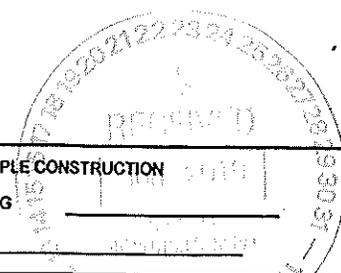


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2010
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2010
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135
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F 000	INITIAL COMMENTS An annual survey was conducted on 025-28/10 and a Life Safety Code survey was conducted on 05/25/10 to determine the facility's compliance with federal regulatory requirements. Deficiencies were cited with the highest scope and severity being an "D".	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 (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	1. The physician for resident # 4 was notified of resident's condition on 5-7-10 and orders were obtained. 2. All current residents' medical records will be reviewed for the past thirty (30) days by the DON/ADON and Unit Managers on 6/23/2010 to identify any residents with a change in condition that did not have Physician Notification. Any identified concerns were immediately corrected. 3. All Licensed nurses will be re-educated by the Director of Nursing or Assistant Director of Nursing on Physician notification for a significant condition changes prior to 6-28-10. See page 2 for F-157	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Deborah Molozzi* TITLE: ADMINISTRATOR (X5) DATE: 6-18-10

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

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F 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to immediately inform the physician of a change of condition with a need to alter treatment for one resident (#4), in the selected sample of 18. Resident #4 was noted to be unresponsive with facial drooping, at 9:10 AM on 05/07/10. Physician notification and orders to send the resident to the hospital for evaluation were not verified, until 4:30 PM. Findings include:</p> <p>Resident #4 was admitted to the facility, on 05/10/06, with diagnoses to include Diabetes Mellitus, Dementia, Mental Retardation, Atrial Fibrillation, Cerebral Vascular Accident and Renal Dysfunction. A review of the Minimum Data Set (MDS), dated 03/24/10, revealed the facility identified Resident #4 with a severe cognitive impairment and total dependence on staff for all care.</p> <p>Observation, on 05/25/10 at approximately at 10:45 AM, revealed Resident #4 was seated in a gerichair in His/Her room with eyes closed. The resident had a feeding pump and wore elbow splints applied bilaterally and a right knee splint to the right leg.</p> <p>A review of a "Physician Notification" form, dated 05/07/10 at 9:10 AM, signed by Licensed Practical Nurse #3, revealed the Resident #4 was observed listless and was staring into space with drooping noted to the right side of the mouth.</p>	F 157	<p>4. The Director of Nursing or Assistant Director of Nursing will audit ten (10) medical records per week for twelve (12) weeks to assure ongoing compliance. The results of the audits will be reviewed by the Quality Assurance committee monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Manager and at least quarterly the Medical Director.</p>	7-6-2010	

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F 157	<p>Continued From page 2</p> <p>The Assessment section of the Physician Notification form had "Lethargic/Unresponsive" circled. The nursing note entry, timed at 2:30 PM, the same date, revealed Registered Nurse (RN) #1 documented the resident "would not respond to questions, could not squeeze my hand". The note also revealed "report given to this nurse that resident not responsive to stimuli. Resident has moderate right sided mouth drooping." A note documented at 4:30 PM, the same date, revealed the physician was notified and orders were received to send the resident to the emergency room for evaluation. The facility notified the ambulance and the resident was transported to the local hospital at 5:00 PM.</p> <p>On 05/26/10 at 2:10 PM, an interview with RN #1 revealed she was told in shift report, on 05/07/10 approximately at 2:00 PM, Resident #4 had experienced a change of condition and had drooping of the mouth. LPN #3 reported she sent a fax to the resident's physician earlier, but had not received a response. RN #1 also stated she assessed Resident #4 and determined He/She was more responsive and she called the physician around 3:15 PM. The physician returned the call shortly after and gave orders to send Resident #4 to the emergency room for evaluation and treatment. RN #1 stated she understood the facility policy required a nurse report a significant change in condition to the physician immediately.</p> <p>An interview with LPN #1, on 05/26/10 with at approximately 2:45 PM, revealed she faxed the physician at approximately 9:10 AM, but did not receive a response from the physician. LPN #1 stated the symptoms of staring and drooping of the mouth could indicate a stroke and the need</p>	F 157	See Pages 1 & 2	7-6-10	

