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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 annual survey was conducted on 03/06/12 through 03/09/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "F."	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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT Is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care in a manner which maintained or enhanced a resident's dignity and respect for one resident (#10), in the selected sample of nineteen residents, related to not pulling the privacy curtain during provision of care. Findings include: A review of the facility's policy/procedure, "Privacy Curtain Policy," dated 2005, from Lippincott Williams and Wilkins, revealed the privacy curtain should be closed during provision of care for a resident. A record review revealed the facility admitted Resident #10 on 01/14/10 with diagnoses to include Morbid Obesity, Type II Diabetes,	F 241	1. Resident #10 was assessed by the Director of Nursing on 3/29/12 to ensure that the resident did not experience any psychosocial implications related to privacy curtain not being pulled around her during care. The Director of Nursing has made random observation of care being provided to Resident #10 and has not identified any issues with the privacy curtain not being pulled.	4/23/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcia Dey
TITLE: Administrator
(X6) DATE: 4/2/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 314	Continued From page 2 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for one Resident (#10), in the selected sample of nineteen residents. Observation of Resident #10's wound care, on 03/07/12, revealed the nurse used the same measuring device to measure multiple wounds. Findings to include: A review of the facility's policy/procedure, "Procedure for Wound Prevention and Treatment," dated April 2009, and a review of the facility's policy/procedure, "Procedure for Measuring/Describing a Wound," dated April 2009, revealed no indications on how to properly use a wound measuring device or when to dispose of the wound measuring device. A record review revealed the facility admitted Resident #10 on 01/14/10 with diagnoses to include Peripheral Vascular Disease, Type II Diabetes, Amputation of the Right Leg and	F 314	1. On 3/25/12, the Director of Nursing observed Resident #10 wound measurements being taken and noted that a new measuring device was used when measuring each individual wound. 2. On 04/02/12, the Director of Nursing observed measurements being done on all residents with wounds in the facility to ensure that a new measuring device was used when measuring each individual wound. No concerns were identified. 3. All licensed nurses will be re-educated by the Education and Training Director by 4/21/12 regarding wound prevention and ensuring that a new measuring device is used when measuring multiple wounds on same resident. 4. The Director of Nursing and/or the Assistant Director of Nursing will observe wound measurement on three (3) residents weekly for twelve (12) weeks to ensure that proper techniques for measuring wounds are being used to include using a new measuring device for each wound. The results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	4/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 314	Continued From page 3 Morbid Obesity. Observation of a skin assessment, on 03/07/12 at 9:00 AM, revealed Licensed Practical Nurse (LPN) #1 did not provide proper infection technique while measuring an area on the resident's coccyx, an area on the left inner buttock, two areas behind the resident's left knee, and an area where the 4th toe of the left foot had been removed. Further observation revealed LPN #1 utilized the same measuring device to measure several areas prior to obtaining a new measuring device. She then laid the used measuring device on Resident #10's bed linen. An interview with LPN #1, on 03/07/12 at 10:20 AM, revealed she normally used a new device for every wound, but stated she was "nervous." An interview with Registered Nurse (RN) #1, on 03/07/12 at 11:00 AM, revealed "I would use a new measuring device every time." An interview with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), on 03/07/12 at 11:05 AM, and on 03/09/12 at 3:15 PM, respectively, reveeled they expected the nurse to use a new measuring device for each wound every time.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	1. On 3/25/12, the Director of Nursing observed incontinence care, including the separation of the resident's legs and cleaning of the vaginal area and vulva being provided to Resident #1 by CNA #1 with no concerns identified.	4/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 315	Continued From page 5 removed." The step by step procedure in Procedure 17-4, item number 15, described female perineal care as "Using the other hand, separate the labia. Clean the vulva by placing your washcloth-covered hand at the top of the vulva and stroking downward to the anus. First clean one side, then the other side, and finally the middle, using e different part of the washcloth each time, until the area is clean." An interview with the Director of Nursing (DON), on 03/08/12 at 11:30 AM, revealed the facility used the "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving" as a guide and procedural manual for incontinent care. She revealed the facility followed the standard of practice for incontinent care. A record review revealed the facility admitted Resident #1 on 04/18/11 with diagnoses to include Chronic Kidney Disease, Type II Diabetes, Mental Disorder, Acute Coronary Syndrome. An observation of incontinent care for Resident #1, on 03/07/12 at 9:19 AM, revealed CNA #1 removed the resident's soiled brief while he/she was in the side-lying position on the bed. Registered Nurse (RN) #2 assisted CNA #1 by holding the resident in the side-lying position. CNA #1 used a washcloth to wipe the resident's anal area and did not separate Resident #1's legs to clean the vaginal/vulva area. An interview with CNA #1, on 03/09/12 at 5:30 PM, revealed she provided