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OFFICE OF INSPECTOR GENERAL

PRINTED: 11/17/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2011
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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F 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted from 11/01/11 through 11/03/11 and a Life Safety Code survey was conducted on 11/01/11 with the highest scope and severity of an "F".</p> <p>An abbreviated survey was initiated on 11/01/11 and concluded on 11/03/11 to investigate KY18539, KY18715 and KY17011. The Division of Health Care unsubstantiated the allegation due to lack of sufficient evidence. Therefore, no regulatory violations was identified.</p>	F 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 (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>	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the nursing supervisor competencies, and record review of the facility's medication pass guidelines audit sheet, it was determined the facility failed to ensure proper medication administration via Enteral tube (a medical device to provide nutrition and medications to patients) for one (1) of sixteen (16) sampled residents. The facility failed to administer medications via enteral tube correctly for Resident #1 which resulted in a clogged enteral tube.</p> <p>The findings include:</p> <p>Record review of the facility's policy titled Medication Administration, dated July 2010, revealed Enteral Tube procedure to prepare</p>	F 281	<p>The Director of Nursing observed on 11-23-2011 that resident # 1 G-tube was patent and that Medications were being crushed, mixed with at least 20 ml of water followed by 30 ml of water per facility policy.</p>	12-15-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE <i>X Administrator X</i>	(X6) DATE <i>11-23-11</i>
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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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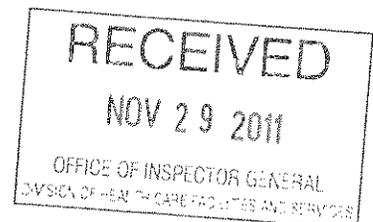
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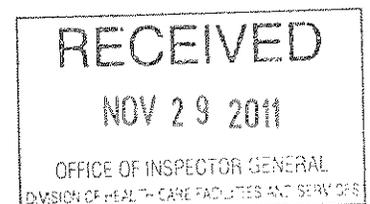
F 281	<p>Continued From page 1</p> <p>medications was to finely crush tablets and mix with twenty (20) ml of water ...verify tube placement and check for gastric contents and reinstall. Flush tube with thirty (30) ml of water before and after medications.</p> <p>Interview, on 11/03/11 at 10:23 AM, with Director of Nursing (DON), revealed medications via enteral tubes should not be placed in a syringe dry due to the risk of a clogged tube.</p> <p>Observation, on 11/02/11 at 8:55 AM, in Resident #1's room with RN #2 revealed during medication administration via enteral tube she placed dry crushed medications into the resident enteral tube followed by five (5) ml of water. The RN preceded to administered three additional cups containing dry, crushed medications followed by five (5) ml of water individually until the enteral tube was clogged.</p> <p>Interview, on 11/02/11 at 8:55 AM to 10:30 AM, with RN #2 revealed she used five (5) ml of water between medications via the enteral tube. RN #2 stated after four (4) of the medications were administered, the tube was clogged. RN #2 confirmed she did not know the facility policy for enteral tube medication administration. She further revealed this was the way she gave enteral medications to facility residents. She stated she crushed the medications and placed them in a syringe dry and added five (5) ml of water between each medication. The nurse could not recall any in-services provided by the facility related to medication administration via enteral tubes.</p> <p>Review of the facility's nursing supervisor competency form utilized by the facility staff,</p>	F 281	<p>The Director of Nursing observed on 11-23-2011 that all residents with g-tube medications had their medications crushed, mixed with at least 20ml of water followed by at least 30ml of water per facility policy. All Licensed staff will be re-educated by the Director of Education and Training, The Director of Nursing, The Assistant Director of Nursing, the District Education and Training Director or Unit Manager on the facility policy for medication administration per g-tube to include crushing medications and mixing with at least 20ml of water followed by 30 ml of water. This education will be completed by 12-17-2011 with no licensed staff working after 12-17-2011 without having had this education. The Director of Nursing, Assistant Director of Nursing or the Unit Manager will complete five (5) G-tube medication administrations per week for twelve (12) weeks to assure on going compliance with crushing medications then mixing with at least 20ml of water followed by 30 ml of water. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	12-18-11
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F 281	Continued From page 2 dated 03/01/05, revealed Registered Nurse (RN) #2 evaluation date was 04/16/11 was completed during the orientation phase. Performance standard #4 titled " Effectively performs nursing functions " , subtitle h. " Gastric (enteral) tubes " indicated a check under column meets standard. Page three of competency sheet confirmed signatures of RN #2 and the DOE. Review of the facility's medication pass guideline tool, dated 2006, used by the DOE on 01/18/11 at 8:05 PM confirmed RN #2 completed medication administered by enteral tube indicating she flushed with thirty (30) ml before and after all medication were administered. Continued interview, on 11/03/11, with DON revealed RN #2 should have mixed the crushed medications with water and flushed with thirty (30) ml of water before and after each medication administration as well as between each medication.	F 281		
F 371 SS=F	483.35(j) 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 This REQUIREMENT is not met as evidenced by:	F 371	F371 The popping corn in the Activity Room was discarded and an observation by the Administrator on 11-23-2100 noted the popcorn to be stored off the floor in a sealed container. The greens noted to exceed the use by date were discarded on 11-3-2011. The crate of milk in the cooler was discarded on 11-4-2011. The freezer temperature was noted by the Director of Nursing to be minus ten degrees on 11-22-2011.	



