she	F 469			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 469	<p>Continued From page 18</p> <p>observed a mouse in the kitchen and had seen one in a trap. Residents reported seeing mice on Wing 2 and kitchen staff reported seeing mice in the kitchen. She stated maintenance was well aware of the problem and sealed holes in the kitchen wall, and placed new door sweeps on some of the doors.</p> <p>An interview with the Maintenance Director, on 03/07/12 at 4:45 PM and at 6:30 PM, revealed he was first aware of the problem about the mice in December and felt it was still a problem. He spoke with the Administrator about it; however, he could not recall the date. He revealed he observed mice that were in traps, and kitchen staff. He filled holes in the kitchen wall in December, and the pest control technician recently filled holes in the foundation of the building. He stated he did not know if the pest control was effective; however, he did not see as many mice. He stated, "we are paying them [pest control company], they should be getting it under control." The Maintenance Director revealed he did not keep a log of the sightings.</p> <p>An interview with the pest control technician, on 03/09/12 at 8:30 AM, revealed he provided a monthly service to the facility as well as an on needed basis, and was available twenty-four hours a day, seven days a week. The facility notified him "two or three times for an as needed service call and he kept a Pest Control Log to show where activity was observed or reported. He did not know the cause of the continued infestation, but stated he suspected they burrowed in the ground in front of the building and may be under the concrete slab foundation. He had patched holes in the foundation, on 02/25/12,</p>	F 469			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/09/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(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 APPRDPRATE DEFICIENCY)	(X5) COMPLETION DATE	
F 469	Continued From page 19 and had bait stations outside, and glue boards, traps and multi-catch units were in the building. He stated the mice were "not messing with the bait station outside, all the activity had been inside the building, and the kitchen was the hot spot" and they keep finding more areas at the building foundation. The pest control technician stated, "no one ever said what I'm doing was not working."	F 469			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH	STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1970</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry and anti freeze sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 03/08/12. Medco of Paducah was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred three (103) beds with a census of ninety six (96) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<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 ten (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>	
-------	---	-------	---	--

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

Manoj Dargan

TITLE

Administrator

(X6) DATE

4/2/12

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: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred three (103) beds with a census of ninety six (96) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/08/12 at 9:30 AM, with the Maintenance Director revealed the smoke partitions extending above the ceiling located in</p>	K 025	<p>Smoke partitions extending above the ceiling located in the attic throughout the facility that are noted to have penetration by wires will be filled with barrier sealant caulk fire rated at least equal to the partition by facility maintenance staff on 4/15/2012.</p> <p>A complete facility audit of all smoke barriers and doors will be completed by the Maintenance department on 04/15/2012 to assure there are no penetrations which allow the passage of smoke. Any identified concerns will be corrected by maintenance staff immediately.</p> <p>Maintenance staff to be re-educated by NHA on 04/02/2012 on ensuring all penetration in smoke partitions to be filled with a material rated equal to the partition to resist the passage of smoke.</p> <p>Maintenance staff to inspect smoke barriers extending above the ceiling monthly for three (3) months. The reports of inspections will be reported to the Administrator. Results of rounds will be brought to Quality Assurance Committee monthly for one (1) quarter for further recommendation. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, Maintenance Director, Social Services Director and the Medical Director on at least a quarterly basis.</p>	4/23/12

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 887 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 2</p> <p>the attic throughout the facility, were noted to have penetrations by wires. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 03/08/12 at 9:30 AM, with the Maintenance Director revealed he was not aware of the penetrations.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 	K 025		

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred three (103) beds with a census of ninety six (96) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/08/12 at 9:30 AM, with the Maintenance Director revealed four (4) unrated homemade smoke barrier access doors located in the smoke partitions above the ceiling in the attic area throughout the facility.</p> <p>Interview, on 03/08/12 at 9:30 AM, with the</p>	K 027	<p>The four (4) identified homemade smoke barrier access doors will be replaced with fire rated doors that are self closing in the smoke partitions above the ceiling in the attic are throughout the facility. This work will be completed by Brewer Construction company by April 15, 2012.</p> <p>Coordinators will be installed on cross corridor doors located in the 100 Hall and 200 Hall to ensure doors close properly in the event of an emergency by facility maintenance staff by April 20, 2012.</p> <p>Maintenance staff trained by NHA on 04/02/2012 that all doors in smoke partitions are to close properly in the event of an emergency as well as the requirement that all access doors have a appropriate fire rating.</p> <p>Maintenance staff to inspect access doors in attic on monthly basis for 3 months. Cross-corridor doors will be inspected weekly for twelve (12) weeks to ensure they are closing properly. Reports of inspections will be reported to the Administrator. Results of rounds will be brought to Quality Assurance Committee monthly for one (1) quarter for further recommendation. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, Maintenance Director, Social Services Director and the Medical Director on at least a quarterly basis.</p>	4/23/12

