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

PRINTED: 03/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185302	A. BUILDING _____ B. WING _____	03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF HARDINSBURG	101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143

(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 A standard health survey was conducted 03/09/10 through 03/11/10 and Life Safety Code survey on 03/10/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203	**F203 It is the policy of Medco Center of Hardinsburg to provide residents and family members with a written notice of transfer, including the reasons for the transfer.** 1. Residents #11 and #12 and their family members were contacted 3/31/10 and provided belated written notices of transfer issued via certified, return receipt mail. Residents and family members stated no harm was done. 2. Records of residents transferred or discharged in last 4 months were audited 4/1/10 to determine if appropriate written notice issued. If written notice was not given, resident and family were contacted, and belated written notice of transfer sent via certified mail, return receipt. 3. The Nursing Home Administrator re-educated the Business Office Manager on providing written notice of transfers/discharges on 3/29/10. The Business Office Manager to re-educate all licensed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Nell Bouvier
TITLE: Nursing Home Administrator
(X6) DATE: 4/1/10

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.

APR 5 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 203	Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the residents with a written notice of transfer including the reasons for the transfer, for two (2) of twenty-one (21) sampled residents (#11 and #12). The findings include: 1. Review of the clinical record for Resident #12 revealed the resident was admitted to the facility with a diagnoses of Depression, Dementia of Alzheimer Type, and Osteoporosis. The resident was transferred to the hospital on 04/16/09 for DVT (deep vein thrombosis) and readmitted to the facility on 04/20/09. The resident was	F 203	nurses on providing written notice of transfers/discharges by 4/10/10. 4. The Nursing Home Administrator will audit weekly x 12 weeks, all transfers/discharges for written notice of transfers sent certified mail, return receipt. Non compliance with providing written notice of transfers/discharges will result in progressive disciplinary action for the staff who fail to follow policy. The results of the audits will be presented monthly to Quality Assurance Committee, consisting of at minimum Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager, and Medical Director (quarterly attendant) for review x3 months. If at anytime concerns are identified the Quality Assurance Committee will make further recommendations. 5. Completion Date April 20, 2010	

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F 203	Continued From page 2 transferred to the hospital again on 11/02/09 due to being combative and was admitted for Dementia of Alzheimer type with disturbance of behavior and mood. There was no evidence in the record to indicate a written notice of transfer was provided to the resident when transferred to the hospital for either discharges. 2. Review of the clinical record for Resident #11 revealed the resident was admitted to the facility with a diagnoses of Depression, Diabetes Mellitus, Congestive Heart Failure, and a Gastrointestinal Hemorrhage. The resident was transferred, and admitted to the hospital on 12/09/09 for coffee ground emesis and readmitted to the facility on 12/12/09. There was no evidence in the record to indicate a written notice of transfer was provided to the resident when transferred to the hospital. Interview on 03/11/10 at 1:20pm with the Director of Nursing (DON) revealed the transfer notices were not done. The DON reported she had thoroughly reviewed the chart and was unable to locate any paperwork for the notice of transfer/bed hold. She stated the facility's policy was to give a notice of transfer/bed hold to each resident upon a transfer or discharge.	F 203		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and	F 205	**F205 It is the policy of Medco Center of Hardinsburg to provide residents with a notice of bed hold policy when transferred to the hospital.** 1. Residents #11 and #12 and their family members were contacted 3/31/10 and provided belated written notices of bed hold policy issued via	