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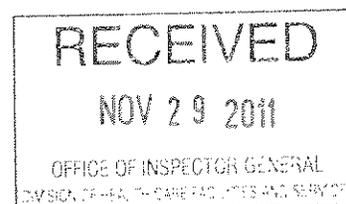
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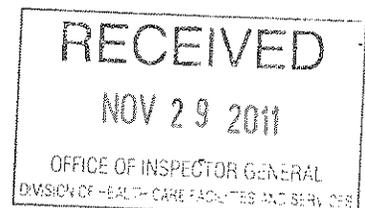
F 371	<p>Continued From page 3</p> <p>Based on observation, interview, and review of the facility's policy on Food Storage and Serving, it was determined the facility failed to store and serve food under sanitary conditions. One (1) of one (1) fifty (50) pound bag of popping corn was found on the floor in the Activity Room open to air. Six (6) of six (6) bags of fresh greens were found in the refrigerator that exceeded the use by date. One (1) crate out of five (5) crates was found in the milk cooler with thirteen (13) individuals cartons of milk that exceeded the use by date.</p> <p>The findings include:</p> <p>Review of the facility's policy for freezer storage revealed freezers should be maintained at a temperature of 0 degrees Fahrenheit or below. The facility did not provide a policy for discarding expired foods and storage of dry goods.</p> <p>Review of the facility's refrigeration temperature log for the small freezer revealed temperatures ranged between 7 degrees Fahrenheit and 12 degree Fahrenheit for the past thirty (30) days.</p> <p>Observation, on 11/01/11 at 9:30 AM, during initial tour revealed one (1) opened bag of lettuce and one (1) unopened bag of lettuce with a use by date of 10/29/11 in the walk-in refrigerator. Thirteen (13) individual cartons of milk were found in the milk cooler with a use by date of 10/28/11.</p> <p>Observation, on 11/02/11 at 7:05 AM, of the activity room revealed one (1) opened, unsealed bag of popping corn on the floor.</p>	F 371	<p>An observation by the Administrator on 11-23-2011 noted there were no foods stored in the activity room that was not covered and stored off the floor. An observation by the Dietary Service Manager on 11-4-2011 noted that there were no expired foods in the refrigerator, freezer or milk cooler. An observation by the Director of Nursing on 11-22-2011 noted the freezer temperatures to be minus 10 degrees.</p> <p>The Activity Director and Assistant Activity Directors will be re-educated by the Administrator by 12-17-2011 related to storage of food items in the activity room to include storing foods off the floor and in appropriate containers. The Dietary Service manager will re-educate the Dietary Staff related to proper storage of foods as well as rotation of stock and discarding items when expired by 12-17-11. In addition, the Dietary Service manager will re-educate the Dietary staff by 12-17-11 related to maintaining appropriate freezer temperatures and notification of the Maintenance Director if concerns are identified with the freezer temperatures.</p> <p>The Activities Director will complete an audit of the Activity Room weekly for twelve (12) weeks to assure all foods are stored</p>	
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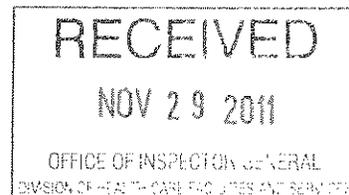
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F 371	Continued From page 4 Observation, on 11/03/11 at 9:45 AM, of the walk-in refrigerator revealed three (3) bags of unopened Spinach with a use by date of 10/30/11. Interview with the Dietary Manager (DM), on 11/03/11 at 9:45 AM, confirmed that expired lettuce, spinach, and milk should be discarded by the use by dates. DM was uncertain what temperatures the freezers should be and said she would review the facility's policies. DM said she was responsible for storage of dry food in the kitchen and was not aware that the popping corn was on the floor in the activity room. DM said dry foods should be sealed and stored off of the floor. Interview with Assistant Activities Director (AAD), on 11/03/11 at 9:45 AM, confirmed that opened popcorn was usually kept in a sealed container on the counter and the opened bag on the floor could attract rodents or insects.	F 371	appropriately. The Dietary Service manager will complete an audit of the food storage areas weekly for twelve(12) weeks to assure all foods are not expired. The Dietary Service Manager will complete an audit of the walk in freezer weekly for twelve (12) weeks to assure freezer temperatures are zero degrees or below. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	F425 Resident # 4's Xanax was delivered on 11-3-2011. An audit of all current resident's medications will be completed by 12-17-2011 by the Director of Nursing, the Assistant Director of Nursing and the Unit Manager to assure all medications are available. Any identified unavailable medications will have immediate replacement. All Licensed staff will be re-educated by the Director of Nursing, the Assistant Director of Nursing, the District Education and Training Director or the Unit Manager on notification of the Director of Nursing and the Physician if medications are not available as well as the procedure for procurement of medications. This education will be completed by 12-17-2011 with no licensed staff working after 12-17-2011 without having receiving this training.	12-18-11	



