

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: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to immediately notify the physician of a significant change in condition for one resident (#2). In the selected sample of fifteen residents. An observation of a skin assessment, on 04/05/12 at 5:30 PM, revealed the facility identified four new purple non-open areas on the resident's feet; however, the resident's physician was not notified of the areas.</p> <p>Findings include:</p> <p>A review of the facility's "Notification of Resident Change and Condition" policy/procedure, revised July 2011, revealed the resident's physician should have been notified at the earliest possible time, during waking hours if there was a critical change in condition.</p> <p>A record review revealed the facility admitted Resident #2 on 08/23/11 with diagnosis to include Type II Diabetes. A review of the quarterly Minimum Data Set (MDS), dated 03/23/12 revealed the facility identified the resident as cognitively impaired with total assistance required for bed mobility and transfers. A review of the Braden Scale, dated 03/15/12, revealed Resident #2 was at moderate risk for pressure sores.</p>	F 157	<p>Manager will audit 24 hour report sheets five (5) days a week for twelve (12) weeks to identify any changes in condition for any resident and to ensure that proper physician notification was completed. The results of the audit will be reviewed by the Quality Assurance Committee monthly for three (3) months to ensure proper physician notification. If at any time concerns are identified, they will be brought to the Quality Assurance Committee for further recommendations as needed. 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.</p>		

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F 157	Continued From page 2 An observation of a skin assessment completed by Registered Nurse (RN) #1, on 04/05/12 at 5:30 PM, revealed the facility identified four purple non open areas on the resident's feet. An area on the right foot, fourth toe, measured 0.4 centimeters (cm) x 0.3 cm; an area on the right foot, fifth toe, measured 0.2 cm x 0.2 cm; an area on the left foot, fourth toe, measured 0.2 cm x 0.2 cm; and an area on the left foot, fifth toe, measured 0.3 cm x 0.2 cm. The areas were on the tip of each toe; round, purple in color and non opened with no drainage noted. A review of the nurses' notes and physician's orders revealed there was no evidence the physician was contacted or made aware of the newly identified areas. An interview with Registered Nurse (RN) #2, on 04/06/12 at 12:30 PM, revealed, all new areas should be reported to the charge nurse, documented on the skin assessment grid and reported to the physician. An interview with the Director of Nursing (DON), on 04/06/12 at 1:30 PM, revealed, the physician should have been notified with the measurements of areas, the wound sheet should be filled out, and the family notified. All areas should be identified on the wound sheet, except for bruises, rashes or skin tears.	F 157			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F226- Develop/Implement Abuse/Neglect Policies 1. The allegation for resident #6 has been reviewed with OIG during the annual survey completed on 4/6/12.	5/19/12	

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F 226	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to implement written policies and procedures that prohibit neglect of residents. The facility failed to thoroughly investigate and report an allegation of neglect for one resident (#6), in the selected sample of fifteen residents. Findings include: A review of the facility's policy and procedure, "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, including Injuries of Unknown Source, and Misappropriation of Resident Property," revised April 2012, revealed "Neglect is the failure to provide good and services necessary to avoid physical harm, mental anguish, or mental illness." Under the investigation portion of the policy and procedure, the facility should review and investigate the allegation through the electronic Accident/Incident Report (eAI), enter details of the investigation into the eAI report and complete investigation summaries and final outcome questions. Additionally, under the "Reporting Section" of the policy and procedure, the facility should report all alleged violations and all substantiated incidents to the State agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. A record review revealed the facility admitted	F 226	APS was contacted by the Administrator on 4/27/12. 2. A review of all of the resident concerns made since our last annual survey has been completed by the Administrator to ensure the facility properly notified OIG and all other agencies as required and completed a proper investigation. All alert and orientated residents were interviewed to identify any concerns related to abuse or neglect by the Administrator on 4/27/12. No deficient practices were identified. 3. The Regional Director of Operations will re-educate the Administrator and Director of Nursing on the policies and procedures related to reporting and investigating allegations of abuse, neglect and misappropriation of property by 5/18/12. 4. The Administrator will audit all resident concerns and any allegations weekly for twelve (12) weeks to ensure that all allegations of abuse or neglect have been reported and investigated as appropriate. The audit will be reviewed by the Quality Assurance Committee monthly for three (3) months to ensure continued compliance. If at any time concerns are identified, they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director		

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F 226	<p>Continued From page 4</p> <p>Resident #6 on 04/06/07 with diagnoses of late effect Cardiovascular Disease, Cerebral Vascular Accident with Hemiparesis, and Senile Dementia.</p> <p>A review of the physician's orders, dated 02/02/12, revealed to wrap the left leg with an Unna Boot, cover with kerlix and ace wrap weekly.</p> <p>A review of the Comprehensive Care Plan, updated 03/29/12, revealed Resident #6 was to be showered two times a week, and bed baths conducted on the other days of the week.</p> <p>A review of the nurses' notes, dated 03/19/12, revealed Resident #6 was transferred from the facility to the hospital as a direct admit to obtain a skin graft.</p> <p>An interview, on 04/05/12 at 9:15 AM, with the hospital Registered Nurse (RN), who admitted and assessed the resident, revealed she identified Resident #6 had an odor. The resident's brief was saturated with urine, and a dressing on the left leg, which was supposed to be changed weekly according to the physician's order, was dated 03/05/12 (two weeks ago). She stated when she removed the dressing, on the left leg, the dressing was dirty and an odor was noted. She stated she reported the resident's condition to the Social Worker at the hospital.</p> <p>An interview with the hospital Social Worker, on 04/05/12, at 9:00 AM, revealed the nurse had informed her that Resident #6 was admitted to the hospital with urine saturation, and was wearing a dressing on the left lower leg, dated 03/05/12, which was supposed to be changed</p>	F 226	<p>of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.</p>	
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F 226	<p>Continued From page 5</p> <p>weekly. She stated she called the facility's liaison and made him aware of the resident's condition, and that she would report the incident to Adult Protective Services (APS).</p> <p>An interview with the Referral Manager (liaison for the facility), on 04/05/12 at 10:55 AM, revealed the hospital Social Worker notified him and informed him that Resident #6 was not clean, and a dressing on the resident's leg was dated 03/05/12. He stated he immediately notified the facility's Administrator about the hospital's concerns and that the hospital was reporting the incident to APS.</p> <p>An interview with the Administrator, on 04/04/12 at 11:10 AM, revealed the Referral Manager made him aware that the hospital called and reported Resident #6 arrived at the hospital and was not clean, and a dressing on the resident's leg was dated 03/05/12. He stated the Referral Manager told him the hospital reported it to Adult Protective Services (APS). He stated an investigation was conducted and it was concluded that the resident was cleaned up prior to leaving the facility and the resident was at the wound care center, on 03/15/12, and the dressing was changed. He revealed he did not report the allegation to the Office of Inspector General (OIG) because it did not cross his mind that he needed to report the incident to the State agency. He did not look at it as an allegation of neglect, even though he was made aware about the hospital notifying APS.</p> <p>A review of the facility's investigation, dated 03/19/12, revealed the Director of Nursing (DON) interviewed and obtained written statements from</p>	F 226			