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F 205	Continued From page 3 the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to provide two (2) of twenty-one (21) sampled residents with a notice of bed hold policy when transferred to the hospital. (Resident's #'s 11 and #12) The findings include: 1. Review of the clinical record for Resident #12 revealed the resident was admitted to the facility with a diagnoses of Depression, Dementia of Alzheimer Type, and Osteoporosis. The resident was transferred to the hospital on 04/16/09 for DVT (deep vein thrombosis) and readmitted to the facility on 04/20/09. The resident was transferred to the hospital again on 11/02/09 due to being combative and was admitted for Dementia of Alzheimer type with disturbance of behavior and mood. There was no evidence in the record to indicate a bed hold policy was provided to the resident when transferred to the hospital for either discharges. 2. Review of the clinical record for Resident #11	F 205	certified, return receipt mail. Residents and family members stated no harm was done. 2. Records of residents transferred or discharged in last 4 months were audited 4/1/10 to determine if appropriate written notice issued. If written notice was not given, resident and family were contacted and belated written notice of bed hold policy sent via certified mail, return receipt. 3. The Nursing Home Administrator re-educated the Business Office Manager on providing written notice of bed hold policy on 3/29/10. The Business Office Manager to re-educate all licensed nurses on providing written notice of bed hold policy by 4/10/10. 4. The Nursing Home Administrator will audit weekly x 12 weeks, all transfers/discharges, for written notice of bed hold policy sent certified mail, return receipt. Non compliance with providing written notice of bed hold policy will result in progressive disciplinary action for the staff who fail to follow policy. The results of the audits will be presented monthly to Quality Assurance Committee, consisting of at minimum Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager, and Medical Director	

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F 205	Continued From page 4 revealed the resident was admitted to the facility with a diagnoses of Depression, Diabetes Mellitus, Congestive Heart Failure, and a Gastrointestinal Hemorrhage. The resident was transferred, and admitted to the hospital on 12/09/09 for coffee ground emesis and readmitted to the facility on 12/12/09. There was no evidence in the record to indicate a bed hold policy was provided to the resident when transferred to the hospital. Interview on 03/11/10 at 1:20pm with the Director of Nursing revealed the bed hold notices were not done. She stated the facility policy was to provide a bed hold notice to each resident upon a transfer or discharge.	F 205	(quarterly attendant) for review x3 months. If at anytime concerns are identified the Quality Assurance Committee will make further recommendations. 5. Completion Date April 20, 2010	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure physician orders were accurately followed for one (1) of twenty-one (21) sampled residents, (Resident #7). Resident #7 continued to receive a medication daily that was ordered to be given every other day for fourteen (14) days. The findings include:	F 309	**F309 It is the policy of Medco Center of Hardinsburg to provide the necessary care and services to attain or maintain the highest practicable, physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.** 1. Resident #7 was assessed for physical, mental, or emotional trauma by a licensed nurse on 3/10/10 as result of med error; none was noted. Family and physician were notified of error on 3/10/10. 2. The Director of Nursing/Assistant Director of Nursing/Education Training Director observed random Medication Administration, 3/31/10, on all shifts with no concerns identified.	

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F 309	Continued From page 5 Record review of Resident #7 revealed the resident was admitted on 02/10/09 with the diagnosis of Subdural Hematoma, Congestive Heart Failure, Diabetes Mellitus, Seizures, Hypertension, Cardiovascular Accident, Cardiomyopathy, Depression, and Osteoarthritis. The Medication Administration Record (MAR) dated 02/01/10 revealed Resident #7 had a physician order dated 12/16/09 for Folic Acid 1 milligram (mg) orally once a day. The physician's order dated 02/24/10 revealed a change for Folic Acid 1 mg orally every other day. The MAR for 02/24/10 revealed the physician's order was transcribed as ordered. The MARs dated 02/25/10 through 03/10/10 revealed Resident #7 continued to receive Folic Acid 1 mg once a day for fourteen (14) days instead of every other day as ordered by the physician on 02/24/10. The facility's policy on Medication Errors dated January 2006 revealed Medication error can result in a disability, may require treatment with a prescription medication, result in cognitive deterioration or impairment, are life threatening, result in deaths, and/or results in congenital anomalies. The facility's policy revealed administration of the medications are given according to the frequency, route, and dose prescribed. Interview with LPN #1 on 03/10/10 at 10:15am revealed a medication error for Resident #7 had occurred from 02/25/10 through 03/10/10. LPN #1 revealed the nurse giving the medication is responsible to read the Medication Administration Record (MAR) correctly and is to give the medications accordingly. She acknowledge her responsibility with the medication error on	F 309	3. Nursing/Assistant Director of Nursing/Education Training Director to re-educate licensed nurses by 4/10/10 on Medication Administration. 4. Director of Nursing/Assistant Director of Nursing/Education Training Director to observe 10% of residents Medication Administration weekly x 12 weeks to ensure no med errors. Licensed Nurses who continue to make med errors will be retrained once, and then receive progressive discipline up to and including termination. Results of audits to be forwarded to Nursing Home Administrator for review weekly x 12 weeks. The audit results will be presented monthly to Quality Assurance Committee, consisting of at minimum Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) for review x 3 months. If at anytime concerns are identified, the Quality Assurance Committee will make further recommendations. 5. Completion Date April 20, 2010	