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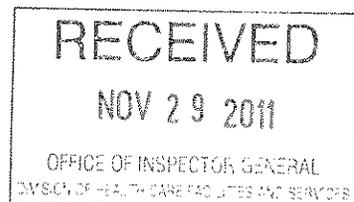
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F 425	Continued From page 5 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's pharmacy policy, it was determined the facility failed to provide pharmaceutical services to obtain and provide medication to meet the needs of one (1) of sixteen (16) sampled residents, Resident #4. Resident #4 did not receive Xanax (a drug to relieve anxiety) during the three (3) days of the survey. The findings include: Review of the facility's pharmacy policy titled Delivery and Receipt of Routine Deliveries, effective date 12/01/07, revealed. . . if any item ordered is not received the facility should contact the Pharmacy for an explanation explaining the reason a medication or item is not delivered. Clinical record review for Resident #4 revealed the facility admitted the resident on 09/03/10 with the diagnoses of Paraplegic, Insomnia, and Anxiety. Review of the Progress Notes, dated 11/01/11, revealed Resident #4 voiced concerns of increased depression related to the condition of his/her mother and that his/her present medication was not helping. Record review revealed the facility assessed Resident #4 was interviewable per the Minimum Data Set dated 09/14/11. Record review of a Physician's Order Sheet, in Resident #4's clinical record revealed a	F 425	The Director of Nursing, The Assistant Director of Nursing, or the Unit Manager will audit Medication Administration Records weekly for twelve (12) weeks to identify and assure all medications are available. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	12-18-11



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F 425	Continued From page 6 physician's order was received 11/01/11 to discontinue Ativan (a medication to relieve anxiety) and to start Xanax. The Xanax was ordered three times a day as needed for anxiety. During interview, on 11/01/11 at 11:30 AM, Resident #4 confirmed he/she had asked Licensed Practical Nurse (LPN #4) at 8:30 AM for the Xanax because he/she was very anxious about his/her mother who was under Hosparus Care. Resident #4 said LPN #4 acknowledged the medication had not yet been delivered. Interview with Resident #4, at 11/01/11 at 3:30 PM, revealed he/she had asked for the Xanax at about 12:00 Noon and LPN #4 said he/she would call the Pharmacy to check on the medication. During observation, on 11/03/11 at 8:45 AM, Resident #4 was laying in bed with the lights out and the blinds closed. When asked if he/she had received the Xanax, Resident #4 responded no, I just want to be left alone. Do not worry about it anymore. LPN #4 confirmed she had not called the Pharmacy to check on the delivery of the Xanax during interview, on 11/03/11 at 8:50 AM. LPN #4 said she should have called the Pharmacy the day before to check on the delivery. LPN #4 commented the facility had recently had some miscommunications with the Pharmacy. Interview with the Director of Nursing (DON), on 11/03/11 at 10:30 AM, revealed there had been a miscommunication between the Pharmacy and the physician's office related to the requirement to fax prescriptions for controlled substances to the Pharmacy. Xanax is a controlled substance and required a faxed prescription from the physician to the Pharmacy. The DON said she had called the physician's office on 11/01/11 when the telephone order was received to request a	F 425			



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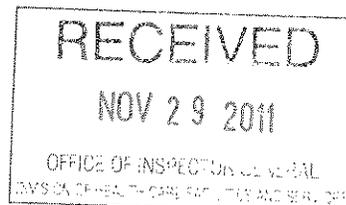
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F 425	Continued From page 7 prescription be faxed to the Pharmacy. The Pharmacy confirmed to her today they had not received a faxed prescription from the physician's office but did confirm an order from the facility for the prescription. The DON said she would call again to request another prescription for the Xanax be faxed to the Pharmacy. The Assistant Director of Nursing (ADON) had confirmed with the Pharmacy the faxed prescription had been received and the medication should be delivered within thirty (30) minutes. The DON acknowledged it was her responsibility to see that the Nurse Managers check the physician orders each morning against the medications carts. Telephone interview with Pharmacy Consultant (PC), on 11/03/11 at 3:40 PM, revealed he did not know why the medication had not been delivered. On 11/03/11 at 4:00 PM, telephone interview with General Manager Pharmacist (GMP) revealed a telephone order was received on 11/01/11 at 2:40 PM for the Xanax for Resident #4 and the GMP was uncertain if the Pharmacy had attempted to contact the physician for a faxed prescription. The GMP was uncertain if the medication had been delivered at the time of this interview.	F 425		
F 441 SS=E	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	F 441	F441 An observation by the Director of Nursing on 11-23-2011 noted that staff were using proper hand washing and hand sanitation during medication pass and during skin assessments. An observation by the Director of Nursing on 11-23-2011 noted the Ice chest scoop and holder to be clean. An observation by the Director of Nursing on 11-23-2011 noted staff to be following proper handwashing and hand sanitation techniques during medication administration, skin assessment and resident care. An observation by the Director of Nursing on 11-23-2011 noted the Ice chest scoop and holder to be	