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F 226	<p>Continued From page 6</p> <p>the staff who provided care and/or saw Resident #6 prior to transferring the resident to the hospital. A CNA stated he had provided incontinent care and changed the resident's clothes prior to the resident's transfer to the hospital. Two nurses stated they did not notice any urine odor prior to the resident's transfer to the hospital. The DON's statement revealed she saw the resident that morning and she did not notice any odor and the resident appeared to be clean. However, a review of the investigation revealed there was no evidence to determine the last time the resident received a bed bath and/or a shower.</p> <p>A review of the "Resident Bathing Type by Day Report," dated 03/05/12 through 03/19/12, revealed Resident #6's last shower was completed on 03/12/12 (seven days prior to being admitted to the hospital), and the last bed bath was completed, on 03/19/12, with no refusals documented.</p> <p>Interviews with Certified Nurse Aide (CNA) #2 and CNA #8, on 04/03/12 at 1:45 PM, and on 04/06/12 at 9:35 AM, respectively, revealed bed baths consisted of washing the residents' hands, face, peri-area and under the arms. Further interview with CNA #8, who provided care for Resident #6 the morning the resident was transferred to the hospital, revealed he only washed the residents' face, hands, underarms, and provided incontinent care.</p> <p>Further review of the facility's investigation, dated 03/19/12, revealed the DON notified the hospital, on 03/15/12, and requested the hospital to send records of the resident's visit to the wound care</p>	F 226			

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F 226	<p>Continued From page 7</p> <p>center. She determined the resident's dressing was changed that day. However, review of the documentation, sent from the hospital, revealed the dressing was changed on the resident's right leg, but not on the resident's left leg. Documented statements from the staff at the wound care center revealed the resident's dressing was changed on the right leg and the resident was scheduled for a skin graft on the right leg. There was no evidence the dressing was changed on the left leg. There was no evidence the facility conducted a thorough investigation to determine which dressing was not changed or when it was last changed.</p> <p>A review of the Treatment Administration Record (TAR), dated March 2012, revealed an order to apply an Unna Boot, and wrap with kerlix and an ace bandage every week. The TAR was initialed on 03/05/12, indicating the dressing was changed on that date. Further review of the TAR revealed initials were written in the boxes, dated 03/12/12 and 03/15/12, indicating that the resident was at the Wound Care Center.</p> <p>An interview with the DON, on 04/04/12 at 4:15 PM, revealed when she conducted the investigation, she was not aware the hospital was talking about the resident's left leg.</p> <p>An interview with the Certified Wound Ostomy and Continence Nurse from the Wound Care Clinic, on 04/04/12 at 9:30 AM, revealed Resident #6 only came to the wound care center once a month. She stated he/she came to the wound care center on 03/15/12. She stated the dressing on the right leg was removed, and treatment was completed with a new dressing applied. She</p>	F 226			

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F 226	Continued From page 8 revealed Resident #6 had an Unna Boot on the left leg, wrapped with kerlix, and an ace bandage for edema. She stated there was no wound on the left leg, so there was no reason for them to remove the Unna Boot.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly and comfortable interior. Findings include: A review of the Housekeeping Inservice for the "7-Step Daily Washroom Cleaning," dated 01/01/00, revealed the proper method to sanitize a washroom in a long term care facility included checking supplies, emptying the trash, dust mopping the floor, cleaning and sanitizing the sink and tub, cleaning and sanitizing the commode, spot cleaning the walls, and damp mopping the floor with a germicide solution. An observation upon entrance to the facility, on 04/02/12 at 6:00 PM, revealed the floors were sticky and dirty. Additionally, salt and pepper	F 253	F253- Housekeeping & Maintenance Services 1. All floors have been cleaned to remove the sticky and dirty substances as observed by the Administrator on 4/12/12. The salt and pepper packets were removed from the dining room floor and the washcloths under one of the dining room tables were removed on 4/12/12. The ammonia odor is no longer present on Hall 1 as observed by the Administrator on 4/12/12. The floors were cleaned and clutter removed in rooms #1, #2, #4,#7. The bath basin in room #6 was removed from the floor and stored properly, the wash basin on the floor next to the toilet has been stored properly and the bathroom garbage has been removed as observed by the Administrator on 4/12/12. Rooms #7, #14, #15, #23, #30 and #34 were observed by the Administrator on 4/23/12 to be free of any odors. The wash tub on the floor in room #9 has	5/19/12

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F 253	<p>Continued From page 9</p> <p>packets were all over the floor in the dining room, prior to the supper meal being served. There were washcloths with a dried brown substance lying under one of the tables in the dining room.</p> <p>Observation during the initial tour, on 04/02/12 at approximately 6:15 PM, revealed the following:</p> <ul style="list-style-type: none"> -On Hall I, there was evidence of a strong ammonia odor present. -Room #1 was cluttered and the floor was dirty and sticky. -Room #2 and Room #4 were cluttered and the floors were dirty. -In Room #6, a bath basin was on the floor next to the bedside table. Bathroom garbage was overflowing on to the floor. A wash basin was on the floor next to the toilet. -In Room #7, there was a strong ammonia odor in the bathroom, the room was cluttered and the floor was dirty and sticky. -In Room #9, a wash tub was on the floor next to the bedside table. -In Room #13, there was an unbagged bedpan with a yellow liquid substance sitting on the back of the toilet. -In Room #14 and Room #15, there was evidence of a strong ammonia odor in the bathroom. -In Room #16, there was an unbagged bedpan in the bathroom, two Nebulizer machines with the tubing unbagged, and one Continuous Positive Air Pressure (C-Pap) machine with the mask on the floor. -In Room #17, there was clutter under the sink and the bed. -In Room #21, there was an unbagged bedpan in the bathroom. -In Room #23, there was a strong ammonia odor 	F 253	<p>been removed from the floor, replaced with a new wash tub and stored properly. The bedpans in rooms #13 and #16 have been replaced with new bedpans and stored properly. The nebulizer machine tubing and the C-Pap machine mask in room #16 have been replaced with new tubing and mask and stored properly. Room #17 has been cleaned of the clutter under the sink and around the bed. The bedpan in room #21 has been replaced with a new bedpan and stored properly, and the clothing at the foot of the bed, under the bed and in the laundry basket in room #23 have been cleaned as needed and put in the closet. All of these observations were made by the Administrator on 4/12/12. Re-education was completed with Housekeeping Aide #1 on 4/3/12 by the Housekeeping Supervisor on proper procedures related to the appropriate changing of mop water. Rooms #10 and #11 were re-mopped on 4/3/12 by the Housekeeping Aide.</p> <p>2. A complete tour of the facility will be completed by the Administrator, Director of Nursing and Housekeeping Supervisor by 5/18/12 to identify other areas with the same identified concerns to include storage of bedpans, bath basins and urinals, nebulizer treatment equipment, odors and general cleanliness of the resident rooms and</p>	
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F 253	<p>Continued From page 10</p> <p>in the bathroom, stacks of clothing at the foot of the bed and under the bed, as well as an overflowing laundry basket.</p> <p>-In Room #30 and Room #34, there was evidence of a strong ammonia odor present.</p> <p>Interviews with Certified Nurse Aide (CNA) #2, CNA #8, and CNA #9, on 04/03/12 at 1:45 PM, on 04/05/12 at 1:10 PM, and on 04/06/12 at 9:35 AM, respectively, revealed it was the CNA's responsibility to ensure residents' rooms were picked up and kept uncluttered. They stated the CNAs should clean up after themselves. Washbasins should be bagged and stored in drawers or closets.</p> <p>An interview with Housekeeping Aide #2, on 04/06/12 at 11:30 AM, revealed she worked from 7:00 AM to 2:00 PM, on 04/02/12. She revealed it was a "really hectic" day. She stated that kitchen staff were supposed to clean the dining room floor after the housekeeping staff left the facility.</p> <p>An observation, on 04/03/12 at 10:25 AM, revealed a housekeeping cart with dark brownish-gray water was sitting in the hallway. Housekeeping Aide #1 used the water to clean two residents' rooms (Room #10 and Room #11). An observation at 11:00 AM, revealed Room #11 had a gray film on the floor, and the floor was sticky.</p> <p>An interview with Housekeeping Aide #1, on 04/06/12 at 9:00 AM, revealed she was supposed to change the mop water after every three residents' rooms, or as needed. She recalled cleaning Room #11 and Room #10, on 04/03/12. She stated that she had cleaned Room #5 first,</p>	F 253	<p>common areas. Any areas identified will be corrected immediately by the Administrator, Director of Nursing and/or the Housekeeping Supervisor.</p> <p>3. All staff will be re-educated by the Education and Training Director by 5/18/12 on keeping the facility clean and free of odors, proper storage of wash basins and bedpans, bagging Nebulizer tubing, keeping C-Pap masks off the floor and stored properly and proper storage of resident clothing. The housekeeping staff have been re-educated by the Housekeeping Supervisor by 5/18/12 on proper procedures related to the appropriate changing of mop water during cleaning as well as the procedure for cleaning and cleaning schedule.</p> <p>4. Rounds audits will be made throughout the facility by the Administrator, Director of Nursing, Assistant Director of Nursing, Housekeeping Supervisor and Unit Manager five (5) days per week for four (4) weeks and weekly for eight (8) weeks to ensure continued compliance with keeping the facility clean and free of odors, proper storage of wash basins and bedpans, bagging Nebulizer tubing, keeping C-Pap masks off the floor and stored properly and proper storage of resident clothing. The Quality Assurance Committee will review the audits monthly for three (3) months for</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104	
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F 253	Continued From page 11 and should have changed the mop water afterward, as the resident in the room "spills things" frequently. An interview with Housekeeping Aide #2, on 04/06/12 at 11:30 AM, revealed she had to remind Housekeeping Aide #1 to change her mop water "the other day." An interview with the Housekeeping Supervisor, on 04/04/12 at 10:30 AM, revealed he expected the housekeeping staff to change mop water every three rooms or as needed. Further interview with the Housekeeping Supervisor, at 11:35 AM, revealed he was "pretty upset" when he walked into the facility on 04/02/12, and stated the appearance was not "usual."	F 253	further recommendations as needed. If at any time concerns are identified, a Quality Assurance meeting will be held to address concerns and implement further recommendations as needed. 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.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for three residents (#6, #9, and #11), in the selected sample of fifteen residents, and for two residents (#19 and #20), not in the selected sample. Resident #6 did not receive scheduled pain medication, and Resident #9 was not administered his/her tube feeding. Additionally, Resident #11, #19, and #20 did not receive	F 281	F281- Services Provided Meet Professional Standards 1. An observation by the Director of Nursing on 4/27/12 noted that resident # 9 was receiving the tube feeding as ordered. An observation of Medication Administration by the Director of Nursing on 4/27/12 noted that residents #6, #9, #11, #19 and #20 were receiving their medications as ordered by the physician. 2. An observation by the Director of Nursing on 4/27/12 noted that all residents who receive a tube feeding were receiving their tube feeding as ordered by the physician. An	5/19/12