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F 157	<p>Continued From page 3 for evaluation and treatment. LPN #1 stated, "it must have been a hectic day".</p> <p>An interview with the Assistant Director of Nursing (ADON), on 05/26/10 at approximately 3:00 PM, revealed Resident #4 experienced a significant change of condition and the physician should have been notified immediately.</p> <p>An interview with the Director of Nursing (DON), on 05/26/10 at 3:30 PM, revealed unresponsiveness and drooping of the mouth could indicate a significant change and the physician should have been notified immediately. The DON stated "I would have done something different".</p> <p>An interview with Resident #4's physician, on 05/27/10 at 9:45 AM, revealed Resident #4 was admitted to the hospital on 05/07/10 with a diagnosis of Hypernatremia (high blood sodium). He stated if a resident was unresponsive, it could look as if there was facial drooping. The physician stated he did not recall receiving a fax related to Resident #4's change of condition. He would not have reviewed the fax until the end of the day. He also stated staff should take time to call and should have transferred Resident #4 to the emergency room when the resident was first identified as unresponsive.</p> <p>An interview with Certified Nurse Aide (CNA) # 1, on 05/27/10 at approximately 2:10 PM, revealed Resident #4 was "spaced out" on 05/07/10 and a nurse (couldn't remember who) asked her to assist Resident #4 to bed and obtain vital signs. CNA #1 stated, the resident "just stared into space", which was unusual.</p>	F 157	See Pages 1 & 2	7-6-10	

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F 157	Continued From page 4 A review of the facility's policy and procedure for physician notification, dated 01/2005 and last revised 06/2009, revealed the Physician Notification form should be used for non-emergency updates and the physician should be called with a resident's change of condition.	F 157	See Pages 1 & 2	
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure one resident (#9), in the selected sample of 18 and one resident (#20), not in the selected sample, had the right to remain free from any chemical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's symptoms. The facility failed to develop and implement interventions prior to the use of a chemical restraint and failed to develop a policy and procedure addressing the use of chemical restraints. The facility failed to ensure staff education regarding what would constitute a chemical restraint. Findings include: A review of the facility's policy and procedure for "Mood and Behavior Crisis Management and Psychoactive Medication", dated last revised January 2008, revealed inclusion of the use of	F 222	F222 1. The medical records for residents # 9 and 20 was reviewed by the Interdisciplinary Team on 6-10-10. The careplans as well as non-pharmacological interventions were implemented for the identified residents' behaviors and the developed non-pharmacological interventions were communicated to the staff on the facility CareTracker system (computerized documentation). The Interdisciplinary Team consisted of the Director of Nursing, Social Services Director, Clinical Reimbursement Coordinator and the Dietary Manager. The physician reviewed res# 9 and #20 charts and the identified medications were discontinued, with orders for evaluations per psych services. 2. A 100% review of all current residents who receive psychotropic medications for behaviors will be reviewed by the Interdisciplinary Team, by 7-5-10, to assure that the careplan includes non-pharmacological interventions to address resident specific behaviors, as well as to identify any residents receiving psychotropic medications for behaviors that may be considered a chemical restraint. Any residents identified will be reviewed with the Physician for necessity as well as a careplan review to assure interventions are in place to reduce or eliminate the target behavior. These non-pharmacological interventions will be communicated to the staff on the CareTracker (computerized documentation system).	