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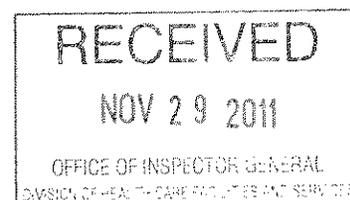
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F 441	<p>Continued From page 8 In the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing 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. (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. (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, it was determined the facility failed to ensure proper hand hygiene during resident contact and medication administration for one (1) of sixteen (16) sampled residents, and three (3) of three (3) un-sampled residents, (Resident #1 and Residents A, B, and C). The facility also failed to ensure the ice scoop holder</p>	F 441	<p>All licensed staff will be re-educated by the Director of Nursing, the Assistant Director of Nursing, the District Education and Training Director, or the Unit Manager related to hand washing and hand sanitation during medication administration, skin assessments and resident care. All direct care staff will be re-educated by the Director of Nursing, the Assistant Director of Nursing the District Education and Training Director, or the Unit Manager related to hand washing and hand sanitation during resident care. This education will be completed by 12-17-2011 with no staff working past 12-17-2011 without having had this education. A cleaning schedule for the Ice scoop and holder has been established and direct care staff will be re-educated on the schedule. All direct care staff will be re-educated on the schedule by the Director of Nursing, the Assistant Director of Nursing, the Director of Education and Training, or the Unit Manager. This education will be completed</p>		



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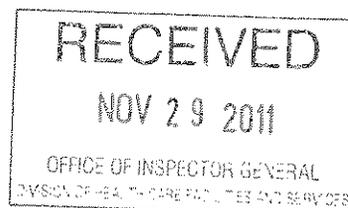
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 9 was stored in a sanitary manner for one (1) of one (1) ice scoop holders.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Med Administration, dated July 2010, revealed 1. Wash hands; 2. Gather appropriate equipment; 3. Identify resident; ...18. Wash hands; 19. Proceed to the next resident as indicated. The Med Administration policy for eye drops indicated #7. to don (put on) clean gloves before placing drop into the eye.</p> <p>Interview with the Director of Nursing, on 11/03/11 at 10:23 AM, revealed the facility's policy on hand hygiene was to wash hands before and after resident contact.</p> <p>Review of the facility's policy titled Infection Control Manual for Hand Hygiene indicated the facility staff were to wash their hands before and after direct contact with residents, after contact with inanimate objects and after removing gloves.</p> <p>Continued interview, on 11/03/11, with the Director of Nursing (DON) revealed the nursing staff performing skin assessments should change gloves and wash their hands after touching privacy curtains, according to facility policy</p> <p>Review of the facility's nursing supervisor competency form, dated 03/01/05, indicated the check list should be completed during the orientation phase and annually thereafter. Included in the check list was the efficient use of manuals on infection control for facility units as well as performance standards for practice and</p>	F 441	<p>by 12-17-2011 with no staff working past 12-17-2011 without having had this education</p> <p>The Director of Nursing, the assistant Director of Nursing or the Unit Manager will conduct ten (10) observations of resident care, skin assessments or medication administration per week for twelve (12) weeks to assure staff are using proper hand washing and hand sanitation techniques. The Director of Nursing, the Assistant Director of Nursing or the Unit Manager will audit the ice chest scoop and holder weekly for twelve(12) weeks to assure scoop and holder are clean. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	12-18-11	