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	<p>Continued From page 4</p> <p>Maintenance Director revealed he was not aware the door in the attic must be rated for use.</p> <p>Observation, on 03/08/12 between 9:30 AM and 11:00 AM, with the Maintenance Director revealed the cross-corridor doors located in the 100 Hall, and the 200 Hall, would not close completely when tested, due to the doors not having a coordinator to ensure the door without the t-astragal would close first.</p> <p>Interview, on 03/08/12 between 9:30 AM and 11:00 AM, with the Maintenance Director revealed they were unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p>	K 027		

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 027	Continued From page 5 Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD	K 027			
K 050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on Fire Drill record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred three (103) beds and the census was ninety six (96) on the day of the survey. The findings include: Fire Drill record review, on 03/08/12 at 8:40 AM, with the Maintenance Director revealed the fire	K 050	A review of the scheduled dates and times of fire drills for the month of April reviewed by the Administrator on 4/2/2012 noted the fire drills to be scheduled at random unexpected times. A review of the scheduled dates & times of fire drills for the month of April reviewed by the Administrator on 4/02/2012 noted the fire drills to be scheduled at random unexpected times. Maintenance staff trained by NHA on 04/02/2012 on conducting fire drills under varying conditions and at unexpected or random times. NHA to review fire drills dates and times of fire drills monthly for three months to ensure they are being conducted under varying conditions at unexpected times. Results of rounds will be brought to Quality Assurance Committee monthly for one (1) quarter for further recommendation. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, Maintenance Director, Social Services Director and the Medical Director on at least a quarterly basis.	4/23/12	

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 6 drills were not being conducted at unexpected times under varied conditions. The first shift fire drills were being conducted between 10:30 AM and 1:15 PM, the second shift fire drills were being conducted between 2:30 PM and 4:30 PM, and the third shift fire drills were being conducted at 6:00 AM. This observation was confirmed with the Administrator at the exit conference. Interview, on 03/08/12 at 8:40 AM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and Fire Alarm record review, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred three (103) beds with a census of ninety six (96)	K 054	Smoke detector sensitivity test conducted by Premier Fire & Security on 03/30/2012 with no issues found and will be conducted per NFPA regulations going forward. Smoke detector sensitivity test to be conducted by Premier Fire & Security on 03/30/2012 with no issues found and will be conducted per NFPA regulations going forward. Maintenance staff educated regarding regulations for smoke detector sensitivity testing by NHA on 04/02/2012.	4/23/12

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 054	<p>Continued From page 7 on the day of the survey.</p> <p>The findings include:</p> <p>Fire Alarm testing record review, on 03/08/12 at 8:30 AM, with the Maintenance Director revealed the facility failed to ensure the Smoke Detector Sensitivity Test was being performed on the fire alarm smoke detectors as required by NFPA 72 (1999 edition) to ensure their reliability.</p> <p>Interview, on 03/08/12 at 8:30 AM, with the Maintenance Director, revealed he was unaware the facility did not have a current sensitivity test on the fire alarm smoke detectors.</p> <p>Reference: NFPA-72 (1999 edition)</p> <p>7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance</p>	K 054	<p>The Administrator will audit testing of all smoke detectors monthly for three months to assure testing occurred per manufacturer's recommendation. Results of rounds will be brought to Quality Assurance Committee monthly for one (1) quarter for further recommendation. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, Maintenance Director, Social Services Director and the Medical Director on at least a quarterly basis.</p>	

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 054	Continued From page 8 alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.	K 054			
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056 SS=F	<p>Continued From page 9</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, fire alarm testing record review, and interview it was determined the facility failed to ensure the building had a complete automatic sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred three (103) beds with a census of ninety six (96) on the day of the survey.</p> <p>The findings include:</p> <p>Sprinkler testing record review, on 03/08/12 at 8:45 AM, with the Maintenance Director revealed the sprinkler contractor that performed the</p>	K 056	<p>All recalled STAR ME1 sprinkler heads throughout the facility will be replaced by 04/23/2012. Facility will obtain a sprinkler head wrench as required by NFPA standards by 04/23/2012. Sprinkler heads in Room #209, #202, #308 and #311 will be changed so that all sprinkler heads in the same compartment will have the same response time by 04/23/2012. This work will be completed by Armor Fire Protection. The shower curtains in Central Bath 1 and Central Bath 2 on Wing 3 have been replaced with curtains with mesh on 04/02/2012.</p> <p>A complete facility audit will be completed by the Nursing Home Administrator or the Maintenance Director on or before April 15, 2012 to identify any recalled sprinkler heads, mixed sprinkler heads in the same compartment with standard response and quick response, or any shower curtain that would block the sprinkler coverage. Any identified concerns will be corrected.</p> <p>Maintenance staff have been re-educated by the NHA on 4/2/2012 regarding replacing any recalled sprinkler heads when notified of the recall, the necessity of having a wrench for sprinkler heads, ensuring all sprinkler heads in the same compartment have the same response times, and ensuring mesh is at the top of curtains that could interfere with performance of sprinklers.</p> <p>Maintenance staff will review quarterly sprinkler inspection reports to identify any areas of concern related to the sprinkler system. Maintenance staff will audit monthly for three</p>	4/23/12