incontinent care for Resident #1 on 03/07/12. She stated she cleaned the resident while he/she was in the side-lying	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 315	Continued From page 6 position and cleaned from front to back, end thought she cleaned the vaginal area; however, she did not separate the resident's legs. CNA #1 stated to complete catheter care for a female resident, she was suppose to start at the labia and go out. CNA #1 revealed she should wipe between the resident's legs front to back, separate his/her legs, and then wipe downward. She stated she did not do this because she knew the nurse was coming in to remove the foley catheter. An interview with RN #2, on 03/09/12 at 5:10 PM, revealed she told the CNA "to check the front" after the resident was rolled onto his/her back. She stated she was distracted by another nurse entering the room with a specimen cup, a syringe, and a needle to obtain a urine specimen. She stated CNA #1 wiped the front but she was not sure if his/her legs were separated or not. RN #2 stated, as the licensed person it was her responsibility to ensure the incontinent care was completed correctly. She stated, due to the foley and due to the feces in the brief, the legs should have been separated to properly clean the resident. Interview with CNA #2 and CNA #3, on 03/09/12 at 8:55 AM and 9:05 AM, respectively, revealed incontinent care should begin with the resident lying on his/her back, separate the legs, and wipe from front to back using a different washcloth for each swipe. Then, the resident should be placed in a side-lying position to clean the anal area. CNA #2 and CNA #3 stated a second person would be needed to assist with positioning and to hold the legs open.	F 315		
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 8 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the documentation of education regarding benefits and potential side effects of vaccines, as well as dates that immunizations were last given, were offered to one resident (#17), in the selected sample of nineteen residents. Findings include:	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 334	Continued From page 9 An interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), on 03/09/12 at 4:00 PM, revealed the facility's policy was to offer and provide education and the influenza and pneumococcal vaccines upon admission. The influenza vaccine was offered between November and March each year, and the pneumococcal vaccine was offered all year round. The ADON revealed the documentation should include a Pneumococcal and Annual Influenza Vaccine Information and Request form and Immunization Record. The DON revealed the facility tracked the residents who received the vaccines. The DON and ADON revealed there were no known contraindications to the vaccines for this resident. A record review revealed the facility admitted Resident #17 on 12/15/11 with diagnosis to include a Femur Fracture. Further review revealed no known allergies or no known contraindications to the vaccines. A review of the Pneumococcal and Annual Influenza Vaccine Information and Request revealed only the center's name end the resident's name. There was no documented evidence the vaccines were offered and/or refused. A review of the Immunization Record revealed only the resident's name, a medical record number, and the date of the resident's admission to the facility. Further review of the Immunization Record revealed there was no documented evidence the vaccines were administered.	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 371	Continued From page 12 frightened of mice, so she asked Kitchen Steff #2 to enter the kitchen first. An interview with Kitchen Staff #2 revealed she entered the kitchen first because Kitchen Staff #1 was afraid whenever mice were visible in the kitchen. Mice were seen in areas of the kitchen for a couple of months. She revealed she did not see mice as frequently, as she did in the past, but observed a mouse in the kitchen about two days ago. An interview with the Registered Dietician, on 03/08/12 at 8:45 AM, revealed mice were a problem in the facility, especially in the kitchen. The pest control company was working to eradicate them and was doing the "routine stuff" such as putting traps outside and inside the facility. He revealed that holes in the wall of the kitchen were filled by maintenance last December. The pest control technician was in the facility on Tuesday (03/06/12), and a total of six mice were found, so they "vamped up the baits." The Dietician revealed there was a risk for illness due to the infestation of mice. An interview with the Maintenance Director, on 03/07/12 at 4:45 PM, and on 03/08/12 at 6:30 PM, revealed he was first aware of the problem regarding mice, in December, and felt it was still a problem. He revealed he saw mice in the traps and the kitchen staff reported sightings of mice to him. The pest control company was notified at that time. He had the holes filled in the kitchen wall in December, and the pest control technician recently filled holes in the foundation of the building. He stated he was unaware if the pest control was effective; however, he was not seeing "as many." He stated, "we are paying them [pest control company], they should be getting it under	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 441	Continued From page 14 (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 wesh their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to maintain an infection control program to help prevent the development and transmission of disease and infection. Observation during a medication pass, on 03/06/12, revealed Registered Nurse (RN) #3 contaminated her hands during administration of a medication via a gastronomy tube (G-Tube) and did not wash her hands or reglove before continuing administration of the medication via the G-tube. Findings include: A review of the facility's policy/procedure, "Enteral Tubes," dated October 2002, revealed standard precautions would be observed throughout the procedure which included clean gloves.	F 441	4. The Director of Nursing, the Assistant Director of Nursing and/or Unit Managers will observe administration of medication to three (3) g-tube resident three (3) times a week on random shifts for two (2) weeks and then one (1) resident weekly for ten (10) weeks to ensure that clean gloves are being used prior to the administration of medications. Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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)	(X6) COMPLETION DATE