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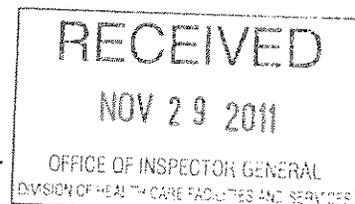
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	<p>Continued From page 10 following the infection control programs.</p> <p>Observation, on 11/02/11 at 3:46 PM, in Resident #1's room during a skin assessment with LPN #5 revealed LPN #5 touched the residents' privacy curtain with her gloved hand then touched the resident. The same gloved hand was used to document with a pen the skin assessment for the resident. The nurse did not wash her hands after the skin assessment or before documenting.</p> <p>Interview, on 11/02/11 at 6:00 PM, with LPN #6 revealed she had touched Resident #1's privacy curtain with a gloved hand during the skin assessment. She confirmed she had used the same gloved hand to document the residents assessment. The nurse acknowledged the potential risk of infection to all residents as a result of poor hand hygiene.</p> <p>Observation, on 11/02/11 at 12:00 PM, with LPN #4 during medication pass with un-sampled Resident C revealed the nurse did not put gloves on before the administration of eye drops according to facility policy and procedure.</p> <p>Interview, on 11/03/11 at 11:04 AM, with LPN #4 revealed she did not remember the policy and thought it was permissible to use her bare hands to give a resident eye drops if she did not touch the eye itself.</p> <p>Observation, on 11/02/11 at 2:10-2:20 PM, with RN #1 during the medication pass with two (2) un-sampled Residents, A and B, revealed no hand hygiene was performed.</p> <p>Interview, on 11/03/11 at 10:50 AM, with the DOE</p>	F 441		



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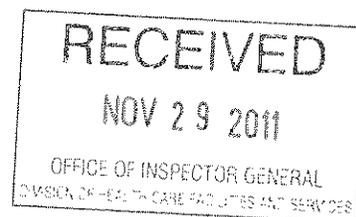
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F 441	<p>Continued From page 11</p> <p>revealed all staff received education and training on infection control and hand hygiene during orientation.</p> <p>Additional interview, on 11/03/11, with the DON revealed all facility staff received hand hygiene in orientation. The DON reported it was the responsibility of the Director of Education to present the policy and procedures of the facility to all new employees during orientation, while the Unit Managers, and herself were to ensure staff were trained on hand hygiene and supervised according to facility policy.</p> <p>Review of the facility policy for Sanitation Procedures for Ice Machines, revised January 2007, stated the ice machine, scoop, and storage container will be maintained in a clean and sanitary condition. The scoop and scoop storage container will be cleaned once per day. The scoop and container will be washed in the dishwasher.</p> <p>Observation, on 11/01/11 at 9:45 AM, of the ice scoop and holder in the maintenance ice utility room revealed the ice scoop holder was soiled with a brownish moist substance and littered with damp scraps of wadded up paper. The scoop holder was cloudy with water spots.</p> <p>During Interview with CNA #7, on 11/02/11 at 7:00 AM, in the ice utility room CNA #7 acknowledged ice was distributed to the residents at 10:00 AM and 2:00 PM during her shift and commented that the ice scoop holder was soiled and needed cleaning. The Regional Director of Clinical Operations (RDCO) came into the ice utility room</p>	F 441			



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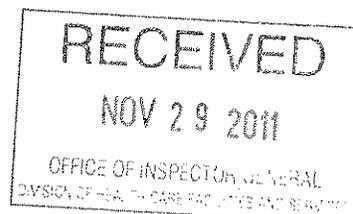
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F 441	Continued From page 12 and removed the ice scoop. CNA #7 said the RDCO removed the scoop, but the scoop holder was what was really dirty.	F 441			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy it was determined the facility failed to maintain a sanitary environment as evidenced by unclean and cracked floors on two (2) of two (2) resident hallways and common areas. The findings include: Review of the facility's Operations Administrative Manual (Revised July 2009) Procedure for the Physical Environment under the Policy heading stated the environment provided would be clean and home-like. However, the policy did not state how the environment would be cleaned.	F 465	F465 The discolored areas on the tile identified during the survey and listed on the 2567 will be corrected by 12-17-2011. The cracked floor tile identified during the survey will be replaced by 12-17-2011. A audit of floors will be completed by the Administrator, the Maintenance Director and the Housekeeping Supervisor to identify any other stains or floor tile needing replacement. Any identified areas will be corrected by 12-17-2011. The Administrator will re-educate the Maintenance Director on completing rounds to identify cracked tile for replacement by 12-17-2011. The Housekeeping Director will educate Housekeeping employees by 12-17-2011 on the cleaning process for floors.		