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 887 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	<p>Continued From page 10</p> <p>quarterly sprinkler test had identified the facility to have recalled STAR ME1 sprinkler heads located throughout the facility.</p> <p>Interview, on 03/08/12 at 8:08 AM, with the Maintenance Director revealed he was not aware of the remarks on the sprinkler contractors report.</p> <p>Observation, on 03/08/12 at 9:40 AM, with the Maintenance Director revealed the facility failed to provide a sprinkler head wrench as required by NFPA standards.</p> <p>Interview, on 03/08/12 at 9:40 AM, with the Maintenance Director revealed he was not aware the sprinkler head wrench was missing.</p> <p>Observation, on 03/08/12 between 10:20 AM and 11:20 AM, with the Maintenance Director revealed a standard response sprinkler head and a quick response sprinkler head located in the same compartment. The compartments affected were, Room # 209, #202, #308, and #311.</p> <p>Interview, on 03/08/12 between 10:20 AM and 11:20 AM, with the Maintenance Director revealed he was not aware that the sprinklers had to have the same response time if the sprinkler heads are located in the same compartment.</p> <p>Observation, on 03/08/12 at 11:20 AM, with the Maintenance Director revealed the curtains in the Wing 3 Central Bath 1 and 2, did not have mesh at the top and would block the sprinkler coverage in the room.</p> <p>Interview, on 03/08/12 at 11:20 AM, with the Maintenance Director revealed he was not aware</p>	K 056	(3) months all sprinkler heads and curtains to assure they are of the same response time and that curtains do not interfere with the performance of the sprinklers. Results of rounds will be brought to Quality Assurance Committee monthly for one (1) quarter for further recommendation. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, Maintenance Director, Social Services Director and the Medical Director on at least a quarterly basis.	

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 11 who hung the curtains without mesh, and did not realize they still had any without mesh. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA-101, 9-7-1-1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 070		

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 807 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070	<p>Continued From page 12</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smcke compartments, residents, staff and visitors. The facility is licensed for one hundred three (103) beds with a census of ninety six (96) on the day of the survey.</p> <p>The findings include:</p>	K 070	<p>Space heaters in the Social Services office, and the Administrators Offices were removed on 03/08/2012.</p> <p>A full facility inspection was completed by the Administrator and the Maintenance Director on March 12, 2012 to assure no other space heaters were present, none were identified.</p> <p>Department heads have been retrained by the NHA on 3/30/2012 that space heaters can only be used in non sleeping areas and employee areas when the heating elements of such devices do not exceed 212 degrees F .</p> <p>NHA will make rounds on weekly basis for four weeks and monthly for two (2) months to ensure that any portable space heaters that are in use do not have heating elements that exceed 212 degrees F. Results of rounds will be brought to Quality Assurance Committee monthly for one (1) quarter for further recommendation. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, Maintenance Director, Social Services Director and the Medical Director on at least a quarterly basis.</p>	4/23/12
	<p>Observation, on 03/08/12 between 10:37 AM and 11:22 AM, with the Maintenance Director revealed a portable space heater located in the Social Services Office, and the Administrators Office.</p> <p>Interview, on 03/08/12 between 10:37 and 11:22 AM, with the Maintenance Director revealed they were not aware the heaters could not exceed 212°F in nonsleeping staff, and employee areas.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.</p>			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 070	Continued From page 13 Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). Reference: NFPA 13 (1999 edition) 4-2.5.2 Valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. Heat tape shall not be used in lieu of heated valve enclosures to protect the dry pipe valve and supply pipe against freezing.	K 070		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred three (103) beds with a census of ninety six (96) on the day of the survey. The findings include:	K 072	An observation by the Administrator on 03/30/2012 noted that there were no linen carts or wheelchairs in the corridors and that the corridors were free for a means of egress. An observation by the Administrator on 03/30/2012 noted that there were no linen carts or wheelchairs in the corridors and that the corridors were free for a means of egress. Facility staff will be retrained by the Director of Nursing or the Nursing Home Administrator related to maintaining a means of egress that is free of obstructions or impediments on or before April 15, 2012.	4/23/12