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

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F 281	<p>Continued From page 12</p> <p>medications according to the physician's orders and standards of nursing practice.</p> <p>Findings include:</p> <p>A review of the facility's procedure for "Medication Administration," revised July 2010, revealed the licensed nurse would check the following to administer medications: the right medication, the right dose, the right dosage form, the right route, the right resident, and the right time.</p> <p>1. A review of Resident #11's physician orders, dated 04/01/12 through 04/30/12, revealed Nateglinide was ordered three times daily, at 7:00 AM, 11:00 AM, and 5:00 PM. Naproxen, Theophylline Extended Release, and Baclofen were ordered twice daily at 7:00 AM and 7:00 PM. Levothyroxine was ordered at 6:00 AM, to be administered on an empty stomach.</p> <p>An observation of a medication pass, on 04/05/12 at 8:40 AM, revealed Licensed Practical (LPN) #1 administered Resident #11's medications which included Nateglinide (for Diabetes Mellitus) 120 milligrams (mg) by mouth (po), Naproxen 500 mg po, Theophylline Extended Release (for Chronic Obstructive Pulmonary Disease) 300 mg po, Baclofen (for muscle spasms) 10 mg po, and Levothyroxine (for Hypothyroidism) 150 micrograms (mcg) po at 8:40 AM.</p> <p>An interview with LPN #1, on 04/05/12 at 2:30 PM, revealed she was suppose to administer medications within one hour before and one hour after the scheduled time. She revealed it was difficult, at times, to administer medications within the required timeframe. She further revealed she</p>	F 281	<p>observation of medication administration by 4/28/12 by the Director of Nursing and Assistant Director of Nursing noted that all residents were receiving their medications as ordered by the physician.</p> <p>3. All licensed nurses will be re-educated on the policy and procedures related to Medication Administration by the Education and Training Director by 5/18/12 as well as administration of tube feeding per physician orders.</p> <p>4. Medication Pass Audits will be completed three (3) times a week for eight (8) weeks and weekly for four (4) weeks by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager to ensure residents are receiving their medications as ordered by the physician. An audit of all residents who receive a tube feeding will be completed by the Director of Nursing or the Assistant Director of Nursing three (3) times per week for eight (8) weeks followed by weekly for four (4) weeks to assure that all residents that receive tube feeding receive their feedings as ordered by the physician. Results of the auditing will be reviewed with the Quality Assurance Committee monthly for three (3) months and according to Quality Assurance Committee recommendations thereafter. If at anytime a concern is identified, a Quality Assurance Committee meeting</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	<p>Continued From page 13</p> <p>was aware the resident's Levothyroxine was due at 6:00 AM, but he/she refused the medication at that time. She revealed "it was better to give late than miss a dose."</p> <p>An interview with the Director of Nursing (DON), on 04/06/12 at 12:15 PM, revealed she expected the staff to follow the standard for administering medications one hour before or one hour after the scheduled time. She revealed staff should consult with the physician when administering late medication.</p> <p>2. A review of the facility's procedure for "Self-Medication Assessment and Management," revised April 2006, revealed the Self-Medication Data Collection and Assessment form was used to evaluate a resident's ability to self-medicate safely. The form would be updated with a change of condition and quarterly.</p> <p>A review of Resident #19's Quarterly Nursing Data Collection and Assessment, dated 11/09/11, revealed he/she does not self-medicate.</p> <p>A review of Resident #19's physician orders, 04/01/12 through 04/30/12, revealed an order for Xanax, Buspar, and Namenda twice daily at 7:00 AM and 7:00 PM. Meloxicam was ordered to give with food or a meal at 7:00 AM.</p> <p>An observation of a medication pass, on 04/04/12 at 8:40 AM, revealed LPN #2 did not administer Resident #19's Astelin Nasal Spray according to the physician's order. LPN #2 asked Resident #19 if he/she used the nasal spray, and the resident replied "no." Additionally, LPN #2 administered Xanax (for anxiety) 0.5 mg po,</p>	F 281	<p>will be held for 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.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	<p>Continued From page 14</p> <p>Buspirone (for depression) 7.5 mg po, Meloxicam 7.5 mg po, and Namenda (for Dementia) 10 mg po at 8:40 AM. LPN #2 did not administer Prilosec (for GERD) 20 mg po. The resident was not eating at the time of the observation.</p> <p>A review of the Medication Administration Record (MAR), dated 04/01/12 through 04/30/12, revealed LPN #2 signed the MAR to indicate the resident's nasal spray had been administered. The MAR indicated to keep the Astelin Nasal Spray at bedside; however, there was no physician's order to keep the resident's medication at bedside. The MAR indicated the resident's Prilosec had been discontinued; however, there was no physician's order to discontinue the medication.</p> <p>An interview with LPN #2, on 04/05/12 at 1:35 PM, revealed a physician's order should be obtained before a resident could keep a medication at bedside. She revealed she should have ensured the resident administered the nasal spray prior to signing the MAR. She stated that medications should be passed one hour before or after the scheduled time; however, 04/04/12 was a "busy day" and she was "behind" on the medication pass. She further revealed a snack should have been offered to Resident #19, before administering the Meloxicam.</p> <p>An interview with the DON, on 04/06/12 at 12:15 PM, revealed she was not aware the resident had not been assessed to self-administer the nasal spray. She was unable to provide documentation to verify Resident #19's Prilosec was discontinued.</p>	F 281			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 281	<p>Continued From page 15</p> <p>3. A review of the procedure for "Metered Dose Inhaler Administration," revised January 2007, revealed staff should instruct the resident to exhale to empty the lungs and place the tip of the spacer in the mouth, maintaining a tight seal. Instruct the resident to activate the inhaler during the first third of a slow maximal inhalation and continue to inhale until lungs are filled with air. The resident should be encouraged to hold their breath for 3-5 seconds. Wait one minute between inhalation unless otherwise instructed by the pharmacy.</p> <p>An observation, on 04/05/12 at 8:45 AM, revealed LPN #1 allowed Resident #20 to self-administer a Ventolin HFA inhaler. LPN #1 did not instruct the resident how to administer the inhaler correctly. The resident administered two puffs of the inhaler, waiting five seconds between the puffs.</p> <p>An interview with LPN #1, on 04/05/12 at 2:30 PM, revealed Resident #20 used the inhaler when he/she was short of breath. She revealed the resident usually took two quick puffs of the inhaler. She further revealed she was unaware the resident was supposed to wait a minute between the puffs.</p> <p>An interview with the DON, on 04/06/12 at 12:15 PM, revealed she was unaware of a time frame to wait between puffs of the same inhaler, but expected the staff to follow the policy.</p> <p>4. A record review revealed the facility admitted Resident #6 on 04/06/07 with diagnoses to include Neuropathy and Cervical Stenosis.</p> <p>A review of the physician's order, dated 01/05/12,</p>	F 281			