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F 309	Continued From page 6 03/10/10 and reported she did not read the MAR in detail.	F 309		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined the facility failed to ensure one resident (#16) of twenty-one (21) sampled residents received their diet as ordered by the physician. Resident #16 who has a physician's order for a dysphagia diet received a regular ground diet that was prepared for another resident. The findings include: Observation on 03/10/10 at 12:15pm revealed Resident #16 was provided a regular ground diet that was ordered for Resident #17. The diet consisted of ground chicken, noodles, green beans and soft fruit.Observations of the meal cards that accompanied Resident #16 and Resident #17's meals revealed they had the same last name. Record review on 03/10/10 revealed Resident #16's diet order was for a Dysphagia Level 3 diet. Review of the diet definition revealed the Dysphagia Level 3 diet was a "regular diet with foods altered in texture to easily form a bolus; ground meats that are moist, no hard, sticky or crunchy foods. The regular with ground meat diet	F 365	**F365 It is the policy of Medco Center of Hardinsburg to provide food in a form designed to meet individual needs.** 1. Resident #16 ate one green bean off Resident #17's tray before staff identified and immediately corrected. Both diets called for the same texture of green beans. Physician and family notified of issue on 3/10/10.Resident #16 suffered no harm. Resident #16 was observed by the Director of Nursing on 3/11/10 to receive the correct diet order for lunch per M.D. order. 2. Director of Nursing, Regional Dietician, and Nursing Home Administrator observed supper meal service on 3/10/10 and lunch meal service on 3/11/10 and validated all residents received correct diet order per M.D. order. The staff member who delivered the wrong tray was re-educated immediately on 3/10/10 on how to read tray cards and resident names by the Director of Nursing . 3. Director of Nursing/Assistant Director of Nursing/Education Training Director to re-educate nursing staff by 4/10/10 on how to read tray cards and resident names. 4. Director of Nursing/Assistant Director of Nursing/Education Training Director to audit meal service for one meal 2 x week x 12 weeks to make sure residents are	

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F 365	Continued From page 7 was described as a regular diet with ground meats or finely diced meats in soups. Review of the "Dysphagia Diet Rollout" revealed in-services were provided to staff on 01/12/10, 01/20/10, and 01/21/10. Interview on 03/10/10 at 12:17pm with CNA #1 revealed, she was new to the facility as of 02/23/10 and had not been trained regarding the residents' diets. She stated she should have looked at the first name of the resident as he/she and the other resident shared the same last names. The CNA stated the resident could choke if he/she had the wrong consistency of food provided to them. Interview on 03/10/10 at 12:15pm with the Registered Dietitian revealed both diets were similar to a mechanical soft diet; however, the differences, for example, is one could have whole crackers and the Dysphagia Level 3 diet should have ground crackers. The Dietitian stated she thought the Dietary Manager had completed a training on dysphagia diets last month; however, she did not know how new staff were trained. She stated it was important residents receive the appropriate diet as ordered.	F 365	receiving the correct diet and tray. Staff who continue to make meal service errors will be retrained once and then receive progressive discipline up to and including termination. Results of audits to be forwarded to Nursing Home Administrator for review weekly. The audit results will be presented monthly to Quality Assurance Committee, consisting of at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director(quarterly attendant) for review x 3 months. If at anytime concerns are identified, the Quality Assurance Committee will make further recommendations. 5. Completion Date April 20, 2010	
F 371 SS=D	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	**F371 It is the policy of Medco Center of Hardinsburg to distribute and serve ice under sanitary conditions.** 1. C.N.A. #1 was immediately shown the ice chest at the bottom of the cart and educated on how to serve ice by Director of Nursing on	

