

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

PRINTED: 09/15/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/31/2011
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NAME OF PROVIDER OR SUPPLIER  MEDCO CENTER OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST FRANKLIN, KY 42135
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F 000	INITIAL COMMENTS  An abbreviated survey (KY #16974) was conducted on 08/26/11 through 08/31/11 to determine the facility's compliance with Federal requirements. The facility did not meet Federal regulatory requirements with deficiencies cited at the highest S/S of "D." KY #16974 was substantiated with deficiencies cited.	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 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. Resident #1 expired on 06/14/2011.  2. All current residents medical records will be reviewed for the past thirty(30) days by the Director of Nursing or Assistant Director of Nursing and the Unit Managers by October 7, 2011 to identify any residents with a change in condition that did not have proper physician notification. Any concerns which are identified through this record review will be immediately communicated to the physician and the facility will follow direction given by the attending physician.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jason* TITLE Administrator (X6) DATE 10/13/2011

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

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F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of facility policy/procedure and record review, it was determined the facility failed to notify the physician for one resident (#1), in the selected sample of three (3), related to a significant change in the resident's physical and mental status. On 06/13-14/11, Resident #1 experienced extreme restlessness, changes in skin color, and periods of apnea (not breathing). The resident expired on 06/14/11.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure "Notification of Resident Change In Condition," dated October 1999 with a revised date of July 2011, revealed "the physician was to be notified immediately of a significant change in a resident's condition."</p> <p>A record review revealed Resident #1 was admitted to the facility on 01/21/10 with diagnoses to include Chronic Renal Failure, Diabetes Mellitus Type II, Hypertension, Colon Cancer, Arthritis and Congestive Heart Failure.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 03/28/11, revealed Resident #1 was moderately cognitively impaired. He/she required supervision with bed mobility, transfers, dressing and ambulation. The resident required extensive</p>	F 157	<p>F157 cont.</p> <p>3. All licensed nurses will be re-educated by the Education and Training Director, Director of Nursing or Assistant Director of Nursing on physician notification for a change in condition by October 7, 2011.</p> <p>4. The Director of Nursing or the Assistant Director of Nursing will audit ten (10) medical records weekly for twelve (12) weeks to assure proper notification of the physician on a change in resident condition. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</p> <p>Completion Date:</p>	<p>1</p> <p>10/8/2011</p>

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F 157	<p>Continued From page 2</p> <p>assistance with hygiene and bathing and was continent of bowel and bladder.</p> <p>A care plan for "Palliative Care with Comfort Measures only," dated 05/26/11, revealed there was no intervention for oxygen (O2) therapy.</p> <p>An interview with Certified Nurse Aide (CNA) #10, on 08/30/11 at 2:20 PM, revealed she was the the only CNA who worked "B" wing on the night of 06/13-14/11. She stated the resident was restless and repeatedly tried to climb out of his/her bed onto the floor mat. She asked another CNA from the "A wing" to assist her with the transfer of Resident #1 to a geri-chair. They assisted the resident to a geri-chair and placed him/her at the nurse's station, in view of the charge nurse who would be able to monitor him/her while CNA #10 provided care for other residents. She stated the resident continued to be restless and tried to take his/her clothes off. She stated she was afraid he/she might try to get up from the geri-chair on his/her own, so she brought the resident along with her while she provided care to the other residents.</p> <p>A review of nurses' notes, dated 06/14/11 at 2:45 AM, revealed the resident was restless and tried to crawl out of his/her bed onto the floor mat. The resident was then placed into a geri-chair. The color of the resident's nail beds was described as "dull and dusky." Further review of the documentation, at 10:00 AM, revealed the resident had periods of apnea (not breathing). There was no documented evidence the physician was notified.</p> <p>An interview with Registered Nurse (RN) #1, on</p>	F 157			

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F 157	Continued From page 3 08/30/11 at 1:40 PM, revealed it was reported to her, at shift change on 06/13/11, about Resident #1 being restless and trying to climb out of his/her bed. The resident was placed in a geri-chair and remained at the nurse's station most of the shift. She stated Resident #1 continued to be restless and tried to disrobe himself/herself. The resident was covered with a sheet which was "tucked" in the back of the geri-chair. She stated she assessed the resident for pain; however, she did not notify the physician.  An interview with Resident #1's physician, on 08/31/11 at 2:05 PM, revealed he was not notified about the resident's change in condition.  An interview with the Director of Nursing (DON, on 08/31/11 at 3:55 PM, revealed the resident was on palliative care; however, the physician should have been notified due to the resident's restlessness, color changes and the episodes of not breathing.	F 157			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on interview, review of facility policy/procedure and record review, it was determined the facility failed to ensure one resident (#1) in the selected sample of three, had the right to be free from a physical restraint	F 221	F221  1. Resident #1 expired on 06/14/2011.  2. All residents will be observed by 09/26/2011 and by 09/27/2011 for restraints by the Director of Nursing or Assistant Director of Nursing. An audit of all current resident charts will be completed by the Director of Nursing or Assistant Director of Nursing before October 7, 2011. Any residents with identified restraints will be reviewed to determine need for restraint as well as determine if an assessment, physician order and care plan are present by the IDT(Interdisciplinary Team) before October 7, 2011.		