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F 222	<p>Continued From page 5</p> <p>psychoactive medications, but should not be the only intervention used for behavioral symptoms. However, the facility had no policy and procedure that specifically addressed the use of chemical restraints.</p> <p>1. A record review revealed Resident #9 was admitted to the facility, on 08/28/08, with diagnoses to include Dementia and Anxiety.</p> <p>A review of the comprehensive care plan for "Mood and Behaviors", dated 08/11/09, revealed the resident exhibited behaviors of tapping other residents on the knuckles, making false accusations toward staff, combative with staff, non-compliant with alarms, threatening to turn room mate's wheelchair over and throwing medication at medication technician. The only care plan interventions to decrease the resident's agitation and behaviors was to redirect the resident and provide medications as ordered.</p> <p>A review of the Medication Administration Record (MAR), dated May 2010, revealed the resident received Seroquel (anti-psychotic) 12.5 milligrams two times a day, Zoloft (anti-depressant) 50 mg. every day, and Ativan (anti-anxiety) one mg., Benadryl (decongestant) 12.5 mg., Haldol (anti-psychotic) 0.5 mg. and Reglan (antiemetic) 10 mg. ABHR (a combination of Ativan, Benadryl, Haldol and Reglan) gel 0.5 milliliter (ml.), apply topically to wrist three times a day.</p> <p>A review of a physician notification sheet, dated 05/05/10 at 4:30 PM, which was faxed to the physician's office, revealed the resident was very restless, wanting to go home and becoming agitated very easily. It indicated the resident had already received all her scheduled medications.</p>	F 222	<p>3. All licensed nurses will be re-educated by the Director of Nurses by 6-28-10 on behavior management to include, definition of a chemical restraint, implementing non-pharmacological interventions to reduce or eliminate behaviors, documentation of interventions and establishing the cause of the behavior as established in the facility Mood and Behavior Policy and procedure. The C.N.A.'s will be retrained on documenting behaviors and non-pharmacological interventions in the Caretracker (computerized documentation system).</p> <p>4. The Director of Nursing or the Assistant Director of Nursing will review five (5) records per week for twelve (12) weeks to assure any use of psychotropic medications for behaviors have appropriate documentation of non-pharmacological interventions and are not a chemical restraint. The results of the audits will be reviewed by the Quality Assurance committee monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Manager and at least quarterly the Medical Director.</p>	7-6-10	

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F 222	<p>Continued From page 6</p> <p>Further review revealed the physician notification sheet was not received back to the facility, until 05/06/10 (no time). The physician responded with an order for Ativan 1 (one) mg. to be given intramuscularly (IM), every four hours as needed (PRN) for "anxiety". A review of the May 2010 MAR, revealed the order was transcribed to be given for "restlessness or agitation".</p> <p>A review of the nurse's progress notes, dated 05/06/10 at 2:30 PM, revealed the resident was in his/her wheelchair on the hall propelling self around the facility. The resident kept saying "Call (a family member's name), I'm going home". The note revealed the resident was anxious and was complaining of being scared to stay at the facility. A review of the nurse's progress note, dated 05/06/10 at 3:00 PM, revealed the resident was given Ativan 1 mg. IM for restlessness.</p> <p>A review of the nurse's notes, dated 05/09/10 at 2:30 PM, revealed the resident was propelling down the hallway and stated she wanted to get on a school bus. The resident stated, "if you don't let me leave, I'll throw a fit". A review of the nurse's note, dated 05/06/10 at 3:00 PM and the May 2010 MAR revealed Ativan 1 mg. IM was given for increased agitation.</p> <p>Further review of the May 2010 MAR revealed Resident #9 received Ativan 1 mg. IM on 05/10/10 on the 2:00 PM-10:00 PM shift. A review of the nurse's note, dated 05/10/10, revealed there documented evidence the resident had been assessed as restless or agitated.</p> <p>Further review of the clinical record related no evidence the resident was assessed for the cause of the behaviors and other interventions</p>	F 222			