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

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F 281	<p>Continued From page 16 revealed an order for Morphine Sulfate 30 mg tablet po two times a day (BID).</p> <p>A review of the MAR, dated 02/12, revealed Resident #6 did not receive his/her Morphine 30 mg two times a day from 02/06/12 at 9:00 PM through 02/13/12 at 9:00 AM. This resulted in nine missed doses.</p> <p>A review of the nurse's notes, dated 02/07/12 through 02/10/12, revealed LPN #4 called the physician's office daily to obtain a script for the Morphine. She stated the physician's office kept telling her that they would fax the script. The script was not received until the evening of 02/10/12, when the physician visited the facility.</p> <p>Interview with LPN #4, on 04/04/12 at 10:15 AM, revealed the facility needed a script from the physician to obtain the Morphine from the pharmacy. She stated there was an order for Hydrocodone as needed (PRN) for breakthrough pain, and it was administered when the resident complained of pain.</p> <p>5. A record review revealed the facility admitted Resident #9 on 03/01/12 with diagnoses to include Post Traumatic Brain Injury, Aspiration Pneumonia, Right Chest Injury Related to Accident, Peripheral Vascular Disease, Respiratory Failure and Diabetes.</p> <p>A review of Resident #9's physician orders, dated 03/13/12, revealed an order for Glucerna 1.2 calorie (cal) at 60 ml/hr continuous for 22 hours a day. According to the order, the feeding should be turned on at 8:00 AM and off at 6:00 AM.</p>	F 281			

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

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F 281	Continued From page 17 An observation, on 04/04/12 at 8:35 AM and at 9:35 AM, revealed Resident #9's tube feeding was turned off. An interview with LPN #4, on 04/05/12 at 2:05 PM, revealed, "It was just a very bad day." She revealed she was not sure what time she started the tube feeding, but stated that it should have been started at 8:00 AM. An interview with DON, on 04/06/12 at 3:30 PM, revealed she expected the nurses to follow the physician's orders.	F 281			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 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 ensure services were provided by qualified persons in accordance with each resident's written plan of care for two residents (#3 and #5), in the selected sample of fifteen residents, related to bed and chair alarms. Findings include: A review of the facility's "Plans of Care" policy and procedure, dated January 2012, revealed the comprehensive care plan describes the services to be provided to attain or maintain the resident's	F 282	F282- Services By Qualified Persons/Per Care Plan 1. Resident #3 has a bed alarm in place, connected and turned on as observed by the Administrator on 4/23/12. Resident #5 has bed and chair alarms in place, connected and turned on as observed by the Administrator on 4/23/12. 2. A 100% audit of all resident alarms was completed by the Director of Nursing on 4/27/12 to ensure that they are in place, connected and turned on. No concerns were identified. 3. All direct care staff will be re-educated by the Education and Training Director by 5/18/12 on following the resident plan of care and ensuring resident bed and chair alarms are in place, connected and turned on.	5/19/12	

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

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F 282	<p>Continued From page 18 highest practicable physical, mental and psychosocial well-being.</p> <p>1. A record review revealed the facility admitted Resident #3 on 09/19/08 with diagnoses to include Dementia and Alzheimer's Dementia with disturbance of mood and behavior.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/10/12, revealed the facility assessed Resident #3 as moderately cognitively impaired and he/she required limited assistance of one staff for transfers and ambulation.</p> <p>A review of the Comprehensive Care Plan for falls, last updated 02/28/12, revealed an intervention for a bed alarm.</p> <p>Observation, on 04/02/12 at 6:15 PM, revealed the resident was lying in bed with a pressure alarm attached to the bed, however, it was not turned on. Further observation, on 04/03/12 at 10:15 AM and 2:20 PM, and on 04/04/12 at 8:55 AM, revealed the resident was lying in bed with the alarm box on the bed, but the wire from the pressure pad to the box was not connected to the box.</p> <p>2. A record review revealed the facility admitted Resident #5 on 01/27/04 with diagnoses to include Schizophrenia and Psychoses with Impulse Control.</p> <p>A review of the quarterly MDS assessment, dated 03/09/12, revealed the facility assessed Resident #5 as moderately cognitively impaired and he/she required the assistance of two staff for transfers</p>	F 282	<p>4. Round audits will be completed five (5) days a week (Mon. – Fri.) for four (4) weeks and weekly for eight (8) weeks by the Administrator, Director of Nursing, Assistant Director of Nursing, and/or Unit Manager, to ensure that alarms are in place, connected and turned on. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months and according to Quality Assurance Committee recommendations thereafter. If at any time concerns are identified, they will be brought to the Quality Assurance Committee for further recommendations as needed. 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.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 19 and ambulation.</p> <p>A review of the Comprehensive Care Plan for falls, last updated 03/06/12, revealed an intervention for a bed alarm and a chair alarm.</p> <p>Observation, on 04/02/12 at 6:30 PM, revealed Resident #5 was lying in bed asleep with no bed alarm on the bed. Further observations, on 04/03/12 at 9:00 AM, 10:15 AM, 11:45 AM, 2:15 PM, and 3:20 PM, and on 04/04/12 at 8:25 AM and 8:50 AM, revealed Resident #5 was sitting in a wheelchair with no alarm on the chair.</p> <p>Interview with Certified Nurse Aide (CNA) #8 and CNA #9, on 04/05/12 at 1:30 PM and at 1:45 PM, respectively, revealed they were responsible to ensure care plans were followed related to safety devices. They revealed they ensured alarms were in place, turned on and hooked up, whenever they provided care to the resident. They were unable to provide an explanation as why Resident #3's alarm and Resident #5's alarm were not in place and/or plugged.</p> <p>Interview with Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #2, on 04/06/12 at 10:45 AM and at 11:10 AM, respectively, revealed the Director of Nursing (DON), Charge Nurse and the nurses on the hall were responsible for ensuring CNAs followed the care plans for all residents.</p> <p>An interview with the DON, on 04/06/12 at 12:10 PM, revealed CNAs should follow the care plans for residents. Nursing staff should monitor to ensure the CNAs implemented the interventions according to the resident's care plans. She stated</p>	F 282			