F 469	Continued From page 16 the facility's pest control agreement, it was determined the facility failed to ensure an effective pest control program so that the facility was free of rodents. Observations of the facility's kitchen revealed areas with visible signs of mouse droppings. Resident rooms were observed with sticky traps and reports of observations of mice. Interviews with staff revealed mice were observed by residents, and staff in the kitchen revealed mice were seen frequently in the kitchen. Findings include: A review of the facility's pest control service agreement, dated 09/22/10, revealed specific pests to be controlled included mice, and included all interior areas of the facility structure. The service guarantee section listed "Complete guarantee for control of said pests(s) for life of the agreement." The agreement was signed by the Administrator. A review of the facility's Pest Control Log listed mice as the "pest type" on 09/25/11, 10/24/11, 12/27/11, 01/17/12, 02/08/12, 02/13/12, 02/17/12 and 02/25/12. Observations of the kitchen, on 03/06/12 at 12:00 PM, on 03/07/12 at 11:40 AM, and on 03/08/12 at 8:45 AM, revealed a baseboard ledge in the kitchen, which was behind the racks of clean dishes, had mouse droppings and irregular brownish colored discolorations along the entire length of the baseboard. An observation, on 03/07/12 at 9:45 AM, revealed there was a glue trap, in Room 212, located on the floor by the base of the wall.	F 469	The pest control company continues to service the facility on a minimum of two (2(times per week and are also available as needed on a 24 hour basis. Additional areas that mice may have entered facility have been identified and repaired/closed. Dietary staff were educated on completing maintenance request for pest control concerns on 03/30/2012 by the Nutrition Service manager. Department Heads have been retrained on 03/30/2012 by the Nursing Home Administrator on completing the pest log with identification of where the pests were sighted and contact NHA or Maintenance so that pest control company can be notified immediately of any pests. Facility rounds will be completed five (5) days per for six (6) weeks then three (3) times per week for six (6) weeks by the maintenance staff to identify any signs of pest activity. Results of these audits will be forwarded to the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 469	Continued From page 17 An interview with Resident A, on 03/07/12 at 9:45 AM, revealed he/she observed mice in his/her room more than once recently and the facility had "placed a sticky trap in the room yesterday." An interview with Kitchen Staff #1 and #2, on 03/07/12 at 11:55 AM, revealed mice were seen in areas of the kitchen for a couple of months, and as recently as two days ago. An interview with the Registered Dietician, on 03/08/12 at 8:45 AM, revealed mice were a problem in the facility, especially in the kitchen, and the pest control company was working to eradicate them. They had been doing the "routine stuff" like traps inside and outside since December. He revealed there were holes in the wall of the dishroom of the kitchen, and maintenance closed the holes in December. The pest control technician was in the facility, on 03/06/12, and six mice were found so they "vamped up the baits." An interview with the Director of Nursing (DON), on 03/07/12 at 3:40 PM, revealed she was aware that Certified Nurse Aides (CNA) reported seeing mice in the shower rooms about two months ago. The DON revealed she did not speak to the Dietary Manager about the mice. She would have spoken to her supervisor, but as DON, she received reports from the staff and then reported to the Administrator. An interview with the Administrator, on 03/07/12 at 5:20 PM, revealed she felt the problem with the mice started in May after there was flooding in the area and then it became worse. In October, she	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 469	Continued From page 18 observed a mouse in the kitchen and had seen one in a trap. Residents reported seeing mice on Wing 2 and kitchen staff reported seeing mice in the kitchen. She stated maintenance was well aware of the problem and sealed holes in the kitchen wall, and placed new door sweeps on some of the doors. An interview with the Maintenance Director, on 03/07/12 at 4:45 PM and at 6:30 PM, revealed he was first aware of the problem about the mice in December and felt it was still a problem. He spoke with the Administrator about it; however, he could not recall the date. He revealed he observed mice that were in traps, and kitchen staff . He filled holes in the kitchen wall in December, and the pest control technician recently filled holes in the foundation of the building. He stated he did not know if the pest control was effective; however, he did not see as many mice. He stated, "we are paying them [pest control company], they should be getting it under control." The Maintenance Director revealed he did not keep a log of the sightings. An interview with the pest control technician, on 03/09/12 at 8:30 AM, revealed he provided a monthly service to the facility as well as an on needed basis, and was available twenty-four hours a day, seven days a week. The facility notified him "two or three times for an as needed service call and he kept a Pest Control Log to show where activity was observed or reported. He did not know the cause of the continued infestation, but stated he suspected they burrowed in the ground in front of the building and may be under the concrete slab foundation. He had patched holes in the foundation, on 02/25/12,	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185272		03/09/2012