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F 222	<p>Continued From page 7</p> <p>implemented prior to giving the resident an injection of Ativan.</p> <p>An interview with the Regional Director of Clinical Services, on 05/28/10 at 3:00 PM, revealed she reviewed the Care Tracker (facility's computer system) documentation related to the above dates and found no documentation of any interventions that were attempted, prior to administering the IM medication.</p> <p>Interviews with Licensed Practical Nurse (LPN) #2, LPN #3, LPN #4 and LPN #6, on 05/28/10 at 2:40 PM, revealed they were not aware an Ativan injection was a potential chemical restraint. They had not received any education related to what constituted a chemical restraint while working at the facility. The nurses stated that if the physician ordered a Psychoactive medication to be given by injection on as needed basis (PRN), for the resident who exhibited agitated and/or aggressive behavior, they gave the medication.</p> <p>2. Resident #20 was admitted on 03/17/10 with diagnoses to include Senile Dementia and Anxiety State.</p> <p>An observation of the medication room on the 200 hall, on 05/28/10 at 10:05 AM, revealed four vials of Ativan injectable prescribed for Resident #20, to be given as needed (PRN) for restlessness or agitation. A review of the physician's orders, dated 05/06/10, revealed the order for Ativan 1 milligram (mg) IM every four hours PRN restlessness or agitation.</p> <p>A review of the nurses progress note, dated 05/09/10 at 2:45 PM, revealed the resident was "agitated with multiple attempts to get up." Ativan</p>	F 222			

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F 222	<p>Continued From page 8</p> <p>1 mg. was given to the resident's right deltoid (upper arm muscle) for agitation. At 3:30 PM, the resident was described in the nurses progress note as "more calm." An interview with RN #1, on 05/28/10 at 11:25 AM, revealed Resident #20's behavior included agitation, increased confusion and repeated attempts to get out of the bed or wheel chair. The resident was on a routine dose of ABHR (Ativan, Benadryl, Haldol and Risperdal) cream, which was applied topically to the left wrist, at 6:00 AM, 2:00 PM and 10:00 PM. The RN stated the resident continued attempts to get out of the bed. CNAs tried assisting the resident to bed and then a wheel chair and offered snacks, but the resident continued to try and get out of the bed and/or wheel chair.</p> <p>An interview on 05/28/10 at 2:00 PM, with the physician, revealed the licensed staff members had called repeatedly regarding the resident fighting, hitting, pinching and biting the staff and other residents. The physician stated he was aware of the regulatory guidelines for using injections for agitation, but felt the benefits out-weighed the risks.</p> <p>An interview with the DON, on 05/28/10 at 2:25 PM, revealed the interventions attempted prior to the administration of the IM Ativan, were normally documented on the Care Tracker System by the CNAs in charge of the resident's care.</p> <p>A review of the care plan, developed for moods and behavior related to psychotropic drug use, dated 03/24/10, did not reveal interventions to utilize, prior to the administration of injectable PRN Ativan.</p>	F 222			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	<p>F281</p> <p>1. The prescribed treatment for resident # 12 is being applied per Physician order as observed by the Director of Nursing on 5-26-2010. The oxygen for resident # 19 was set at two (2) liters per Nasal Cannula as ordered on 5/25/10 by the Unit Manager.</p>		