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to distribute and serve ice under sanitary conditions. The findings include: Observation on 03/09/10 at 11:00am during the lunch pass on the West Hall revealed that Certified Nurse Assistant's (CNA) were retrieving milk cartons from a container filled with ice with bare hands for resident use. Further observation on 03/09/10 at 11:10am, revealed CNA #1 took an ice scoop and scooped the ice located on top of the cartons of milk, then placed the ice in a container on top of the transport cart, and put into cups for resident use and delivered to resident rooms. Interview on 03/09/10 at 11:15am with CNA #1 revealed that she thought it was "OK" to use ice from the top of the cartons of milk for resident use. She stated she had not been trained not to use ice from the top of cartons of milk and was not aware that an ice cooler was located at the bottom of the transport cart. Interview on 03/11/10 at 3:00pm with the facility staff Educator revealed the norovirus or an infection could occur if ice is pulled from the top of the milk cartons and used directly for resident consumption. She stated there was no training on the transportation and delivery of ice. In addition, she stated new staff/orientee's should get on-the-floor training by an experienced staff.	F 371	3/09/10. Observation of supper meal service on 3/9/10 and lunch service on 3/10/10 by Director of Nursing/Assistant Director of Nursing/Education Training Director revealed no concerns with transport and distribution of ice during meal service. 2. Observation of supper meal service on 3/9/10 and lunch service on 3/10/10 by Director of Nursing/Assistant Director of Nursing/Education Training Director revealed no concerns with transport and distribution of ice. No residents were affected. 3. Director of Nursing/Assistant Director of Nursing/Education Training Director to educate all nursing staff on transportation and delivery of ice by 4/10/10. Transportation and ice delivery techniques to be added to nurse aide competency check sheet for orientation. 4. Director of Nursing/Assistant Director of Nursing/Education Training to audit meal service for one meal 2 x week x 12 weeks to make sure ice is being transported and delivered to residents correctly. Staff who transport and serve ice incorrectly will be retrained once and then receive progressive discipline up to and including termination. Results of audits to be forwarded to Nursing Home	

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F 371	Continued From page 9 Record review of the Infection Prevention and Control Program Policy dated November 2009, revealed health care workers will utilize Standard Precautions at all times and will utilize the Transmission-Based Precautions (Contact, Droplet, Airborne) as applicable.	F 371	Administrator for review weekly x 12 weeks. The audit results will be presented monthly to Quality Assurance Committee, consisting of at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) for review x 3 months. If at anytime concerns are identified, the Quality Assurance Committee will make further recommendations. 5. Completion date April 20, 2010	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	**F431 It is the policy of Medco Center of Hardinsburg to ensure expired medications are removed and not available and accessible for use for residents.** 1. The expired medications identified on 3/11/10 -- forty-five (45) tablets of bisacodyl EC 5 mg, eighty-two (82) tablets of Buspirone HCL 10 mg, one (1) vial set of Glucagen injectable, twenty-six (26) capsules of Loperamide Hydrocholoride 2 mg. seventy (70) tablets of Promethazine 25 mg, and sixty (60) tablets of Metoclopramide 5 mg – were immediately removed from these medication carts on 3/11/10. New medication was ordered from pharmacy by the Director of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185302		03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF HARDINSBURG	101 FAIRGROUNDS ROAD HARDINSBURG, KY 40143

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F 431	Continued From page 10 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure expired medications were removed and not available and accessible for use for residents on three (3) of four (4) medication carts. The findings include: Record review of the facility's policy on Storage and Expired Date of Drugs, Biologicals, Syringes, and Needles effective 12/01/07, and revised on 01/15/09 revealed the facility should ensure that drugs and biologicals that; (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier. Observation on 03/11/10 at 03:15pm revealed, expired medications remained on the West Hall Back, East Hall Back, and East Hall Front medication carts. The expired medications identified on the medication carts included forty-five (45) tablets of Bisacodyl EC 5 mg expired on 02/05/10, eighty-two (82) tablets of Buspirone HCL 10 mg expired on 10/15/09, one (1) vial set of Glucagen injectable expired on 02/2010, twenty-six (26) capsules of Loperamide Hydrochloride 2 mg expired on 02/15/10, seventy (70) tablets of Promethazine 25 mg on 02/15/10, and sixty (60) tablets of Metoclopramide 5 mg	F 431	Nursing to replace the expired medication. No residents received expired medications. 2. All medication carts were audited for expired medications by Director of Nursing/Assistant Director of Nursing/Education Training Director on 3/11/10. Any concerns were corrected. No residents received expired medications. 3. Director of Nursing has developed a schedule whereby licensed nurses check each medication cart weekly for expired meds, pull expired meds, and re-order medications if needed. Director of Nursing/Assistant Director of Nursing/Education Training Director to re-educate licensed nurses on "How to check for Expired Medications" and "How to Use the Schedule to Audit the Medication Carts" by 4/10/10. 4. Director of Nursing/Assistant Director of Nursing/Education Training Director to audit all med carts weekly x 12 weeks for expired meds. Results of these audits will be forwarded to Nursing Home Administrator for review weekly. The audit results will be presented monthly to Quality Assurance Committee, consisting of at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition	