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 469	Continued From page 19 and had bait stations outside, and glue boards, traps and multi-catch units were in the building. He stated the mice were "not messing with the bait station outside, all the activity had been inside the building, and the kitchen was the hot spot" and they keep finding more areas at the building foundation. The pest control technician stated, "no one ever said what I'm doing was not working."	F 469		

SOD Due 04/20/12

DIVISION OF HEALTH CARE FACILITIES AND SERVICES
Life Safety Code PACKET PROCESS LIST

FACILITY: Medco Center of Bowling Green CITY: Bowling Green

LEVEL OF CARE: SNF/NF SURVEY DATE(S): 4-4-12

SURVEY TYPE: INITIAL RECERT. REVISIT OTHER _____
COMPLAINT #_____ PRIORITY: 1 2 3 4

TEAM LEADER: Jeremy Taylor LSC

ACTION	INITIALS	DATE
Packet Completed (placed in LSC tray, email to team leader and RPM	JT	4-9-12
Deficiency(ies)? (YES) NO		
RPM Review KLeff 04/30/12 PoC received	Cm	04/20/12
	KLeff SOD to Facility	04/20/12
POC Acceptable: YES (NO) Admin. notified 06/08/12 @ 5pm	Cm	06/08/12
PoC Returned To Facility 06/11/12 KLeff		
Team Leader Notified of acceptability: (email team leader and RPM) 2nd PoC Received 06/22/12 KLeff		
2nd Poc acceptable	JT	Revisit Completed 06/26/12
Revisit Required: (YES) NO		
Packet Completed (placed in LSC tray, email to team leader and RPM)	JT	6-28-12

Highest Scope/Severity F

Date to be corrected (45 day after health survey exit) 05/21/12

Latest POC date 05/19/12

IDR Requested _____ IDR Scheduled _____ IDR Held _____
Changes to SoD? YES NO (if yes, give summary of changes and why)

07/10/12 KLeff

05/01 updated L&T, Survey properties & AEM Case For PoC Received - PoC & packet To Jeremy For Review

06/11/12 Compiled unacceptable PoC letter - Emailed letter & unacceptable PoC to facility updated L&T, & AEM Case - packet to LSC working files

06/22/12 updated L&T, Survey properties & AEM Case for PoC Received PoC & packet to Jeremy for Review

07/03/12 Compliance letter to Facility

07/18/12 Reviewed/updated 670s, Survey properties & AEM Case, Closed AEM Case Attached in Aspen-ACO-ALPHA as: 04-04-12 LSC Record

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

PRINTED: 04/20/2012
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
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1962 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (200) SMOKE COMPARTMENTS: Five (5) smoke compartments FIRE ALARM: Complete fire alarm system with heat detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is natural gas. A standard Life Safety Code survey was conducted on 04/04/12. Medco Center of Bowling Green was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty six (66) beds and the census was sixty two (62) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		

