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

PRINTED: 06/06/2012
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
	185272	A. BUILDING B. WING	C 05/22/2012

RECEIVED JUN 2012 OFFICE OF INSPECTOR GENERAL

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF PADUCAH	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 An abbreviated survey (KY #18376) was conducted on 05/18/12 through 05/22/12 to determine the facility's compliance with Federal requirements. KY #18376 was substantiated with deficiencies cited at the highest scope/severity of a "D" related to the allegation.	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 Title18, 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 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 interview, record review, and review of the facility's policy and procedure, it was determined the facility failed 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 for one resident (#1), in the selected sample of three residents. The facility failed to conduct ongoing post fall assessments and neurochecks for Resident #1 after he/she sustained a fall on 03/17/12. Findings include: A review of the facility's policy and procedure for Episodic Documentation, last revised November	F 309	1. Resident #1 no longer resides at facility. Resident discharged to hospital on 3/19/12. 2. On 6/13/12, the Director of Nursing, the Assistant Director of Nursing, and the Education and Training Director conducted an audit on all residents with fall in last 30 days to ensure that post fall assessments and neurological assessments were conducted if warranted. Physician was notified of any issues identified.	6/17/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: NHA (X6) DATE: 6/15/12

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.

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F 309	Continued From page 1 2011, revealed facility staff should document in the nurse's progress notes for a minimum of every shift for 72 hours to include vital signs and neurological assessment, if applicable. A record review revealed the facility admitted Resident #1 to the facility on 11/10/11 with diagnoses to include Dementia, Psychotic Disorder, Renal Failure, Renal Dialysis, Metabolic Encephalopathy and Osteoporosis. A review of the quarterly Minimum Data Set, (MDS) assessment, dated 02/02/12, revealed the facility assessed Resident #1 as cognitively intact and required extensive assistance of two staff for transfers and one staff for bed mobility. Further review revealed Resident #1 had two falls since admission with no injury. A review of the Comprehensive Care Plan, dated 11/2011, revealed the facility care planned Resident #1 at risk for falls with an intervention to conduct neurochecks per protocol. A review of the nurse's progress notes and post fall assessment, dated 03/17/12, revealed Resident #1 sustained a fall from his/her bed at 12:45 AM. Further review revealed the neurological assessment was initiated which should have included an assessment every 15 minutes times four, every 30 minutes times four, every hour times four, every four hours times four, then every eight hours. The assessment included vital signs, pupil reaction, motor functions, level of consciousness, pain response and any other noted changes. Further review of the assessments revealed facility licensed staff did not conduct the every four hour or eight hour	F 309	3. All licensed nurses will be reeducated by the Education and Training Director by 6/16/12 on post fall assessments to ensure that licensed staff document in the nurse's progress notes for a minimum of 72 hours to include vital signs, and neurological assessment if applicable. 4. The Director of Nursing, the Assistant Director of Nursing and/ or Unit Managers will review falls daily Monday through Friday for four (4) weeks, then weekly for eight (8) weeks to ensure that post fall assessments are being documented for a minimum of 72 hours every shift and neurological assessments are completed according to policy. The results of these audits will be forward 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.	

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F 309	Continued From page 2 assessments. Review revealed the last time Resident #1 received a neurological assessment was on 03/18/12 at 2:00 AM. Licensed staff should also have conducted neurological assessments on 03/18/12 at 10:00 AM and 6:00 PM, and on 03/19/12 at 2:00 AM. Further review of the nurse's progress notes and vital signs sheets, dated 03/17/12 - 03/19/12, revealed there was no evidence the facility conducted episodic documentation for Resident #1, to include vital signs on 03/18/12 during day shift and night shift, which resulted in the resident going over 24 hours without an assessment. Interview with Registered Nurse (RN) #1 and RN #3, Licensed Practical Nurse (LPN) #2, LPN #3, and LPN #4, on 05/18/12 at 2:30 PM, and on 05/21/12 at 11:10 AM, 11:15 AM and 11:20 AM, respectively, revealed if a fall was unwitnessed or if staff witnessed the resident hit his/her head during a fall, the licensed staff should initiate neurological assessments according to the the neuro-check flow sheet. When a resident sustained a fall, documentation was to be completed every shift for 72 hours. Licensed staff were suppose to assess the resident to determine if the resident was having any pain, had any injuries, if there were any further falls, or any changes in mental status and vital signs. A review of a physician communication and progress note, dated 03/19/12 at 11:00 AM, revealed the resident was unresponsive, his/her temperature was 102.2 degrees Fahrenheit, pupils were non-reactive, a blood pressure reading of 148/102, pulse 96, rapid and thready, respirations were 28 with an oxygen saturation of	F 309		

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F 309	Continued From page 3 89%. The physician and family were notified and the resident was sent out to the hospital. A review of the hospital's history and physical, dated 03/19/12, and discharge summary, dated 04/27/12, revealed when Resident #1 arrived at the hospital, he/she was able to move his/her upper and lower extremities. Further review revealed the physician felt the resident had an infection related to perma-cath for dialysis, and was started on antibiotics. Later that evening, the resident began to complain of neck pain and was unable to move his/her upper and lower extremities. A Magnetic Resonance Imaging (MRI) was ordered due to the possibility of an epidural abscess, and revealed Resident #1 had a fracture to the C4 and C5 with posterior subluxation with C4 and spinal cord compression. The examination was consistent with quadriplegia. An interview with the Director of Nursing (DON), on 05/21/12 at 10:40 AM, revealed licensed staff should have monitored Resident #1 after the fall every shift for 72 hours. Additionally, neurological assessments should have been conducted according to the neuro check flow sheet every 15 minutes times four, every 30 minutes time four, every hour times four, every four hours times four, and every eight hours times four.	F 309		