

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

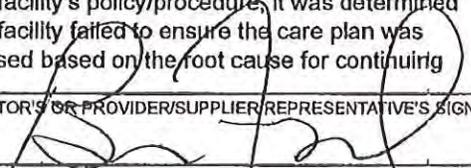
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/08/2012
--	--	--	---

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 000	INITIAL COMMENTS An abbreviated survey (KY #18412) was conducted on 06/06/12 through 06/08/12 to determine the facility's compliance with Federal requirements. KY #18412 was substantiated with deficiencies cited at the highest scope and severity of a "D."	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the care plan was revised based on the root cause for continuing	F 280	F280- Right to Participate Planning Care-Revise CP 1. Resident #1's care plan has been reviewed and revised to ensure interventions are appropriate and effective by the Director of Nursing, Social Services Director and Activities Director on 6/13/12. Resident #1 was admitted to the hospital on 6/12/12 and will be on increased supervision upon return. 2. Care plans of all current residents with behaviors have been reviewed and revised by the Director of Nursing, Social Services Director and Activities Director by 6/20/12 to ensure interventions are appropriate and effective. Those residents identified as not having effective interventions were reviewed for root cause analysis and care plan revision by the Director of Nursing, Social Services Director and Activity Director by 6/20/12. 3. The interdisciplinary care plan team has been re-educated by the Regional	6/21/12



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE MHA	(X6) DATE 7/2/12
--	--------------	---------------------

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

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

PRINTED: 06/22/2012
FORM APPROVED
OMB NO. 0938-0391

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 C 06/08/2012
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 1 behaviors for one resident (#1), in the selected sample of four residents.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure for the "Mood and Behavior Program," effective October 2005 and revised January and October 2008, revealed behaviors were to be reviewed utilizing the Resident Assessment Indicators (RAI); Discuss with the nursing assistants and determine the effectiveness of the current interventions and medications; Rule out possible causes of behavior symptoms such as pain, medical illness, other residents, treatable or preventable causes or changes in routines; Plan to further assess or treat, as needed.</p> <p>A record review revealed Resident #1 was admitted to the facility on 02/14/11 with diagnoses to include Mood Disorder, Cerebrovascular Accident (CVA) and Manic/Depressive Episodes.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 04/19/12, revealed the resident was independent in cognition, transfer and ambulation, and continent of bowel and bladder. The mood interview revealed the resident had little interest or pleasure in doing things and no problem with behaviors.</p> <p>A review of the care plan for behavioral symptoms related to verbal and/or physical abuse, resisting care and socially inappropriate behaviors, last reviewed on 04/19/12, revealed in response to inappropriate social behavioral symptoms such as throwing objects, the resident was to be reassured, re-approached, allowed to</p>	F 280	<p>Director of Clinical Services by 5/30/12 on the behavior management program and identification of root cause of behaviors and effective intervention.</p> <p>4. The facility will audit the behavior documentation of 10 residents with behaviors a week for twelve weeks to ensure interventions are effective and if not behaviors are reviewed for new interventions. The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, 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> <p>THE SUBMISSION OF THE PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION BY THE PROVIDER OF ANY FACT OR</p>	
-------	---	-------	--	--

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

PRINTED: 06/22/2012
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 C 06/08/2012
--	--	--	---

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 280	<p>Continued From page 2</p> <p>vent feelings and concerns. In response to resisting therapy, showers and /or medications, staff members were to reapproach and see what time was good for the resident. Additionally, the resident was to be redirected as needed, and /or placed on every 15 minute checks.</p> <p>A review of the nurses' notes, dated 05/03/12 at 5:45 PM, revealed Resident #1 was seated at the dining room table and was cursing at another resident, then slammed a coffee cup on the table, then threw the coffee cup which hit another resident (#2), on the forehead. Resident #1 was placed on 15 minute checks and the physician and family was made aware. The cause of the behavior had not been determined and no new interventions had been put in place. Other behaviors included loudly cursing the staff, residents and visitors, throwing a remote at staff members, refusing to allow his/her bedroom door to be opened, demanding residents sit in certain areas, and cursing residents when they do not comply with his/her instruction and other attention seeking and demanding behaviors.</p> <p>An interview with Resident #1, on 06/06/12 at 10:05 AM, revealed he/she "got into fusses" with other residents and admitted to striking another resident with a coffee cup, but denied striking any other resident.</p> <p>An interview with Certified Nurse Aide (CNA) #1 and CNA #2, on 06/07/12 at 8:50 AM and 8:56 AM, respectively, revealed the reason for the resident's behaviors was "just the way [he/she] was" and neither CNA stated they had discussed the reason for his/her acting out behavior with the resident. The interventions were to redirect,</p>	F 280	<p>CONCLUSION SET FORTH IN THE STATEMENT OF DEFICIENCY. THIS PLAN OF CORRECTION IS BEING SUBMITTED BECAUSE IT IS REQUIRED BY LAW.</p>	
-------	---	-------	--	--

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

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 C 06/08/2012
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	<p>Continued From page 3</p> <p>remind him/her the behavior was inappropriate and try to get him/her to calm down or be involved in an activity.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 06/06/12 at 2:30 PM, revealed Resident #1 "liked to curse" and did not go by the rules of the facility and was easily angered. The day the resident threw the cup, the resident was upset because another resident would not sit where Resident #1 wanted him/her to sit. The LPN stated she told the resident that seats were not assigned except for meal times. The LPN stated the reason for the resident's behaviors were due to "anger issues."</p> <p>An interview with Registered Nurse (RN) #1, on 06/06/12 at 2:50 PM, revealed Resident #1 "was rude when [he/she] did not get [his/her] way" and threatened to hit others when angry, but RN #1 had not witnessed the resident strike anyone. When asked to calm down, the resident would go to his/her room or out to the porch and was able to calm down. The RN stated when the resident became angry, staff members tried to distract the resident with an activity, set limits or place on every 15 minute checks. However, there was no evidence a root cause for the acting out behaviors was determined.</p> <p>An interview with the Social Worker (SW), on 06/06/12 at 3:05 PM, and on 06/07/12 at 3:07 PM and 3:45 PM, revealed Resident #1's typical behaviors were cussing at staff and residents, throwing things, pushing chairs, and she stated the behaviors were "not an everyday thing." They were related to the resident's moods which were described as "cussing you one minute and</p>	F 280		
-------	---	-------	--	--

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

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 C 06/08/2012
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BOWLING GREEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1661 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 4</p> <p>reading poems the next minute." The SW stated she had not been made aware that the resident intentionally hit anyone. The SW interviewed Resident #2, and he/she stated that Resident #1 "threw the cup and hit the table and then the coffee cup hit me." The SW tried to speak with Resident #1 during this time, but the resident would go to the room and refuse to talk. There was no root cause analysis completed for the resident's behaviors. The SW stated, "if the resident acted out and did not respond to the staff's instruction to calm down, or go to the room or porch to calm down, or get involved in another activity, the staff were instructed to call the physician and the resident was to be "sent out" to a behavioral unit.</p> <p>An interview with the Director of Nursing (DON), on 06/07/12 at 2:15 PM, revealed a root cause analyses of the resident's behaviors, to include pain, medical illness, problems with other residents or other treatable or preventable causes was not completed.</p> <p>An interview with the Physician, on 06/07/12 at 3:20 PM, revealed he knew the resident for many years and denied the resident having any intent to harm. The resident was described as having "occasional emotional problems," that stemmed from a divorce and was "good to help people" The physician revealed he did not feel that the resident would ever intentionally harm anyone.</p>	F 280			