RECEIVED
JUN 2012
OFFICE OF INSPECTOR GENERAL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 6/21/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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		
	Deficiencies were cited with the highest deficiency identified at "F" level.			
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		
	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4		K 025 – LIFE SAFETY CODE STANDARD 1. The identified penetrations in the smoke partitions have been sealed with the appropriate sealer by the Maintenance Director by 4/24/12. 2. An audit of all penetrations in the smoke partitions has been completed and noted to be sealed with the appropriate sealer by the Maintenance Director by 4/24/12. 3. The Maintenance Director will be re-educated by 5/18/12 by the Administrator regarding the requirements set forth in Life Safety Code K025. 4. The Maintenance Director will audit the smoke partitions monthly for three (3) months to ensure there are no penetrations. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the	5/19/12
	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 sixty six (66) beds with a census of sixty two (62) on the day of the survey.			
	The findings include: Observations, on 04/04/12 between 8:50 AM and 9:30 AM, with the Director of Maintenance revealed the smoke partitions, extending above the ceiling had multiple penetrations due to wires, sprinkler pipes, and conduit. All four smoke			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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
K 025	Continued From page 2 barrier walls were penetrated and the spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Non-rated quick foam was also used to try and fill some of the penetrations in the smoke barriers. Interview, on 04/04/12 between 8:50 AM and 9:30 AM, with the Director of Maintenance revealed he was not aware of the penetrations and that he had only been up in the attic a couple of times since he has worked there. 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	K 025	Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 025	Continued From page 3 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		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross -corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observation, on 04/04/12 between 8:50 AM and 9:32 AM, with the Director of Maintenance and the Administrator revealed the cross-corridor doors, located at the front of A Hall and B Hall, would not close completely when tested. This was due to the doors not having a coordinator to	K 027	K 027- LIFE SAFETY CODE STANDARD 1. The identified fire doors will be equipped with a coordinator to ensure the doors close properly by 5/18/12. 2. All fire doors have been observed by the Maintenance Director on 4/9/12 to ensure they are closing properly. No have been further concerns identified. 3. The Maintenance Director will be re-educated on K 027 related to proper closing of fire doors by the Administrator by 5/18/12. 4. The Maintenance Director will conduct monthly audits for three (3) months to ensure fire doors are closing properly. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations.	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 4 ensure the door without the t-astragal would close first. Interview, on 04/04/12 between 8:50 AM and 9:32 AM, with the Director of Maintenance and the Administrator revealed they were unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency. NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027	The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029	K 029- LIFE SAFETY CODE STANDARD 1. The conduit pipes will be re-routed and the opening will be sealed with the proper sealant by the Maintenance Director by 5/18/12. Door closers will be installed on the doors to the activity office, medical records, Administrator closets, dietary supply, admissions office,	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1661 NEWTON AVE. BOWLING GREEN, KY 42104