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 14 Observation, on 03/08/12 at 9:35 AM, with the Maintenance Director revealed linen carts, and wheelchairs were being stored in the corridors throughout the facility. Interview, on 03/08/12 at 9:35 AM, with the Maintenance Director revealed the facility routinely stored linen carts, and wheelchairs in the corridors. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	Rounds will be made five days per for 4 weeks and once per week for 8 weeks on all shifts by department heads to ensure means of egress are maintained without obstructions. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, Maintenance Director, Social Services Director and the Medical Director on at least a quarterly basis. The junction box located under the kitchen sink was covered on 03/08/2012 by facility maintenance staff.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	All power strips identified on 03/08/2012 having medical equipment or another power strip plugged into them were removed by facility maintenance staff prior to March 15, 2012. This includes the battery charger for the bed batteries located in the Wing 1 Med Room; the oxygen concentrator and bed in room #100; a wound vac and bed in room #101; an oxygen concentrator in room #102; the power strip in room #107; a bed and damaged cord in room #111; a bed, refrigerator and air conditioning unit in room #108; a bed and air mattress in room #110; a bed in room #212; a bed, B-Pap and a mini nebulizer in room #207; a bed in room #206; three (3) refrigerators in Wing 2 Med Room; the power strips in the Social Services office; a bed an IV pump in room #300; beds in rooms #302, 307 and 320; an oxygen concentrator and nebulizer in room #304; an oxygen concentrator and mini nebulizer in room #312; and, a bed and mattress pump in room #311.	4/23/12
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred three (103) beds with a census of ninety six (96) on the day of the survey. The findings include:			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 15 Observations, on 03/08/12 between 9:44 AM and 11:19 AM, with the Maintenance Director revealed: 1) An open electrical junction box under the kitchen sink. 2) A battery charger for the bed batteries was plugged into a power strip located in the Wing 1 Med Room. 3) An oxygen concentrator and a bed were plugged into a power strip located in room #100. 4) A wound vac was plugged into an extension cord, and a bed was plugged into a power strip located in room #101. 5) An oxygen concentrator was plugged into a power strip located in room #102. 6) A power strip was lying across the residents sink, located in room #107. 7) A bed was plugged into a power strip, and the television cord was damaged and repaired with electrical tape located in room #111. 8) A bed was plugged into a power strip, also a refrigerator and an air conditioning unit were plugged into a power strip located in room #108. 9) A bed and an air mattress pump in a power strip located in room #110. 10) A bed in a power strip located in room #212. 11) A bed, B-PAP, and a mini nebulizer were in a power strip located in room #207. 12) A bed in a power strip located in room #206. 13) Three (3) refrigerators were plugged into a power strip located in the Wing 2 Med Room. 14) A power strip was plugged into another power strip located in the Social Services Office. 15) A bed and an IV pump were plugged into a power strip located in room # 300. 16) A bed was plugged into a power strip located in room #302,307, and 320.	K 147	The Maintenance Director will audit the entire facility on or before April 15, 2012 to identify any additional areas where power strips are being employed inappropriately or any uncovered junction boxes. Any identified additional issues will be corrected immediately upon discovery. Department heads and maintenance staff have been retrained on not using multiple power strips and not plugging medical equipment into power strips by the Administrator on 04/02/2012. Maintenance staff will make weekly rounds for four (4) weeks to identify any power strips that may have been brought into the facility and remove them. After the initial four (4) weeks, the Maintenance staff will make monthly rounds for the same purpose for two (2) additional months. Results of rounds will be brought to Quality Assurance Committee monthly for one (1) quarter for further recommendation. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, Maintenance Director, Social Services Director and the Medical Director on at least a quarterly basis.	

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 16 17) An oxygen concentrator and a nebulizer were plugged into a power strip located in room #304. 18) An oxygen concentrator and a mini nebulizer were plugged into a power strip located in room #312. 19) A bed and a mattress pump were plugged into a power strip located in room #311. Interview, on 03/08/12 between 9:44 AM and 11:19 AM, with the Maintenance Director revealed he was not aware the extension cords were only for temporary use, or the power strips were being misused. He was also not aware of the open electrical junction boxes in the attic.	K 147		
	Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 edition) 370.28(c) Covers.			

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185272	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF PADUCAH			STREET ADDRESS, CITY, STATE, ZIP CODE 867 MCGUIRE AVE. PADUCAH, KY 42001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	Continued From page 17 All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147			