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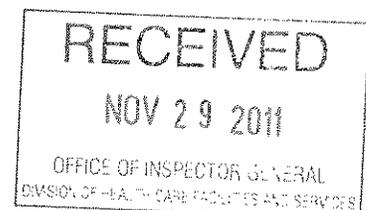
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F 465	<p>Continued From page 13</p> <p>Review of the facility's Infection Control Manual (Revised November 2011) Procedure under the subject Cleaning Methods (Housekeeping) stated cleaning resident rooms was to be performed routinely, to include the floors.</p> <p>The facility did not have a policy for the care and maintenance of the floors within the facility per the District Manager Over Environmental Services.</p> <p>Observation, on 11/02/11 at 7:00 AM, revealed the hallway entrance to Unit One (1) missing parts of the tile on the floor making the floor uneven and the spaces discolored brown. Also on Unit One (1), under the water fountain there was a black discoloration outside the floor seams. There was a brown colored build-up in the corner under the water fountain. Black/brown stains were noted in the hall between Room Four (4) and Room Six (6). The Housekeeping Closet had a cracked raised tile by the door. The floor outside the resident shower room had a brown discoloration on top of wax build-up. The Unit One (1) hall continued to reveal multiple blackened areas, dots of discoloration, and black stains to the floor in front of the Nurses Station.</p> <p>Observation, on 11/02/11 at 10:15 AM, revealed cracked discolored tile in the back hallway between the nursing stations for Unit One (1) and Unit Two (2). In addition, the hall outside the laundry by the double doors was noted discolored dark and uneven. The hallway outside the main dining room was noted to have cracked, discolored tile the width of the hallway. Additional observations of the hall for Unit Two (2) revealed discolored areas to the floor outside Room</p>	F 465	<p>The Administrator, the Maintenance Director and the Housekeeping Supervisor will make weekly rounds for twelve (12) weeks to assure floor stains are removed and that floor tile have been repaired as needed. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	12-18-11	



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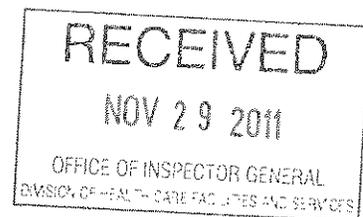
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
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F 465	Continued From page 14 Forty-Seven (47) and Room Twenty-Seven (27). Observation, on 11/03/11 at 4:25 PM, revealed the Physical/Occupational Therapy Department floor had a T-shaped dark discoloration larger than a tile square. Interview, on 11/02/11 at 9:50 AM, with Registered Nurse (RN) #1 revealed the floors were hard to keep clean. She stated other than replacing the floors she did not know what could be done to improve the appearance of the floors. Interview, on 11/02/11 at 9:55 AM, with Certified Nursing Assistant (CNA) #2 revealed she thought the floors were not clean. Interview, on 11/02/11 at 10:00 AM, with CNA #3 revealed the floors could use "some work". Interview, on 11/02/11 at 10:10 AM, with Licensed Practical Nurse (LPN) #3 revealed the floors were not clean. Interview, on 11/03/11 at 6:50 AM, with Housekeeper #1 revealed she had been trained on how to clean the floors. Interview, on 11/03/11 at 7:05 AM, with Housekeeper #2 revealed she had been trained on how to clean the floors. Interview, on 11/02/11 at 4:15 PM, with the Housekeeping Manager revealed the floors were cleaned and mopped every day. The floors were stripped and waxed as needed. There are areas that will not clean or buff out. She stated the tile (floor) is damaged and would like to see the tile	F 465		



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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 465	Continued From page 16 replaced. The floors in the facility were not homelike. The majority of resident rooms had cracks in the floors. Dirt builds up in the cracks and expands the crack, she stated. In addition, she stated the floors could be a trip hazard for the residents by how uneven the floor was in some areas. She stated the floors were cleaned, buffed and waxed but the floors were "bad". Continued interview on 11/03/11 at 7:10 AM revealed she was new to this building. Her training for her position was the same as the other housekeepers, which included in-services on deep cleaning and the steps to clean. Her position as housekeeping manager had her as the person responsible for the cleanliness of the floors.	F 465			
F 520 SE=B	483.76(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the	F 520	F520 A Quality Assurance Committee was held on 11-17-2011 with the Medical Director Present. A Quality Assurance Committee was held on 11-17-2011. The Regional Director of Clinical Operations re-educated the Administrator regarding the requirement for Medical Director participation in Quality Assurance at least Quarterly on 11-23-2011. The Regional Director of Clinical Operations will review the Quality Assurance Committee minutes monthly for six (6) months to assure Medical Director attendance at least quarterly. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	12-18-11	



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F 520	<p>Continued From page 16 requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Quality Assurance meeting roster revealed the Medical Director failed to attend three (3) of the four (4) quarterly quality assurance committee meetings.</p> <p>The findings include:</p> <p>Record review of the facility's quarterly meeting roster revealed the Medical Director (MD) attended the 06/2011 meeting. However, the remaining three quarterly Quality Assurance (QA) Meeting Rosters were not signed by the MD.</p> <p>Interview with the Administrator, on 11/03/11 at 11:25 AM, revealed the MD attended the 06/2011 QA meeting and did not attend the other three (3) quarterly meetings. She reported the MD was notified of each meeting. She reported she has attempted to locate another medical director; however, was unsuccessful. She reported the need for a medical director to attend the Quality Assurance meetings was to evaluate and provided input regarding medical issues such as infection control, accident prevention and nursing issues.</p>	F 520			