(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 029	Continued From page 5 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards, 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 sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observation, on 04/04/12 at 10:39 AM, with the Director of Maintenance revealed the ceiling plate leading to the attic was open and there were conduit pipes leading into the opening with standard quick foam used as a smoke sealant in the back boiler room. Interview, on 04/04/12 at 10:39 AM, with the Director of Maintenance revealed he was not aware the ceiling plate was open and that quick foam was not allowed as a sealant. Observation, on 04/04/12 between 10:30 AM and 1:30 PM, with the Director of Maintenance and the Administrator revealed the doors to the activity office, medical records, Administrator ' s	K 029	clean linen office area and the dirty linen in the laundry area by the Maintenance Director by 5/18/12. 2. All other areas in the building have been evaluated by the Maintenance Director on 4/9/12 to determine if there is a need for a door closer, open ceiling plates or non approved sealant. No other areas were identified. 3. The Maintenance Director will be re-educated on K 029 related to door closers and openings leading to the attic by the Administrator by 5/18/12. 4. Facility round audits will be completed by the Maintenance Director monthly for three (3) months to ensure continued compliance. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 029	Continued From page 6 closets, dietary supply, admissions office, clean linen office area, and the dirty linen in the laundry area did not have a self closing device. Interview, on 04/04/12 between 10:30 AM and 1:30 PM, with the Director of Maintenance and the Administrator revealed they were not aware the storage in these rooms made them a hazardous area therefore requiring a self closing device Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of	K 029	Manager, and Medical Director at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 029	Continued From page 7 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting 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 sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observation, on 0/04/12 between 10:38 AM and 12:00 PM, with the Director of Maintenance revealed the exterior exits at the side exit located next to the kitchen and the exit next to therapy	K 045	K 045- LIFE SAFETY CODE STANDARD 1. The identified exits have been equipped with lighting containing two (2) bulbs as observed by the Administrator on 4/24/12. 2. All other exits were observed to meet the standard by the Maintenance Director on 4/24/12. 3. The Maintenance Director will be re-educated on the illumination of means of egress, including exit discharge by the Administrator by 5/18/12. 4. Facility round audits will be completed by the Maintenance Director monthly for three (3) months to ensure continued compliance. The audit results will be reviewed by the Quality	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 045	Continued From page 8 were equipped with a single bulb for illuminating egress path to the public way from the exit. Interview, 04/04/12 between 10:38 AM and 12:00 PM, with the Director of Maintenance revealed was unaware the lighting fixtures serving the exterior exits must include more than one bulb. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. Reference: NFPA 101 (2000 edition) Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by:	K 050	K 050- LIFE SAFETY CODE STANDARD 1. Fire drills will be conducted a random times by the Maintenance Director by 5/18/12. 2 Fire drills will be conducted a random times by the Maintenance Director by 5/18/12 3. The Maintenance Director will be re-educated by the Administrator by 5/18/12 on conducting fire drills at random times on all shifts. 4. Fire drill times will be reviewed monthly by the Quality Assurance Committee for three (3) months to	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 9 Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Fire Drill review, on 04/04/12 at 9:30 AM, with the Director of Maintenance revealed the fire drills were not being conducted at unexpected times under varied conditions. Second shift fire drills were being conducted predictably between 2:07 PM and 2:25 PM, and third shift was between 4:30 AM and 5:50 AM. Interview, on 04/04/12 at 9:30 AM, with the Director of Maintenance revealed he was unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	ensure continued compliance. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056	K 056- LIFE SAFETY CODE STANDARD 1. The standard sprinkler heads in the therapy room were replaced with quick response sprinkler heads by 4/23/12. The phone system closet	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 10 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, 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 sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observation, on 04/04/12 at 10:56 AM, with the Director of Maintenance revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment located in the therapy area. Interview, on 04/04/12 at 10:56 AM, with the Director of Maintenance revealed they were not aware that the sprinklers had to have the same response time if the sprinkler heads are located in the same compartment.	K 056	will be cut down 18" from the ceiling to allow coverage from existing sprinkler. 2. All other areas were observed by the Maintenance Director on 4/24/12 to ensure sprinkler heads were the same in each compartment and all other areas of the building were properly equipped with sprinklers. No concerns were identified. 3. The Maintenance Director will be re-educated by the Administrator by 5/18/12 on K 056 standards. 4. Facility round audits will be completed by the Maintenance Director monthly for three (3) months to ensure continued compliance. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 11 Observation, on 04/04/12 at 11:35 AM, with the Director of Maintenance and the Administrator revealed the phone system closet had no sprinkler coverage. Interview, on 04/04/12 at 11:35 AM, with the Director of Maintenance and the Administrator revealed they were not aware the closet did not have a sprinkler head installed. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type.	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 12 Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072	K 072- LIFE SAFETY CODE STANDARD 1. The linen carts, wheelchairs and lifts were removed from the corridors of A Hall, B Hall and the side exit corridor next to therapy on 4/9/12 as observed by the Administrator. 2. A complete walkthrough of the facility was completed on 4/9/12 by	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 13 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observation, on 04/04/12 between 8:22 AM and 2:00 PM, with the Director of Maintenance revealed linen carts, wheelchairs, and lifts were being stored in the corridors of A Hall, B Hall, and the side exit corridor next to Therapy. Interview, on 04/04/12 between 8:22 AM and 2:00 PM, with the Director of Maintenance revealed the facility routinely stored linen carts, wheelchairs, and lifts in these corridors. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant usa in the case of fire or other emergency.	K 072	the Administrator to ensure all corridors were free from items being stored. No concerns were noted. 3. All staff will be re-educated on keeping all corridors free of obstructions or impediments by the Education and Training Director by 5/18/12. 4. The Maintenance Director will complete rounds three (3) times a week for four (4) weeks and weekly for eight (8) weeks to ensure continued compliance. The round results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable	K 073	K 073- LIFE SAFETY CODE STANDARD	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 073	Continued From page 14 character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility 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 sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observation, 04/04/12 at 2:51 PM, with the Director of Maintenance revealed no policy for flame retardant spraying at the facility. Interview, 04/04/12 at 2:51 PM, with the Director of Maintenance revealed the facility did not have a policy or system in place to ensure the decorations were treated with a flame retardant material. Reference: NFPA 101 (2000 Edition). 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	1. All identified decorations will be treated with a flame retardant material and logged for tracking purposes by the Maintenance Director by 5/18/12. 2. All other decorations in the facility will be sprayed with a flame retardant material and logged for tracking purposes by the Maintenance Director by 5/18/12. 3. The Maintenance Director will be re-educated on the requirement to treat all combustible decorations with a flame retardant material and logged for tracking purposes by the Administrator by 5/18/12. 4. The Maintenance Director will present the tracking log to the Quality Assurance Committee monthly for three (3) months to ensure continued compliance. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films	K 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185224		04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 074	Continued From page 15 serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observation, on 04/04/12 at 1:55 PM, with the Director of Maintenance revealed the privacy curtains within the shower room located on the B Hall, were of a solid fabric hung directly below the	K 074	K 074- LIFE SAFETY CODE STANDARD 1. The Maintenance Director will replace existing shower curtains in B Hall Shower Room with curtains having at least 18" of mesh at the top by 5/18/12. 2. A complete facility audit revealed that there were no other areas of the facility affected by this practice as observed by the Maintenance Director on 4/24/12. 3. The Maintenance Director will be re-educated by the Administrator by 5/18/12 on the requirements set forth in K 074 involving the use of privacy curtains in a manner that they do not obstruct the spray pattern of the sprinkler heads. 4. Facility round audits will be completed by the Maintenance Director monthly for three (3) months to ensure continued compliance. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations.	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 074	Continued From page 16 ceiling. The solid fabric would obstruct the spray pattern of the automatic sprinklers in the event of a fire. Interview, on 04/04/12 at 1:55 PM, with the Director of Maintenance revealed he was unaware the shower curtains must contain 18" of mesh at the top of the curtain to not obstruct the spray pattern of the sprinkler heads.. NFPA 13 Cubicle curtains; Reference to: NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074	The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K 144- LIFE SAFETY CODE STANDARD 1. A vendor will be brought in to ensure the battery charger is not	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1581 NEWTON AVE. BOWLING GREEN, KY 42104