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F 281	<p>Continued From page 9</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure services provided meet professional standards of quality, for one resident (#12), in the selected sample of 18 and one resident (#19), not in the sample, related to the failure to follow physician's orders for oxygen therapy or medication. The facility failed to administer a topical medication timely for Resident #12. The facility failed to ensure Resident #19 received oxygen therapy as prescribed. Findings include:</p> <p>1. Resident #12 was admitted to the facility with diagnoses to include Muscle Weakness and Syncope. A review of the Minimum Data Set (MDS), dated 05/20/10, revealed Resident #12 was assessed and identified with modified independence cognitively, with some difficulty in new situations only.</p> <p>A review of a Physician's Order, dated 01/28/10, revealed Betamethasone (corticosteroid) 0.05 % to entire body, neck to toes, three times a day. A review of the MAR revealed the medication was to be administered at 9:00 AM, 1:00 PM and 5:00 PM.</p> <p>An observation and interview with Resident #12, on 05/25/10 at approximately 11:05 AM, revealed the resident was seated on the side of the bed. Resident #12 stated He/She had intense itching and pain over the resident's entire body. The</p>	F 281	<p>2. A 100% audit of resident treatment records has been conducted by the Unit Managers on 5-26-10 to ensure that treatments were completed timely and per Physician orders. Any identified concerns were addressed with the physician. A 100% audit of oxygen orders compared to administered oxygen was conducted by the Unit Managers on 5/25/2010 with no concerns identified.</p> <p>3. Licensed nurses will be re-educated by the Director of Nurses on following Physician orders. This re-education will be completed by 6-28-2010.</p> <p>4. Unit Managers will audit all treatment records five (5) times weekly for two (2) weeks, then weekly x ten (10) weeks to assure treatments are completed per MD orders. The Unit Managers will audit Oxygen orders to Oxygen administration five (5) times weekly for 2 weeks, then weekly for ten (10) weeks to assure physician orders for oxygen are followed. The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Manager and at least quarterly the Medical Director.</p>	7-6-10	

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PRINTED: 06/09/2010
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/28/2010
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135		
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F 281	<p>Continued From page 10</p> <p>topical medication He/She was supposed to receive every morning, had not been provided. Observation of the visible skin on the resident's the neck, arms and lower legs revealed the skin was very dry, red and flaky. Resident #12 was observed to rub His/Her forearms with the palms of His/Her hands and described the itching and pain as "unbearable". The resident stated He/She was supposed to receive the topical medication three times a day, but did not receive the medication three times every day. Resident #12 stated He/She had requested a shower or bath assistance from one of the staff, because it provided relief from the intense itching and pain. The staff member told Him/Her to wait until the second shift, when the shower was scheduled. The resident had recently seen a Dermatologist and received a prescription order for the cream to help relieve the itching and pain. The resident was observed to cry and requested prayer for relief from itching and pain, which was "miserable".</p> <p>An interview with a Nurse Practitioner, on 05/25/10 at approximately 11:35 AM, revealed she expected the medication ordered for Resident #12 to be provided as ordered.</p> <p>An interview, on 05/25/10 at approximately 11:30 AM, with LPN #7 revealed Resident #12 had a topical cream ordered to be provided at 9:00 AM, but she had not provided it because she "just didn't have the time".</p> <p>2. Resident #19 was admitted to the facility with diagnoses to include Alzheimer's Disease and Chronic Airway Obstruction.</p>	F 281		7-6-10	

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F 281	Continued From page 11 Observations, on 05/25/10 at approximately 10:05 AM, 11:00 AM, 2:00, 5:00 PM and 6:05 PM revealed the resident was lying in bed with closed eyes. The resident had a tube feeding infusing and wore a nasal cannula attached to an oxygen concentrator, however, the oxygen regulator was set on zero/liters per minute. A review of the current May 2010 Physician's Orders revealed Resident #19 had an order for the oxygen at 2/liters per minute. On 05/25/10 at 6:05 PM, an observation made with the Unit Manager, LPN #1, revealed the Oxygen was set on zero/liters per minute. LPN #1 stated the assigned nurse should verify the Oxygen setting when checking Oxygen saturation levels and/or when care was provided for the resident's feeding tube. An interview with LPN #7, on 05/26/10 at approximately 3:45 PM, revealed she was unaware Resident #12 Oxygen was set on zero and she admitted she had not checked the resident's oxygen.	F 281		7-6-10
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	F309 1. The prescribed treatment for resident # 12 is being applied per physician order as observed by the Director of Nursing on 5/26/2010. 2. A 100% audit of resident treatment records has been conducted by the Unit Managers on 5/25/2010 to ensure that treatments were completed timely and per physician orders. Any identified concerns were addressed with the physician. 3. Licensed nurses will be retrained by the director of Nurses on following MD orders related to the application of ointments by 6-28-10.	7-6-10