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F 431	Continued From page 11 expired on 08/15/09. Interview on 03/11/10 at 3:15pm with Licensed Practical Nurse (LPN) #1 revealed that each nurse is responsible to check the expiration date on the medication prior to opening the package. She indicated expired medications were not to be given to residents. She did not have any explanation as to why expired medications remained on the medication cart. She reported the pharmacy group does on-site visits to review the carts and the medications every so often; however, she could not define when the last on-site visit was conducted. Interview on 03/11/10 at 3:20pm with the Director of Nursing (DON) revealed the night shift nurses do a monthly medication cart check. The DON indicated she did not have a method in place to ensure the medication carts were assigned to a specific person on a monthly basis. The DON reported the pharmacy representative does come to the facility to review the medications as well. She was unable to provide a specific date when the pharmacy representative last visited the facility, but, indicated the pharmacy was here and checked the medications on a quarterly basis. The DON revealed the facility notifies the pharmacy when they need to send cancelled or expired drugs back, and the facility reorders a fresh supply of medications as needed for the residents. Telephonic interview with the Executive Director of the Pharmacy (EDPH) on 3/11/10 at 3:58pm revealed he is the Executive Director of the company and not the consulting pharmacist for the facility. He was unable to provide a date for the last on-site pharmacist consultant visit during	F 431	Services Manager and Medical Director (quarterly attendant) for review monthly x 3 months. If at anytime concerns are identified, the Quality Assurance Committee will make further recommendations. 5. Completion date April 20, 2010	

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F 431	Continued From page 12 this interview, and unable to provide any information regarding the last on-site visit as that person was not in the facility. The EDPH reported he believed the Quality Assurance (QA) Consultant is in the facility every other month, and was unable to provide a date for the last visit to the facility. The EDPH indicted he did not know everything the Pharmacy consultant does, but did reveal the Pharmacy consultant evaluates the medications for appropriate drug therapy and opportunity to improve the drug therapies and does not review for expired dates on the medications.	F 431		
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure that a nurse aid completed the orientation process to ensure competency in skills to carry out appropriate infection control precautions and safety procedures necessary to care for residents' needs. A nurse aid was observed to retrieve ice from an iced milk container and serve it to residents for consumption. A resident (#16) who was to receive a dysphasia tray received a tray that was prepared for another resident who was on a regular ground diet. The findings include:	F 498	**F498 It is the policy of Medco Center of Hardinsburg that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care.** 1. Certified Nursing Assistant #1 will complete general orientation on 4/2/10. 2. The Director of Nursing/Assistant Director of Nursing/Education Training Director will audit all new hires from the previous 90 days to assure all have completed general orientation. Any identified will be given general orientation. 3. DVD player was replaced on 3/11/10. Education Training Director to be re-educated by Director of Nursing by 4/15/10.	