(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 144	Continued From page 17 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator 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 sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observation, on 04/04/12 at 2:10 PM, with the Director of Maintenance revealed the generator's battery charger was hooked directly to the generator battery. Battery chargers cannot be hooked directly to the generator battery due to increase risk of fire. Interview, on 04/04/12 at 2:10 PM, with the Director of Maintenance revealed he was not aware of the battery charger being hooked directly to the generator battery. Reference: NFPA 110 (1999 Edition).	K 144	hooked directly to the generator battery by 5/18/12. 2. The center has no other generators therefore no other areas affected by this practice. 3. The Maintenance Director will be re-educated by the Administrator on ensuring the generator's battery charger is not hooked directly to the generator battery by 5/18/12. 4. The Maintenance Director will check the generator on a monthly basis for three (3) months to ensure continued compliance. The results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185224		04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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 144	Continued From page 18 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers ' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144		
K 147 SS=F	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 sixty six (66) beds with a census of sixty two (62) on the day of the survey. The findings include: Observations, on 04/04/12 between 8:15 AM and 2:10 PM, with the Director of Maintenance and Administrator revealed: 1) A power strip was plugged into a power strip that was plugged into another power strip in the Conference Room.	K 147	K 147- LIFE SAFETY CODE STANDARD 1. The power strip plugged in to a power strip in the Conference Room was removed, the extension cord going to the soda machine in the break room and the multi-plug adapter were removed, the power strip in room #11 was removed and the outlet cover replaced, the bed in room #10 was unplugged from the power strip and plugged in to the wall outlet, the extension cord was removed from room #16, the refrigerator was unplugged from the power strip in room #5, the extension cords have been removed from room #3 and the bed and refrigerator are now plugged in to wall outlets, the bed and television are now plugged in to a wall outlet and the extension cord has been removed in room #1, the power strip plugged in to a power strip has been removed in the Dietary	5/19/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 19 2) An extension cord going to the Soda Machine in the break room was plugged into a multi-plug adapter. 3) A bed and mini nebulizer were plugged into a power strip in room #11. 4) The outlet cover was badly damaged next to the bed in room #11. 5) A bed was plugged into a power strip in room #10. 6) An extension cord was in use for the computer in room #16. 7) A refrigerator was plugged into a power strip in room #5. 8) Two extension cords and a bed were plugged in a power strip and a refrigerator was plugged into one of the extension cords in room #3. 9) A bed and a television plugged into an extension cord in room #1. 10) A power strip was plugged into another power strip in the Dietary Office. 11) Multiple battery chargers were plugged into a powers strip in the Nurses Aid Supply Closet. 12) A bed and mini nebulizer were plugged into a power strip in room #35. 13) A mini nebulizer was plugged into a multi-plug adapter in room #21. 14) A refrigerator was plugged into a power strip in room #31. 15) A open junction box was located in the attic, above the corridor, adjacent to the conference room Interview, on 04/04/12 between 8:15 AM and 2:10 PM, with the Director of Maintenance and Administrator revealed they were not aware the extension cords were only for temporary use, or the power strips were being misused. They were also not aware of the open junction box in the	K 147	Office, the battery chargers in the Nurse Aid Supply closet are now plugged in to wall outlets and the power strips have been removed, the bed and nebulizer in room #35 are now plugged in to wall outlets, the multi-plug adapter has been removed from room #21, the power strip was removed from room #31 and the open junction box in the attic has been repaired. This was verified by the Administrator on 4/27/12. 2. A complete facility audit was completed by the Maintenance Director on 4/27/12 and there were no other areas of the facility affected by this practice as observed by the Maintenance Director on 4/24/12. 3. All staff will be re-educated by the Education and Training Director by 5/18/12 on the correct use of power strips and on not using extension cords. The Maintenance Director will be re-educated by the Administrator by 5/18/12 on the requirements to have covers on all junction boxes. 4. Facility round audits will be completed by the Maintenance Director monthly for three (3) months to ensure continued compliance. The audit results will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 20 attic. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Reference: NFPA 70 (1999 edition) 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
185224	A. Building B. Wing 01 - MAIN BUILDING 01	6/26/2012