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F 309	<p>Continued From page 12</p> <p>Based on observation, interviews and record review, It was determined the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental and psychosocial well-being for one resident (#12) in the selected sample of 18. The facility failed to ensure Resident #12 received medication for a painful and itching skin condition in a timely manner and assisted to shower to relieve the pain and itching when He/She made a request.</p> <p>Findings include:</p> <p>Resident #12 was admitted to the facility with diagnoses to include Muscle Weakness and Syncope. A review of the Minimum Data Set (MDS), dated 05/20/10, revealed Resident #12 was identified by the facility with modified Independence cognitively, with some difficulty in new situations only. Extensive assistance of one person was required for assistance in bathing.</p> <p>A review of a Physician's Order, dated 01/28/10, revealed Betamethasone (corticosteroid) 0.05% cream was to be applied to the resident's entire body, neck to toes, three times a day. A review of the MAR, dated 05/10, revealed the medication was to be scheduled for application at 9:00 AM, 1:00 PM and 5:00 PM. A review of the care plan for skin integrity, dated 05/20/10, included an intervention to "Provide treatment per MD order".</p> <p>On 05/25/10 at approximately 11:05 AM, Resident #12 was observed seated on the side of the bed. An interview with the resident revealed He/She was experiencing intense itching and pain over His/Her entire body. The resident's morning dose of a topical medicated cream, to help relieve the itching and pain, had not been provided. The</p>	F 309	<p>4. The Unit Managers will audit all treatment records five (5) times per week for two (2) weeks, then weekly for ten (10) weeks. Unit Managers will audit all treatment records five (5) times per week for two (2) weeks, then weekly for ten (10) weeks to assure treatments are completed per MD orders. The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Manager and at least quarterly the Medical Director.</p>	7-6-10	

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F 309	Continued From page 13 visible skin on the resident's neck, arms and lower legs was observed red, dry and flaky. Resident #12 rubbed His/Her forearms with His/Her hand and stated the itching and pain was "unbearable" and He/She was "miserable". The resident stated the facility did not provide the treatment three times a day as prescribed. Resident #12 stated he had requested assistance with a shower or bath to help with the itching and pain and was told to wait until the next shift, when the shower was scheduled. An interview with Licensed Practical Nurse (LPN) #7, on 05/25/10 at approximately 11:30 AM, revealed Resident #12 was supposed to have the medicated topical cream applied at 9:00 AM, but she "just didn't have the time". An interview with a Certified Nurse Aide (CNA) # 2, on 05/28/10 at approximately 11:25 AM, revealed Resident #12 was described as "needy" and "on the call light a lot", frequently requesting a shower to relieve the pain and itching of His/Her skin condition.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	1. The Oxygen for resident # 19 was set at 2 Liters per nasal Cannula as ordered on 5/25/10 by the Unit Manager. 2. A 100% audit of Oxygen orders to administered Oxygen was conducted by the Unit Managers on 5/25/2010 with no concerns identified. 3. Licensed nurses will be retrained on following M.D.orders related to oxygen administration. By the Director of Nurses by 6-28-10	7-6-10