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2011
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1967</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system</p> <p>GENERATOR: Type II generator, fuel source is natural gas with propane back-up.</p> <p>A standard Life Safety Code survey was conducted on 11/01/11. Medco Center of Henderson was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety (90) beds and the census was seventy seven (77) 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 (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>	12-18-11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *W. D. HFA* TITLE *Administrator* (X6) DATE *11-23-11*

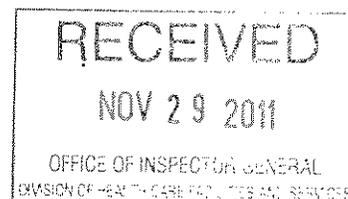
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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

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If continuation sheet Page 1 of 10
NOV 29 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE REGULATION

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

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OMB NO. 0938-0391

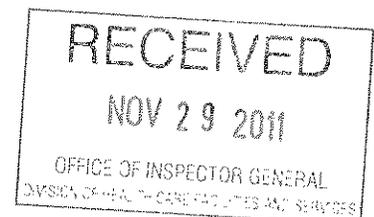
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186402	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2011
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutos. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in corridors were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety (90) beds with a census of seventy seven (77) on the</p>	K 018	<p>K018</p> <p>The wooden gates to rooms #10,14, and 19 were removed and the doors latch as observed by the Administrator on 11-23-2011. The latch to the door for room # 7 will be repaired to latch by 12-17-2011.</p> <p>An audit of all corridor doors will be completed by the Maintenance Director by 12-17-2011 to assure all latch any identified will be repaired.</p> <p>The Maintenance Director will be re-educated by the Administrator to assure that all corridor doors latch by 12-17-11.</p> <p>The Maintenance Director will visually audit 100% of facility corridor doors monthly for three (3) months to assure all latch. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	12-18-11



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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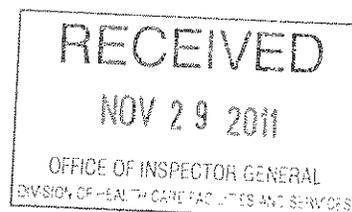
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON			STREET ADDRESS, CITY, STATE, ZIP CODE: 2500 NORTH ELM ST. HENDERSON, KY 42420		
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K 018	<p>Continued From page 2 day of the survey.</p> <p>The findings include:</p> <p>Observation, on 11/01/11 at 1:55 PM, with the Maintenance Director revealed the facility had installed hinged wooden gates on resident room #10, 14, and 19, to prevent wandering residents from entering these rooms. Further observation revealed the gates when closed, impede access to the room door to enable closure during a fire, if the resident room doors were fully opened.</p> <p>Interview, on 11/01/11 at 1:55 PM, with the Maintenance Director revealed the facility had placed the gates on the resident room doorframes due to residents wandering into other resident rooms.</p> <p>Observation, on 11/01/11 at 2:25 PM, with the Maintenance Director revealed the corridor door to room #7, did not latch.</p> <p>Intorview, on 11/01/11 at 2:25 PM, with the Maintenance Director confirmed the observation.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3 Corridor Doors.</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the</p>	K 018			



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K 018	Continued From page 3 passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at	K 025		



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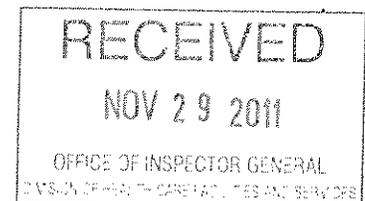
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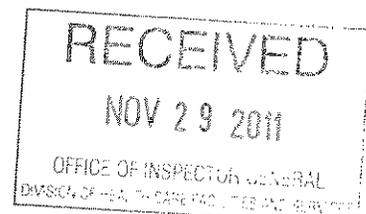
K 025	Continued From page 4 least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers 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 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 ninety (90) beds with a census of seventy seven (77) on the day of the survey. The findings include: Observation, on 11/01/11 at 2:45 PM, with the Maintenance Director revealed the smoke partitions extended above the ceiling and located throughout the facility were noted to have penetrations by wires, or plng. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.	K 025	K025 The identified smoke barrier penetrations will be repaired using a material rated equal to the partition by 12-17-2011. An audit of all smoke barriers will be completed by 12-17-2011 to ensure there are no penetrations, identified concerns will be immediately corrected. The Maintenance Director will be re-educated by the Administrator related to the requirement for smoke barriers per NFPA 101. This education will be completed by 12-17-2011. The Maintenance Director will audit all smoke barriers monthly for three (3) months to assure that there are no penetrations to the smoke barriers. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	12-18-11
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K 025	Continued From page 5 Interview, on 11/01/11 at 2:45 PM, with the Maintenance Director revealed he was not aware of the penetrations. Reference: NFPA 101 (2000 Edition). 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: (a) The space between the penetrating item and the smoke barrier shall 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. (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 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. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 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	K038 The identified fire exit will have a durable surface access installed to a public way by 12-17-2011. An audit will be completed by the Administrator to assure all fire exits have a durable surface access to a public way by 12-17-2011. The Maintenance Director will be re-educated related to the requirement that all fire exits have a durable surface access to a public way by the Administrator. This education will be completed by 12-17-2011. The Maintenance Director will audit all fire exits monthly for three(3) months to assure all have a durable surface access to a public way. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		12-18-11