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

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F 282	Continued From page 20 they have a program called Caring Partners which consists of the Administrative Department Staff making rounds every morning Monday through Friday to ensure safety devices are in place according to the residents care plans.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for one resident (#6), in the selected sample of fifteen residents. The facility failed to ensure Resident #6's dressing was changed on his/her left leg every week according to the physician's order. Findings include: A record review revealed the facility admitted Resident #6 on 04/06/07 with diagnoses of late effect Cardiovascular Disease, Cerebral Vascular Accident with Hemiparesis, and Senile Dementia.	F 309	F309- Provide Care/Services for Highest Well Being 1. Resident #6's left leg dressing was changed per physician orders as observed by the Director of Nursing on 4/25/12. 2. An observation by the Director of Nursing, Assistant Director of Nursing and/or the Unit Manager on 4/27/12 noted that all residents had received any ordered dressing changes as prescribed by the physician. 3. The licensed staff will be re-educated by the Education and Training Director by 5/18/12 on providing skin treatments as ordered by the physician. 4. The Director of Nursing, Assistant Director of Nursing and/or the Unit Manager will observe five (5) resident treatments per week for twelve (12) weeks to assure that treatments are completed per physician orders. Results of the monitoring will be reviewed with the Quality Assurance Committee monthly for three (3) months and according to Quality Assurance	5/19/12	

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

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F 309	<p>Continued From page 21</p> <p>A review of the Comprehensive Care Plan, last updated 03/29/12, revealed Resident #6 was to be showered two times a week and bed baths conducted on the other days.</p> <p>A review of the physician's orders, dated 02/02/12, revealed to wrap the left leg with an Unna Boot, cover with kerlix and an ace wrap weekly.</p> <p>A review of the Treatment Administration Record (TAR), dated 03/12, revealed an order to apply an Unna Boot to the left leg, and wrap with kerlix and an ace bandage every week. Further review revealed the TAR was initialed on 03/05/12, which indicated the date of the last dressing change. Further review of the TAR revealed initials were written in the box, for 03/12/12 and 03/15/12, which indicated that the resident was at the Wound Care Center.</p> <p>A review of the nurses' notes, dated 03/19/12, revealed Resident #6 was transferred from the facility to the hospital as a direct admit to obtain a skin graft.</p> <p>An interview with the Registered Nurse (RN), on 04/05/12 at 9:00 AM, who admitted the resident to the hospital on 03/19/12, revealed when Resident #6 arrived at the hospital, the dressing on the left leg was dated 03/05/12. She stated the physician's order revealed the dressing was supposed to be changed every week. She stated she removed the dressing and there was no skin breakdown, but there was a strong odor.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 04/05/12 at 1:45 PM, revealed she was unable</p>	F 309	<p>Committee recommendations thereafter. If at any time concerns are identified, they will be brought to the Quality Assurance Committee for further recommendations as needed. 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.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2012
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F 309	Continued From page 22 to get Resident #6's treatment completed on the left leg, on 03/12/12, because she ran out of time. She stated she passed it on to the next shift. An interview with the Certified Wound Ostomy and Continence Nurse from the Wound Care Clinic, on 04/04/12 at 9:30 AM, revealed Resident #6 only came to the Wound Care Center once a month. She stated he/she came to the wound care center on 03/15/12. She stated the dressing on the right leg was removed and treatment was completed with a new dressing applied. She revealed Resident #6 had an Unna Boot on the left leg, wrapped with kerlix and an ace bandage for edema. She stated there was no wound on the left leg, so there was no reason for them to remove the Unna Boot.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure the environment remained as free of accident hazards as is possible; and/or each resident received adequate supervision and assistance	F 323	F323- Free of Accident Hazards 1. Resident #3 has a bed alarm in place, connected and turned on as observed by the Administrator on 4/23/12. Resident #5 has bed and chair alarms in place, connected and turned on as observed by the Administrator on 4/23/12. The nebulizer machine was unplugged from the power strip and removed from the bed on 4/5/12 and the power strip was removed from the bed on 4/5/12 by the Maintenance Director. 2. A complete walkthrough of the facility was completed by the Administrator by 4/23/12 to ensure that the environment was free of accident	5/19/12

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F 323	<p>Continued From page 23</p> <p>devices to prevent accidents for three residents (#3, #5 and #13), in the selected sample of fifteen residents. The facility failed to ensure bed and chair alarms were in place and/or working for Resident #3 and Resident #5, and failed to ensure Resident #13 was free from accident hazards related to a power strip across the bed.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Falls and Injuries," last revised April 2012, revealed the facility provides an environment that is free of accident hazards and supervision and assistive devices to each resident to prevent avoidable accidents.</p> <p>1. A record review revealed the facility admitted Resident #3 on 09/19/08 with diagnoses to include Dementia and Alzheimer's Dementia with disturbance of mood and behavior.</p> <p>A review of the Daily Care Review notes, dated 01/27/12, revealed Resident #3 sustained a fall by ambulating to the bathroom without calling for assistance.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/10/12, revealed the facility assessed Resident #3 as moderately cognitively impaired. Further review revealed he/she required limited assistance of one staff for transfers and ambulation and sustained a fall with injury.</p> <p>A review of the Comprehensive Care Plan for falls, last updated 02/28/12, revealed an intervention was added, on 02/27/12, for a bed</p>	F 323	<p>hazards as is possible. No concerns were identified. A 100% audit of all resident alarms will be completed by the management team by 5/18/12 to ensure that they are in place, connected and turned on. Any identified issues will be corrected immediately.</p> <p>3. All staff will be re-educated by the Education and Training Director by 5/18/12 on policies and procedures related to providing a safe environment for the residents to include the use of power strips. All direct care staff will be re-educated by the Education and Training Director by 5/18/12 on following the resident plan of care and ensuring resident bed and chair alarms are in place, connected and turned on.</p> <p>4. An audit will be completed 3 times a week for 4 weeks and weekly for 8 weeks by the Administrator, Director of Nursing or Assistant Director of Nursing to assure the environment is free of accident hazards as is possible. Round audits will be completed 5 days a week (Mon. – Fri.) for 4 weeks and weekly for 8 weeks by the Administrator, Director of Nursing, Assistant Director of Nursing and/or the Unit Manager to ensure alarms are in place, connected and turned on. Identified issues/concerns will be addressed immediately. The Quality Assurance Committee will review audit results</p>	