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F 328	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, it was determined the facility failed to provide the proper care and treatment for one resident (#19), not in the selected sample. The facility failed to ensure the resident received oxygen therapy in accordance with the prescribed rate, of 2 liters per minute. Findings include:</p> <p>Resident #19 was admitted to the facility with diagnoses to include Alzheimer's Disease and Chronic Airway Obstruction.</p> <p>Observations, on 05/25/10 at approximately 10:05 AM, 11:00 AM, 2:00 PM, 5:00 PM and 6:05 PM, revealed the resident was lying in bed with eyes closed. Oxygen tubing with a nasal cannula was in place and connected to the Oxygen concentrator, however, the regulator was set on zero liters per minute.</p> <p>A review of the Physician's Orders, dated 05/10, revealed the resident's prescribed rate for oxygen therapy was 2liters per minute.</p> <p>A review of the respiratory care plan, dated 05/04/10, revealed the oxygen therapy should be provided in accordance with physician' orders.</p> <p>An observation, conducted with the Unit Manager, LPN #1, on 05/25/10 at 6:05 PM, revealed the oxygen concentrator regulator was set at zero liters per minute. LPN #1 stated the nurse assigned responsibility for resident care should verify the oxygen rate when checking Oxygen saturation and providing feeding tube care for</p>	F 328	<p>4. The Unit Managers will audit oxygen orders to oxygen administration five (5) times per week for two (2) weeks then weekly x ten (10) weeks ensuring physician orders for oxygen are followed. The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Manager and at least quarterly the Medical Director.</p>	7-6-10

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F 328	Continued From page 15 Resident #19.	F 328	See pages 14,15, for F 328	7-6-10	
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure food was served at the proper temperature for one resident (#10), in the selected sample of 18. Findings include: An observation, on 05/25/10 at 11:00 AM, revealed pureed cole slaw was sitting in an unheated steamer vat on the tray line. A temperature taken of the cole slaw at 11:30 AM, revealed the cole slaw was 58 degrees F and had been served to Resident #10. An interview on with the Dietary Manager, on 05/25/10 at 11:40 AM, revealed the shredded cabbage was mixed with the mayonnaise and other ingredients early that morning and chilled in the refrigerator, prior to being pureed. The regular consistency cole slaw was served up in individual serving bowls and placed on trays. The	F 364	F-364 1. Cold foods are being served at the correct temp. of forty (40) degrees or below. As observed by the Dietary Services Manager on 5-27-10. 2. An observation was made by the Dietary Services Manager on 5-27-10 who noted the service line temps of the cold foods was below forty (40) degrees. 3. All dietary staff have been re-educated on the proper procedures to follow when serving cold foods, as well as the need to not store cold foods near hot items. This education was provided by the Dietary services Mang. on 5-27-10. Cold food items are no longer stored near hot items on the service line.	5-27-10	

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F 364	Continued From page 16 pureed cole slaw was left in a stainless steel bowl and placed in the steamer vat, located next to the meatloaf, which had a temperature of 172 degrees F.	F 364	4. The Dietary Service Manager will audit service line temps. three (3) times per week for four weeks, then twice a week for eight (8) weeks. The results of the audit will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum the Director of Nursing, Administrator, Social Service Director, Dietary Services Mang. and the Medical Dir., who will attend at least quarterly.	7-6-2010	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431			
					F 431 See page 18,