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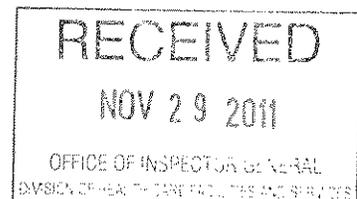
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420
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K 038	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for ninety (90) beds with a census of seventy seven (77) on the day of the survey. The findings include: Observation, on 11/01/11 at 2:03 PM, with the Maintenance Director revealed the an exit next to resident room #17, did not have a durable surface to a public way. The exit is primarily used by the employees to stand outside and smoke. The exit is identified on the evacuation plan as an exit in the event of an emergency. Interview, on 11/01/11 at 2:03 PM, with the Maintenance Director revealed he was not aware the exit needed a durable surface to a public way. The Maintenance Director also confirmed the exit was identified on the evacuation plan. Exits must have a durable surface to the public way to support wheelchairs, beds, equipment, etc., in case of an emergency situation.	K 038		
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K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for ninety (90) beds with a census of seventy seven (77) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 11/01/11 at 3:00 PM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. Third shift fire drills were being conducted predictably around 6:20 AM, when the Maintenance Director would arrive for work.</p> <p>Interview, on 11/01/11 at 3:00 PM, with the Maintenance Director revealed they were unaware the fire drills were not being conducted</p>	K 050	<p>K050</p> <p>Fire drills will be scheduled by the Administrator for various times to assure drills are unexpected. This schedule will begin by 12-17-2011.</p> <p>Fire drills will be scheduled by the Administrator for various times to assure drills are unexpected. This schedule will begin by 12-17-2011</p> <p>The Maintenance Director will be re-educated related to the requirement that all fire drills be unexpected and under varied conditions by the Administrator. This education will be completed by 12-17-2011.</p> <p>The Administrator will audit all fire drills monthly for three(3) months to assure fire drills are conducted at times that are unexpected with variable conditions. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>	12-18-11
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 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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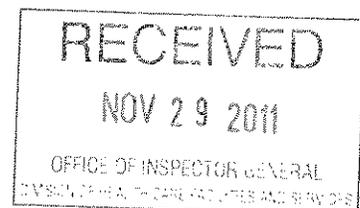
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF HENDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420
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K 050	Continued From page 8 as required.	K 050		
K 147 SS=F	Reference: 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. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 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 five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety (90) beds with a census of seventy seven (77) on the day of the survey. The findings include: Observation, on 11/01/11 between 11:30 AM and 3:30 PM, with the Maintenance Director revealed: 1) A refrigerator plugged into an extension cord that was plugged into a power strip, located in the Business Office. 2) Resident beds plugged into a power strip, located in room #28, 30, 34, and 38. 3) An oxygen concentrator plugged into a power	K 147	K147 The identified power strips with medical equipment attached and extension cords will be removed by the Maintenance Director by 12-2-2011. An audit of all facility rooms including offices will be conducted by the Maintenance Director by 12-17-2011 to identify any concerns with power strips used for medical equipment or extension cords. Any identified concerns will be immediately corrected. The Maintenance Director will be re-educated related to the requirement that extension cords not be used and that power strips may not be used for medical equipment by the Administrator. This education will be completed by 12-17-2011.	12-18-11



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K 147	Continued From page 9 strip located in room #38. 4) A 1875 watt hair dryer and three (3) curling irons plugged into a power strip rated for 1875 watt maximum, located in the Beauty Shop. 5) An extension cord in use in the Housekeeping Office. 6) A suction pump plugged into a power strip located in room #24. 7) Two (2) extension cords in use in room #21. 8) A mini nebulizer and the resident bed were plugged into a power strip located in room #19. 9) An extension cord in use in the Med Room next to Nurses Station One. Interview, on 11/01/11 between 11:30 AM and 3:30 PM, with the Maintenance Director revealed they were unaware of the extension cords and power strips being misused. 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.	K 147	The Maintenance Director will audit all facility rooms including offices monthly for three(3) months to assure that no extension cords are used and that power strips are not used for medical equipment. The results of these audits will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations as needed. If at any time concerns are identified the Quality Assurance Committee will be convened to review for recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	12-18-11
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