Name of Facility	Street Address, City, State, Zip Code
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 05/19/2012	ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 05/19/2012	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 05/19/2012
ID Prefix Reg. # NFPA 101 LSC K0045	Correction Completed 05/19/2012	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 05/19/2012	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 05/19/2012
ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 05/19/2012	ID Prefix Reg. # NFPA 101 LSC K0073	Correction Completed 05/19/2012	ID Prefix Reg. # NFPA 101 LSC K0074	Correction Completed 05/19/2012
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/19/2012	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 05/19/2012	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By Gm	Date: 07/01/12	Signature of Surveyor: Jeremy Taylor LSC/Gm	Date: 07/01/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/4/2012	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
185224	MEDCO CENTER OF BOWLING GREEN

Type of Survey (select all that apply)

I	D	H		

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 31113	06/26/2012	06/26/2012	0.50	0.00	2.00	0.00	3.00	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.75

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 1.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
185224	MEDCO CENTER OF BOWLING GREEN

Type of Survey (select all that apply)

I	H			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 31113	04/04/2012	04/04/2012	0.50	0.00	7.00	0.00	3.00	6.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 2.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 2.25

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Steven L. Beshear
Governor

Audrey Tayse Haynes
Secretary

Division of Health Care
2400 Russellville Road
Hopkinsville, KY 42240
(270) 889-6052
Fax: (270) 889-6089
http://chfs.ky.gov/os/oig

Mary Reinle Begley
Inspector General

Connie Payne
Director

June 11, 2012

via EMAIL: Brian L Ford (BLFord@extendicare.com)

Mr. Brian Ford, Administrator
Medco Center Of Bowling Green
1561 Newton Ave.
Bowling Green, KY 42104

Re: Life Safety Code Survey

Dear Mr. Ford:

The Division of Health Care has received your facility's plan of correction regarding the deficiencies identified during the Life Safety Code survey completed on April 4, 2012. The plan of correction submitted was determined to be unacceptable.

As you were informed in the April 20, 2012 letter accompanying the CMS-2567/Statement of Deficiencies, your plan of correction must contain the following:

1. What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice;

2. How you will identify other residents/patients having the potential to be affected by the same deficient practice;

3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

4. How the facility plans to monitor its performance to ensure that solutions are sustained; and

5. **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

Your plan of correction is being returned for amendment, as it did not meet the above criteria as follows:

K025

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K027

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K029

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K045

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K056

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K072

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K073

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K074

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K144

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

K147

Criteria # 5 not met - If actions were completed on or by 05/18/12 in the Plan of Correction (POC), then 05/18/12 cannot be the completion date. The completion day would be the day after all actions (reviews, re-education, etc.) were completed.

902 KAR 20:008 Section 2.(5)(b) and/or 42 CFR 488.28, 42 CFR 456, and 42 CFR 489.453 requires that you submit a modified or amended plan of correction **within ten (10) days of receipt of this notice** that the previously submitted plan of correction was unacceptable. **Failure to submit an acceptable plan of correction within ten (10) days of receipt of this letter will result in a recommendation that action be taken against your state-issued license and/or your Medicare provider agreement be terminated**.

If you should have questions regarding this information, please contact our office.

Sincerely,

Samantha Higginbotham /cm

Samantha Higginbotham
Assistant Director
Division of Health Care

SH/JT:lef

Enclosures