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F 221	<p>Continued From page 4</p> <p>imposed for purposes of discipline or convenience, and not required to treat the resident's symptoms. On 06/13/11, Resident #1 was restless while up in a geri-chair and tried to disrobe himself/herself. The resident was then covered with a sheet, which was "tucked" in the back of the geri-chair.</p> <p>The findings include:</p> <p>A review of the facility's restraint policy and procedure "Safety Device-Least Restrictive," dated January 2009 and revised January 2011, revealed a restraining device to be "any manual method, physical or mechanical safety device, material or equipment attached to the resident's body which cannot be removed or restricts freedom of movement or normal access to one's body." Examples included, "tucking a sheet so that a resident's movement is restricted."</p> <p>A record review revealed Resident #1 was admitted to the facility on 01/21/10 with diagnoses to include Chronic Renal Failure, Diabetes Mellitus Type II, Hypertension, Colon Cancer, Arthritis and Congestive Heart Failure. /</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 03/28/11, revealed Resident #1 to be moderately cognitively impaired, required supervision with bed mobility, transfers, dressing and ambulation. He/she required extensive assistance with hygiene/bathing and was continent of bowel and bladder.</p> <p>A review of the Comprehensive Care Plan for "Safety Device," dated 06/13/11, did not include the use of a sheet as a safety device.</p>	F 221	<p><i>F221 Cont.</i></p> <p>3. All licensed staff will be reeducated by October 7, 2011 on the definition of a restraint as well as the requirements for application of a restraint. Any new orders or device changes will be reviewed by the IDT(Interdisciplinary Team). All Direct care staff will be educated by the Director of Nursing or the Education and Training Director by October 7, 2011 on the definition of a restraint.</p> <p>4. The Director of Nursing or the Education and Training Director will complete observations five (5) days a week for 5 weeks, then four (4) days a week for 5 weeks, then three (3) days a week for five weeks and report the results to the QA committee. The observations will include observing for restraints in the building that have not been assessed properly or are without orders or properly care planned. The Director of Nursing or the Education and Training Director will complete five (5) record reviews on residents with restraints weekly for twelve (12) weeks and report to the QA Committee any findings. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</p> <p><i>Completion Date:</i></p>	10/8/2011

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F 221	<p>Continued From page 5</p> <p>An interview with Certified Nurse Aide (CNA) #10, on 08/30/11 at 2:20 PM, revealed she was the the only CNA who worked "B" wing on the night of 06/13-14/11. She stated the Resident #1 was restless and repeatedly tried to climb out of his/her bed onto the floor mat. She asked another CNA from the "A wing" to assist her with the transfer of the resident to a geri-chair. They assisted the resident to a geri-chair and placed him/her at the nurse's station, in view of the charge nurse who was to monitor him/her while CNA #10 provided care for other residents. She stated the resident continued to be restless and tried to take his/her clothes off. She stated she was afraid he/she might try to get up from the geri-chair on his/her own, so she brought the resident along with her while she provided care to the other residents.</p> <p>An interview with Registered Nurse (RN) #1, on 08/30/11 at 1:40 PM, revealed, in shift report on 06/13/11, it was reported to her about Resident #1 being restless and trying to climb out of his/her bed. The resident was placed in a geri-chair and remained at the nurse's station most of the shift. She stated Resident #1 continued to be restless and tried to disrobe himself/herself. The resident was covered with a sheet which was "tucked" in the back of the geri-chair.</p> <p>An interview with the Director of Nursing (DON), on 08/31/11 at 3:55 PM, revealed no sheets/covers should be "tucked in" around any resident.</p> <p>An interview with the Administrator, on 08/26/11 at 10:40 AM, revealed he did not conduct a</p>	F 221		
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F 221	Continued From page 6 formal investigation related to the resident having a sheet "tucked in" around him/her while in a geri-chair. No further explanation was provided.	F 221		
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