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F 498	Continued From page 13 Review of the facility policy for General Orientation on 03/11/10 revealed; "Each employee must participate in the General Orientation Program before they can begin work within their new role. All members of the management team will present the General Orientation Program to ensure an interdisciplinary experience for new employees." The purpose identified in the policy revealed General Orientation will provide basic information to new employees on the corporate health services, the mission, philosophies on customer service, and policies and procedures relating to all facets of the nursing home operation. A responsibility identified of the interdisciplinary team was to ensure all employees participate in General Orientation before their first shift on the floor. The policy noted "No employee can work a shift without having attended General Orientation first." 1. Observation on 03/09/10 at 11:00am during the lunch pass on the West Hall, revealed that Certified Nurse Aids (CNA) were retrieving milk cartons from a container filled with ice with bare hands for resident use. Further observation on 03/09/10 at 11:10am, revealed CNA #1 took an ice scoop and scooped the ice located on top of cartons of milk, then placed the ice in a container on top of the transport cart, that was then placed into cups for resident use and delivered to resident rooms. Interview on 03/09/10 at 11:15am with CNA #1 revealed that she thought it was "OK" to use ice from the top of the cartons of milk for resident use. She stated she had not been trained not to use ice from the top of cartons of milk and was not aware that an ice cooler was located at the	F 498	4. Nursing Home Administrator to audit new hires monthly x 3 months to ensure general orientation done. The audit results will be presented monthly to Quality Assurance Committee, consisting of at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) for review x 3 months. If at anytime concerns are identified, the Quality Assurance Committee will make further recommendations. 5. Completion date April 20, 2010	

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F 498	Continued From page 14 bottom of the transport cart. Interview on 03/11/10 at 3:00pm with the Nurse Educator revealed the norovirus or an infection could occur if ice is pulled from the top of the milk cartons and used directly for resident consumption. She stated there was no training on the transportation and delivery of ice. In addition, she stated new staff/orientee's should get on-the-floor training by an experienced staff. Record review of the Nursing Assistant Competencies Checklist revealed performance standard of CNA will effectively follow infection control programs. No training on delivery of ice is present on the Nursing Assessment Competencies Checklist. Record review of the Infection Prevention and Control Program Policy dated November 2009, revealed health care workers will utilize Standard Precautions at all times and will utilize the Transmission-Based Precautions (Contact, Droplet, Airborne) as applicable. 2. Observation on 03/10/10 at 12:15pm revealed Resident #16 was provided a regular ground diet that was ordered for Resident #17. The diet consisted of ground chicken, noodles, green beans and soft fruit. Observations of the meal cards that accompanied Resident #16 and Resident #17's meals revealed they had the same last name. Record review on 03/10/10 revealed Resident #16's diet order was for a Dysphagia Level 3 diet. Review of the diet definition revealed the Dysphagia Level 3 diet was a "regular diet with foods altered in texture to easily form a bolus;	F 498		

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F 498	Continued From page 15 ground meats that are moist, no hard, sticky or crunchy foods. The regular with ground meat diet was described as a regular diet with ground meats or finely diced meats in soups. Review of the "Dysphagia Diet Rollout" revealed in-services were provided to staff on 01/12/10, 01/20/10, and 01/21/10. Interview on 03/10/10 at 12:17pm with CNA #1 revealed, she was new to the facility as of 02/23/10 and had not been trained regarding the residents' diets. She stated she should have looked at the first name of the resident as he/she and the other resident shared the same last names. The CNA stated the resident could choke if he/she had the wrong consistency of food provided to them. Interview on 03/10/10 at 12:15pm with the Registered Dietitian revealed both diets were similar to a mechanical soft diet; however, the differences is one could have, for example, whole crackers and the Dysphagia Level 3 diet should have ground crackers. The Dietitian stated she thought the Dietary Manager had completed a training on Dysphagia diets last month; however, she did not know how new staff were trained. She stated it was important residents receive the appropriate diet as ordered. Interview on 03/11/10 at 9:10am with the Nurse Educator revealed she was new to the position and had limited experience training new staff. She stated CNA #1 had not completed the orientation process prior to working on the unit. She stated she had gone over basic information to include abuse/neglect, HIPPA, patient rights, and Human Resources personnel had gone over the required paper work with CNA#1. She stated	F 498		