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F 323	<p>Continued From page 24 alarm.</p> <p>Observation, on 04/02/12 at 6:15 PM, revealed the resident was lying in bed with a pressure alarm attached to the bed; however, it was not turned on. Further observations, on 04/03/12 at 10:15 AM and 2:20 PM, and on 04/04/12 at 8:55 AM, revealed the resident was laying in bed with the alarm box on the bed; however, the wire from the pressure pad to the box was not connected to the box.</p> <p>2. A record review revealed the facility admitted Resident #5 on 01/27/04 with diagnoses to include Schizophrenia and Psychoses with Impulse Control.</p> <p>A review of the quarterly MDS assessment, dated 03/09/12, revealed the facility assessed Resident #5 as moderately cognitively impaired. Further review revealed he/she required the assistance of two staff for transfers and ambulation and sustained a fall with no injury.</p> <p>A review of the Comprehensive Care Plan for falls, last updated 03/06/12, revealed interventions for a bed alarm and a chair alarm.</p> <p>Observation, on 04/02/12 at 6:30 PM, revealed Resident #5 was laying in bed asleep with no bed alarm on the bed. Further observations on 04/03/12 at 9:00 AM, 10:15 AM, 11:45 AM, 2:15 PM, and 3:20 PM; and on 04/04/12 at 8:25 AM and 8:50 AM, revealed Resident #5 was sitting in a wheelchair with no alarm on the chair.</p> <p>Interview with Certified Nurse Aide (CNA) #8 and CNA #9, on 04/05/11 at 1:30 PM and 1:45 PM,</p>	F 323	<p>monthly for 3 months and make further recommendations for continuing audits thereafter. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. 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.</p>	
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F 323	<p>Continued From page 25</p> <p>respectively, revealed the CNAs were responsible to ensure bed and chair alarms were in place, turned on, and hooked up whenever they provided care for the resident. They were unable to provide an explanation as to why Resident #3's and Resident #5's alarms were not in place and/or plugged.</p> <p>Interview with Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #2, on 04/06/12 at 10:45 AM and 11:10 AM, respectively, revealed the Director of Nursing (DON), Charge Nurse and nurses on the hall were responsible for ensuring the CNAs made sure alarms were in place for the residents.</p> <p>An interview with the DON, on 04/06/12 at 12:10 PM, revealed CNAs were responsible for ensuring bed and chair alarms were in place and working. Nursing staff should monitor to ensure the alarms were in place and working. She stated they have a program called "Caring Partners," which consisted of the Administrative Department Staff making rounds every morning, Monday through Friday, to ensure safety devices were in place and working.</p> <p>3. Observations, on 04/02/12 at 7:00 PM, on 04/03/12 at 9:00 AM, 9:30 AM, 10:30 AM, 11:00 AM, 11:30 AM, 12:00 PM, 1:00 PM, 1:30 PM, 2:00 PM, 3:00 PM, 4:00 PM, and on 04/04/12 at 8:30 AM, revealed Resident #13 had a power strip lying on his/her bed, with the bed, nebulizer machine and a cell phone plugged into it. The nebulizer machine was also lying on the bed.</p> <p>Interview with CNAs #6, #5, #4, #10, #11, and #3, on 04/05/12 at 9:10 AM, 9:35 AM, 9:45 AM, 2:30</p>	F 323		

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

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F 323	Continued From page 26 PM, 2:45 PM, and 4:30 PM, respectively, revealed power strips should not be lying on the residents' bed and the nebulizer machine should be sitting on the bedside table, and not on the bed. Interview with LPN #4, and LPN #3, on 04/05/12 at 10:00 AM and 3:55 PM, respectively, revealed power strips should not be lying on the residents' beds, and the nebulizer machines should be on the resident's bedside table, not on the bed. Interview with RN #1, and RN #2, on 04/05/12 at 4:05 PM and 4:15 PM, respectively, revealed power strips should not be lying on the resident's bed and the nebulizer machine should be on the bedside table, and not on the bed.	F 323		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies and procedures, it was determined the facility failed to ensure it was free of medication error rates of five percent or greater for one resident (#11), in the selected sample of fifteen residents, and for two residents (#19 and #20), not in the selected sample. Observation of 42 opportunities with thirteen (13) medication errors resulted in a medication error rate of 30 percent.	F 332	F332- Free of Medication Error Rates of 5% or More 1. An observation by the Director of Nursing and the Assistant Director of Nursing by 4/28/12 noted that medications were being administered at the correct time with no errors noted in administration. 2. An observation by the Director of Nursing and the Assistant Director of Nursing by 4/28/12 noted that medications were being administered at the correct time with no errors noted in administration. 3. Medication Administration times are being staggered on each hall way. All licensed nurses will be re-educated on	5/19/12

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F 332	<p>Continued From page 27</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure for "Medication Administration," revised July 2010, revealed the licensed nurse would check the following to administer medications: the right medication, the right dose, the right dosage form, the right route, the right resident, and the right time.</p> <p>1. A review of Resident #11's physician orders, dated 04/01/12 through 04/30/12, revealed Nateglinide was ordered three times daily, at 7:00 AM, 11:00 AM, and 5:00 PM. Further review revealed Naproxen, Theophylline Extended Release, and Baclofen were ordered twice daily at 7:00 AM and 7:00 PM. Levothyroxine was ordered at 6:00 AM, to be administered on an empty stomach.</p> <p>An observation of a medication pass, on 04/05/12 at 8:40 AM, revealed Licensed Practical (LPN) #1 administered Resident #11's medications which included Nateglinide (for Diabetes Mellitus) 120 milligrams (mg) by mouth (po), Naproxen 500 mg po, Theophylline Extended Release (for Chronic Obstructive Pulmonary Disease) 300 mg po, Baclofen (for muscle spasms) 10 mg po, and Levothyroxine (for Hypothyroidism) 150 micrograms (mcg) po at 8:40 AM.</p> <p>An interview with LPN #1, on 04/05/12 at 2:30 PM, revealed she was suppose to administer medications within one hour before and one hour after the scheduled time. She revealed it was difficult, at times, to administer medications within the required timeframe. She further revealed she was aware the resident's Levothyroxine was due</p>	F 332	<p>the policy and procedures related to Medication Administration by the Education and Training Director by 5/18/12.</p> <p>4. Medication Pass Audits will be completed 3 times a week for 8 weeks and weekly for 4 weeks by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager to ensure continued compliance. Results of the auditing will be reviewed with the Quality Assurance Committee monthly for 3 months and according to Quality Assurance Committee recommendations thereafter. If at anytime a concern is identified a Quality Assurance Committee meeting will be held for 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.</p>		

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F 332	<p>Continued From page 28</p> <p>at 6:00 AM, but he/she refused the medication at that time. She revealed "it was better to give late than miss a dose."</p> <p>An interview with the Director of Nursing (DON), on 04/06/12 at 12:15 PM, revealed she expected the staff to follow the standard for administering medications one hour before or one hour after the scheduled time. She revealed the staff should consult with the physician when administering late medications.</p> <p>2. A review of the facility's procedure for "Self-Medication Assessment and Management," revised April 2006, revealed the Self-Medication Data Collection and Assessment form was used to evaluate a resident's ability to self-medicate safely. The form would be updated with a change of condition and quarterly.</p> <p>A review of Resident #19's Quarterly Nursing Data Collection and Assessment, dated 11/09/11, revealed he/she does not self-medicate.</p> <p>A review of Resident #19's physician orders, 04/01/12 through 04/30/12, revealed an order for Xanax, Buspar, and Namenda twice daily at 7:00 AM and 7:00 PM. Meloxicam was ordered to give with food or a meal at 7:00 AM.</p> <p>An observation of a medication pass, on 04/04/12 at 8:40 AM, revealed LPN #2 did not administer Resident #19's Astelin Nasal Spray according to the physician's order. LPN #2 asked Resident #19 if he/she used the nasal spray, and the resident replied "no." Additionally, LPN #2 administered Xanax (for anxiety) 0.5 mg po, Buspirone (for depression) 7.5 mg po, Meloxicam</p>	F 332		