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F 431	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined, the facility failed to ensure storage or proper disposal of narcotics for two residents (#21 and #23), not in the selected sample.</p> <p>Resident #21, was discharged, on 05/23/10, and narcotics belonging to the resident were observed stored in the refrigerator on 05/28/10, six days after discharge. Additionally, narcotics belonging to Resident #23 were stored in the medication room and not protected by the required double lock.</p> <p>Findings include:</p> <p>An observation, on 05/28/10 at 9:55 AM, revealed five vials of Ativan two milligrams (mg) per one milliliter (ml), prescribed for Resident (#23), in addition to six tablets of Ambien five mg, six tablets of Ativan five mg, six tablets of Lortab 5/500 mg and six vials of Morphine Sulfate 10 mg, stored in the medication refrigerator in the medication room on the 100 hall. The drugs were not stored under double lock.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 05/28/10 at 10:00 AM, revealed Resident #21 was discharged from the facility five days prior to the inspection of the medication room and the LPN was not aware of the Ativan left in the refrigerator. LPN #1 stated the licensed staff were supposed to let her and the DON know when there were discharged resident's narcotics in the locked box of the refrigerator, so the narcotics could be disposed of properly and within</p>	F 431	<ol style="list-style-type: none"> 1. Narcotics for resident # 21 were destroyed on 5/28/2010 by the Unit Manager and DON. The narcotic emergency drug kit was placed on the A wing Medication cart on 5/28/2010 to be counted each shift. 2. An audit of all narcotics and medication refrigerators was completed on 5/28/2010 by the Unit Managers to assure all discontinued narcotics have been destroyed and that all narcotics are stored under double lock. No further concerns were identified. 3. Licensed nurses will re-educated by the Director of Nurses by 6/28/2010 related to drug disposition on discharge or discontinuation of medications as well as narcotic storage requiring double lock. 4. The Unit Managers will audit the medication room and refrigerators daily for two (2) weeks then weekly x ten (10) weeks to assure that narcotics are stored, disposed of or returned per policy. The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Social Services Director, Dietary Services Manager and at least quarterly the Medical Director. 	7-6-2010
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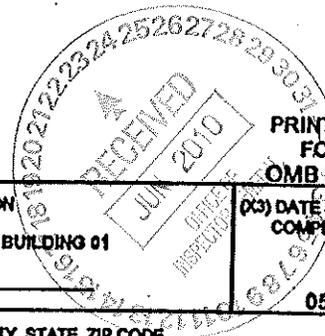
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEBY ST. FRANKLIN, KY 42135
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F 431	<p>Continued From page 18</p> <p>a timely manner. The four boxes of emergency medications were supposed to be in the medication cabinet attached to wall, but the lock for the cabinet was broken and had not been replaced.</p> <p>An interview with the maintenance worker, on 05/28/10 at 3:10 PM, revealed the replacement of the lock was on the list of things to do and he "had just not gotten to it yet."</p> <p>An interview with the Director of Nurses (DON), on 05/28/10 at 3:05 PM, revealed she was unaware of the need to dispose the discharged resident's narcotics or the improper storage emergency narcotics.</p> <p>A review of the facility policy for acquisition, receipt and disposition of medication, dated January 2001 and revised September 2007; October 2008 and April 2005, revealed the proof-of-use sheet would be attached to the controlled substance and given to the nursing management per facility policy for safe-keeping of the medication until destroyed.</p>	F 431		
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K 000	INITIAL COMMENTS	K 000		
K 144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview conducted on 05/25/10, it was determined the facility failed to exercise the generator under load for 30 minutes per month as required by NFPA 99. 3.4.4.1.</p> <p>A review of the emergency generator log on 05/25/10, at 11:00 AM revealed the generator was exercised under load from 20 to 25 minutes per month and not 30 minutes per month as required by NFPA.</p> <p>An interview conducted with the Maintenance Director on 05/25/10, at 11:05 AM revealed he did not realize the generator had to be exercised for</p>	K 144	<p>K - 144</p> <p>As of 6-1-10, the generator will be run/tested under load for thirty (30) minutes each week. An observation by the administrator on 6-1-10 revealed the maintenance director conducted a thirty (30) minute run/test under load. The maintenance director was re-educated by the administrator on 5-28-10 regarding the requirement to conduct a thirty (30) minute run/test under load. A monthly audit will be performed by the administrator to ascertain that thirty (30) minute run times are occurring by the maintenance director.</p>	6-1-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alfred Molloy TITLE: ADMINISTRATOR (X6) DATE: 6-18-10

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

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

PRINTED: 06/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/25/2010
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF FRANKLIN			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135	
(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 1 at least 30 minutes per month under load.	K 144	This audit will be kept in a manifest. The audit will run for a period of three (3) months. The audit results will be presented to the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and make further recommendations as needed. The Quality Assurance Committee will consist of the Director of Nursing, Administrator, Maintenance Director, Social Service Director and at least quarterly, the Medical Director.	6-1-10