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F 498	Continued From page 16 the videos were a part of the orientation; however, the DVD player was not working and she was not able to utilize them as an educational tool for the two new CNA's she had trained on 02/23/10. She stated the new orientee's should have one complete day of orientation; however, she had only been with them for about three (3) to four (4) hours. She stated they were allowed several breaks and some time for the Human Resource person to complete the required paper work. She stated other staff were not utilized to train the new orientees. She stated the new orientee should have an experienced staff to monitor them and assist as needed. She said a new employee competency would be evaluated after the first month. She stated since she was new to training the new orientee's she had not scheduled other departments such as dietary to talk with CNA#1. The Nurse Educator stated she was not familiar with the facility policy regarding the training requirements. She stated CNA#1 was immediately placed on the unit to work without an experienced staff to monitor her. In addition; she had not followed up with the new CNA's to assure they were competent in their new positions. She stated she had informed the Director of Nurses (DON) and the Assistant Director of Nursing (ADON) that the two new staff had not completed the orientation process; however, they were allowed to work on the unit with the residents. Interview on 03/11/10 at 8:55am with the DON revealed they had not started a formal mentoring program; however, they would normally assign an experienced staff to train new employees on the floor. She stated CNA#1 was assigned to work on the unit without a person to work with her because they did not have an available staff at the time. The DON stated she knew the training	F 498		

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F 498	Continued From page 17 for CNA #1 had not been completed. She stated new employees were to be evaluated for competencies after the first month.	F 498		

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4/5/10

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185302	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/10/2010

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K 000	INITIAL COMMENTS A Life Safety Code survey was completed on 03/10/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest scope/severity identified at an "F" (K 211).	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 03/10/10, it was determined the facility failed to ensure sprinkler heads were free of lint and dust as required by NFPA 25 1999 Edition. The findings include: A tour of the facility conducted 03/10/10 at 9:30am revealed five sprinkler heads in the kitchen had a build-up of lint and dust. Interview with the Maintenance Director on 03/10/10 at 9:35am revealed he was unaware of the build-up of lint and dust on the sprinkler heads.	K 062	**K062 It is the policy of Medco Center of Hardinsburg that automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.** 1. Five dry pendant sprinkler heads in kitchen have been cleaned. 2. All sprinkler heads in facility inspected by Maintenance Director on 3/31/10;all free of lint and dust. 3. Nursing Home Administrator to re-educate Maintenance Director on requirement to keep sprinkler heads free of lint and dust on 4/1/10. Maintenance Director to inspect facility sprinkler heads monthly for lint and dust buildup as part of Preventive Maintenance check list; monthly cleaning schedule developed for sprinkler heads. 4. Maintenance Director to report to Quality Assurance Committee monthly x 3 months as part of Preventive Maintenance Report on status of Sprinkler Head Replacement and Cleaning needs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mary Nell Bouvier — Nursing Home Administrator — 4/1/10

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

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K 062	Continued From page 1 Reference to: NFPA 25 1999 Edition 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	The Quality Assurance Committee, consisting of at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) will make further recommendations if additional sprinkler concerns are identified. 5. Completion Date: April 20, 2010	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview conducted on 03/10/10, it was determined the facility failed to conduct inspections every six months of the exhaust hood as required by NFPA. The findings include: Record review conducted on 03/10/10 revealed the exhaust hood was inspected on an annual basis. An interview conducted with the Maintenance Director on 03/10/10 at 10:00 am revealed the exhaust hood in the kitchen was inspected once a year by a fire safety contractor. The Maintenance	K 069	**K069 It is the policy of Medco Center to conduct inspections every six months of the exhaust hood as required by NFPA.** 1. Koorson Company will continue to inspect facility kitchen exhaust hood q 6 months and Pure Air Inc. will clean the facility kitchen exhaust hood q 6 months. The next scheduled inspection and cleaning is 4/12/10 @ 3:30 p.m. The last inspection and cleaning was done in 10/09. 2. There are no other kitchen exhaust hoods in the Center. 3. Nursing Home Administrator will reeducate on 4/1/10 Maintenance Director on NFPA regulations regarding inspection and cleaning	