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F 332	<p>Continued From page 29</p> <p>7.5 mg po, and Namenda (for Dementia) 10 mg po at 8:40 AM. LPN #2 did not administer Prilosec (for GERD) 20 mg po. The resident was not eating at the time of the observation.</p> <p>A review of the Medication Administration Record (MAR), dated 04/01/12 through 04/30/12, revealed LPN #2 signed the MAR to indicate the resident's nasal spray had been administered. The MAR indicated to keep the Astelin Nasal Spray at bedside; however, there was no physician's order to keep the resident's medication at bedside. The MAR indicated the resident's Prilosec had been discontinued; however, there was no physician's order to discontinue the medication.</p> <p>An interview with LPN #2, on 04/05/12 at 1:35 PM, revealed a physician's order should be obtained before a resident could keep a medication at bedside. She revealed she should have ensured the resident administered the nasal spray prior to signing the MAR. She stated that medications should be passed one hour before or after the scheduled time; however, 04/04/12 was a "busy day" and she was "behind" on the medication pass. She further revealed a snack should have been offered to Resident #19, before administering the Meloxicam.</p> <p>An interview with the DON, on 04/06/12 at 12:15 PM, revealed she was not aware the resident had not been assessed to self-administer the nasal spray. She was unable to provide documentation to verify Resident #19's Prilosec was discontinued.</p> <p>3. A review of the procedure for "Metered Dose</p>	F 332			

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F 332	Continued From page 30 Inhaler Administration," revised January 2007, revealed staff should instruct the resident to exhale to empty the lungs and place the tip of the spacer in the mouth, maintaining a tight seal. Instruct the resident to activate the inhaler during the first third of a slow maximal inhalation and continue to inhale until lungs are filled with air. The resident should be encouraged to hold their breath for 3-5 seconds. Wait one minute between inhalation unless otherwise instructed by the pharmacy. An observation, on 04/05/12 at 8:45 AM, revealed LPN #1 allowed Resident #20 to self-administer a Ventolin HFA inhaler. LPN #1 did not instruct the resident how to administer the inhaler correctly. The resident administered two puffs of the inhaler, waiting five seconds between the puffs. An interview with LPN #1, on 04/05/12 at 2:30 PM, revealed Resident #20 used the inhaler when he/she was short of breath. She revealed the resident usually took two quick puffs of the inhaler. She further revealed she was unaware the resident was supposed to wait a minute between the puffs. An interview with the DON, on 04/06/12 at 12:15 PM, revealed she was unaware of a time frame to wait between puffs of the same inhaler, but expected the staff to follow the policy.	F 332			
F 364 SS=E	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	F 364	F364- Nutritive Value/Appear Palatable/Prefer Temp 1. The lunch meal on 4/25/12 was noted by the Dietary Manager to be palatable	5/19/12	

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

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F 364	<p>Continued From page 31 temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure food was palatable and attractive.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Dining Service," revised July 2011, revealed the facility would provide all residents a pleasurable dining experience by offering attractive meals served in a courteous, dignified manner.</p> <p>During the resident group interview, on 04/03/12 at 3:00 PM, two out of four residents voiced concerns about the food at the facility. They stated that the food does not always look appetizing or taste flavorful.</p> <p>An interview with Resident #1, on 04/05/12 at 10:45 AM, revealed the food served at the facility did not "look good," and if did not "look good," the resident stated he/she did not eat it.</p> <p>An interview with Resident #27, on 04/02/12 at 6:15 PM, revealed that his/her food was usually "cold and tasted terrible."</p> <p>An interview with Resident #28, on 04/05/12 at 11:00 AM, revealed the food did not have a good taste and he/she could not always tell what food items were being served. The resident revealed he/she had to confirm the food served by reading</p>	F 364	<p>and attractive. Cook # 1 is no longer employed.</p> <p>2. The lunch meal on 4/25/12 was noted by the Dietary Manager to be palatable and attractive.</p> <p>3. The Dietary Manager and all Dietary staff will be re-educated by the Administrator by 5/18/12 on the policy and procedures related to serving food that is palatable, attractive, and at the proper temperature.</p> <p>4. The Administrator, Dietary Manager and/or Dietician will conduct test tray audits 2 times a week for 4 weeks and weekly for 8 weeks to ensure that the food served is palatable, attractive, and at the proper temperature. Palatability of food will be reviewed with the Resident Council monthly for three (3) months. The Quality Assurance Committee will review audit results monthly for 3 months and make further recommendations for continuing audits thereafter. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. 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.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2012
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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BOWLING GREEN	STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104
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(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 364	<p>Continued From page 32 the menu board.</p> <p>An observation in the kitchen, on 04/03/12 at 11:55 AM, revealed Cook #1 prepared meal trays for the residents. The menu items were Hawaiian chicken, wax beans, and rice. Further observation revealed the juice from the wax beans was spreading all over the plates, causing the trays to look unattractive in presentation. The Dietary Manager was in the kitchen at the time, as the staff served the trays to the residents.</p> <p>An observation, on 04/03/12 at 12:15 PM, revealed the test tray was unattractive in appearance as evidenced by the Hawaiian chicken, wax beans and rice being mixed together and all to one side of the plate. The juice from the wax beans was all over the plate.</p> <p>An interview with Cook #1, on 04/03/12 at 2:10 PM, revealed the kitchen was "real hot" at that time, and he was "frustrated" after having to reheat some of the food to get it to the proper temperature.</p> <p>An interview with the Dietary Manager, on 04/03/12 at 2:20 PM, revealed she was aware that the food was "sloshed" around on the trays. No further explanation was provided.</p> <p>An interview with the Administrator, on 04/06/12 at 12:30 PM, revealed the Dietary Manager should have stepped in and corrected the situation. He expected the residents' food trays to appear attractive and the food to be separated on the plate.</p>	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 33</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure food was stored under sanitary conditions.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Refrigerator Storage," revised October 2011, revealed leftover foods should be stored in containers which were single use plastic bags or seamless containers with tight fitting lids. Label all leftovers with item name and date of storage. A review of the procedure for Freezer Storage, revised October 2011, revealed to store leftover foods in containers which were single use plastic bags or seamless containers with tight fitting lids. Discard frozen leftovers after six months. An interview with the Administrator, on 04/06/12 at 12:30 PM, revealed he expected the staff to follow the policy/procedure for food storage.</p> <p>An observation, on 04/02/12 at 6:30 PM, revealed an undated container of thickened water opened.</p>	F 371	<p>F371- Food Procure, Store/Prepare/Serve - Sanitary</p> <ol style="list-style-type: none"> The undated container of thickened water was removed on 4/2/12. The undated medium-sized ham wrapped loosely in tin foil was thrown away on 4/2/12. The package of bologna was sealed and dated on 4/2/12. The chicken strips, french fries and riblets were sealed and dated on 4/2/12. The pollock fillets were thrown away on 4/2/12. The two opened bags of french fries were sealed and dated on 4/5/12. The above tasks were completed by the Dietary Manager. All food in the refrigerator and freezer was checked by the Dietary Manager on 4/9/12 to ensure it was stored properly. No other concerns were identified. All dietary staff will be re-educated by 5/18/12 by the Dietary Manager on policies and procedures related to storing, preparing and distributing food under sanitary conditions. The Dietary Manager will perform a "Quick Kitchen Sanitation Rounds" 5 times a week for 4 weeks, 3 times a week for 4 weeks and weekly for 4 weeks to ensure continued compliance with storing, preparing and distributing food under sanitary conditions. The results of the audits will be presented to the Quality Assurance Committee for 	5/19/12	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	<p>Continued From page 34</p> <p>in the refrigerator. An undated medium-sized ham was wrapped loosely in tin foil. An opened package of bologna was not sealed or dated. There was an unsealed and undated bag of chicken strips, french fries, and riblets opened in the freezer. An unsealed and undated package of pollock fillets was opened, with visible frost noted on the fillets. An observation, on 04/05/12 at 11:00 AM, revealed there were two open bags of french fries in the freezer, unsealed and undated.</p> <p>An interview with Cook #2, on 04/05/12 at 1:20 PM, revealed bags in the freezer were suppose to be resealed and dated when opened. He revealed he sometimes got into a "rush" and would forget. He revealed items opened in the refrigerator were suppose to be sealed and dated, and discarded after three days. He stated that the bologna in the refrigerator was probably his fault as he was "in a hurry."</p> <p>An interview with the Dietary Manager, on 04/05/12 at 11:05 AM, revealed she expected the staff to wrap food in the refrigerator or freezer tightly, label, and date it when opened.</p>	F 371	<p>review and 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.</p>	
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections</p>	F 441	<p>F441- Infection Control</p> <p>1. The catheter bags and tubing for residents #5, #22, #23, #24 and #25 were observed by the Administrator 4/23/12 to be off the floor. 2. All residents with catheters were observed on 4/23/12 by the</p>	5/19/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 35</p> <p>in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain an infection control program which ensured catheter bags and tubing were kept off the floor to prevent the spread of infections for one resident (#5), in the selected sample of fifteen residents, and for four residents (#22, #23, #24 and #25), not in the selected sample.</p>	F 441	<p>Administrator to ensure catheter bags and tubing were off the floor. No concerns identified.</p> <p>3. All staff will be re-educated by the Education and Training Director by 5/18/12 on ensuring catheter bags and tubing are kept off the floor to prevent the spread of infections.</p> <p>4. Observations will be completed by the Director of Nursing, Assistant Director of Nursing and/or the Unit Manager 3 times a week for 4 weeks and weekly for 8 weeks to ensure continued compliance. The results of the observations will be presented to the Quality Assurance Committee for review and further recommendations. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. 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.</p>		

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F 441	Continued From page 36 Findings include: An interview with the Director of Nursing (DON), on 04/04/12 at 4:15 PM, revealed the facility's policy and procedure did not address keeping the urinary catheter bags and tubing off the floor, but the facility expected the staff to keep them off the floor for infection control purposes. Observations of Resident #5, on 04/03/12 at 9:00 AM, 10:15 AM, 11:45 AM, 2:15 PM, and 3:20 PM, on 04/04/12 at 8:25 AM, and on 04/05/12 at 2:00 PM and 4:00 PM, revealed Resident #5 was sitting in a wheelchair with his/her urinary catheter bag under the wheelchair and the catheter tubing laying on floor. Observations of Resident #22, on 04/02/12 at 6:15 PM, and on 04/03/12 at 10:55 AM, revealed Resident #22 was sitting in his/her geri-chair with the urinary catheter bag and tubing on the floor. Observations of Resident #23, on 04/02/12 at 6:15 PM, and on 04/03/12 at 10:55 AM, revealed Resident #23 was laying in the bed asleep with the urinary catheter bag and tubing on the floor. Observations of Resident #24 and Resident #25, on 04/02/12 at 7:45 PM and 7:55 PM, respectively, revealed their catheter bags were lying on the floor. Interview with Certified Nurse Aides (CNA) #2, CNA #8, CNA #9, CNA #6, CNA #5, CNA #4, CNA #10, CNA #11, and CNA #3, on 04/03/12 at 1:45 PM, on 04/05/12 at 1:10 PM, on 04/06/12 at 9:35 AM, on 04/05/12 at 9:10 AM, 9:35 AM, 9:45 AM,	F 441	THE SUBMISSION OF THE PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION BY THE PROVIDER OF ANY FACT OR CONCLUSION SET FORTH IN THE STATEMENT OF DEFICIENCY. THIS PLAN OF CORRECTION IS BEING SUBMITTED BECAUSE IT IS REQUIRED BY LAW.	

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F 441	<p>Continued From page 37</p> <p>2:30 PM, 2:45 PM, and 4:30 PM, respectively, revealed urinary catheter bags and tubing should be hung properly in a dignity bag, so the bag and tubing does not touch the floor. They were unable to provide an explanation as to why Resident #5's, Resident #22's, Resident 23's, Resident #24's and Resident #25's urinary catheter bags and/or tubing were on the floor.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, and LPN #3, on 04/05/12 at 10:00 AM and 3:55 PM, respectively, revealed catheter bags should not be lying on the floor.</p> <p>Interview with Registered Nurse (RN) #2, on 04/06/12 at 11:10 AM, revealed it was the responsibility of the nurses and the Charge Nurse to ensure the urinary catheter bags and tubing were kept off the floor.</p> <p>Interview with the DON, on 04/06/12 at 12:10 PM, revealed it was the responsibility of the Charge Nurse and nurses on the floor to ensure the CNAs kept the urinary catheter bags and tubing off the floor.</p>	F 441			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1962</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>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.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten 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.

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K 000	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>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.</p> <p>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</p>	K 025	<p>K 025 – LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> 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

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K 025	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 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. <p>(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</p> <ol style="list-style-type: none"> 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. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p>	K 025	<p>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.</p>	

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K 025	Continued From page 3	K 025		
K 027 SS=E	<p>1. Be made on either side of the smoke barrier, or</p> <p>2. Be made by an approved device designed for the specific purpose.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>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.</p> <p>The findings include:</p> <p>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</p>	K 027	<p>K 027- LIFE SAFETY CODE STANDARD</p> <p>1. The identified fire doors will be equipped with a coordinator to ensure the doors close properly by 5/18/12.</p> <p>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.</p> <p>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.</p> <p>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.</p>	5/19/12

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
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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	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,		
			K 029- LIFE SAFETY CODE STANDARD	5/19/12	

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

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K 029	<p>Continued From page 5</p> <p>field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>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.</p> <p>The findings include:</p> <p>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.</p> <p>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.</p> <p>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</p>	K 029	<p>clean linen office area and the dirty linen in the laundry area by the Maintenance Director by 5/18/12.</p> <p>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.</p> <p>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.</p> <p>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</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 029	<p>Continued From page 6</p> <p>closets, dietary supply, admissions office, clean linen office area, and the dirty linen in the laundry area did not have a self closing device.</p> <p>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</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>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:</p> <ol style="list-style-type: none"> (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	<p>Manager, and Medical Director at least quarterly.</p>		

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

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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	

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

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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

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

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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	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056	<p>Continued From page 10</p> <p>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</p> <p>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.</p> <p>The findings include:</p> <p>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.</p> <p>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.</p>	K 056	<p>will be cut down 18" from the ceiling to allow coverage from existing sprinkler.</p> <p>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.</p> <p>3. The Maintenance Director will be re-educated by the Administrator by 5/18/12 on K 056 standards.</p> <p>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.</p>		

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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			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 2 1/2 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	

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

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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 use 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	

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

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NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
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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 combustibile 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. NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films	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 combustibile 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		K 074			

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K 074	<p>Continued From page 15</p> <p>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.</p> <p>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</p> <p>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</p> <p>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.</p> <p>The findings include:</p> <p>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</p>	K 074	<p>K 074- LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> 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	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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

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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.		

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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	

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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		

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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.		