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K 069	Continued From page 2. Director was unaware of the requirement that the exhaust hood should be inspected every six months by a qualified person. NFPA-96 1998 Edition 8-2* Inspection. An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. 8-2.1 All actuation components, including remote manual pull stations, mechanical or electrical device, detectors, actuators, and fire-actuated dampers, shall be checked for proper operation during the inspection in accordance with manufacturer's listed procedures. In addition to these requirements, the specific inspection requirements of the application NFPA standard shall also be followed. 8-2.2 Fusible links (including fusible links on fire-actuated damper assemblies) and automatic sprinkler heads shall be replaced at least annually, or more frequently if necessary, to ensure proper operation of the system. Other devices shall be serviced or replaced in accordance with the manufacturer's recommendations. Exception: When automatic bulb-type sprinklers	K 069	of facility kitchen exhaust hood to ensure facility in compliance. 4. The Maintenance Director will monitor facility kitchen exhaust hood to ensure cleaning done q 6 months. The results of the inspection will be forwarded to the Nursing Home Administrator and presented monthly to the Quality Assurance Committee, consisting of at minimum Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) for review. If concerns are identified, Quality Assurance Committee will make further recommendations. 5. Completion Date: April 20, 2010	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185302	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 069	Continued From page 3 or spray nozzles are used and annual examination shows no buildup of grease or other material on the sprinkler or spray nozzles.	K 069		
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 03/10/10, it was determined the facility failed to ensure decorations used in the facility were flame-retardant as required by NFPA 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. The findings include: Observations during the Life Safety Code tour conducted on 03/10/10, at 9:30am, revealed the doors to the following rooms, #2, #3, #5, #17, #23, and the door to the Administrator's office, were decorated with wreaths. An interview conducted with the Maintenance Director on 03/10/10 at 9:35am revealed the wreaths had been put on the doors by family members and the facility did not have any documentation that would indicate the flame rating of the wreaths on the doors.	K 073	**K073 It is the policy of Medco Center that no furnishings or decorations of highly flammable character are used.** 1. Wreaths were immediately removed from all doors on 3/10/10.Wreaths sprayed by Maintenance Director with approved fire retardant and documentation done. 2. Maintenance Director conducted environmental rounds on 4/1/10, to identify any other decorations that may not be flame retardant; none were identified. 3. Nursing Home Administrator re-educated Maintenance Director on Flame Retardant requirements on 3/31/10. Residents, staff, and family members notified per letter dated 4/3/10 that decorations are not to be put on doors or in rooms unless the family can provide documentation that decorations are flame retardant or treated by facility with approved fire retardant and documentation done. New residents to receive this information upon admission to facility beginning 4/3/10. 4. Maintenance Director to conduct monthly rounds x 3 months to identify any decorative items that may not be flame retardant. The	
K 211 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser	K 211		

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K 211	Continued From page 4 capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 03/10/10, it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source. The findings include: The Life Safety Code Tour conducted on 03/10/10 at 9:45am, with the Director of Maintenance, revealed Alcohol Based Hand Rub dispensers were installed over or adjacent to the light switch in rooms throughout the facility. An interview conducted with the Maintenance Director on 03/10/10 at 9:50am revealed Alcohol Based Hand Rub dispensers were installed over or adjacent to light switches throughout the facility.	K 211	results of the inspection will be forwarded to the Nursing Home Administrator monthly x 3 months and presented monthly to the Quality Assurance Committee, consisting of at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager and Medical Director (quarterly attendant) for review x 3 months. If concerns are identified, Quality Assurance Committee will make further recommendations. 5. Completion Date: April 20, 2010 **K211 It is the policy of Medco Center of Hardinsburg to ensure that Alcohol Based Hand Rub dispensers are not installed over or adjacent to an ignition source.** 1. Hand sanitizer dispensers were taken down and moved to a location that is not over or adjacent to an ignition source on 4/5/10 2. All hand sanitizer dispensers in the facility were checked on 4/5/10. to ensure they are located in an approved location. Concerns were corrected. 3. Nursing Home Administrator re-educated Maintenance Director on Life Safety Code and placement of	

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			Alcohol Based Hand Rub dispensers on 4/1/10. 4. The Nursing Home Administrator will monitor by conducting rounds monthly x 3 months to ensure that future placement of Alcohol Based Hand Rub dispensers meets Life Safety Code requirements. If concerns are identified they will be presented to the Quality Assurance Committee for recommendations. The Quality Assurance Committee consists of, at minimum, Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Nutrition Services Manager, and Medical Director(quarterly attendant). 5. Completion date: April 20, 2010	

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