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

PRINTED: 04/21/2015
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
APR 30 2015
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/09/2015
NAME OF PROVIDER OR SUPPLIER: NIM HENSON GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 420 JETT DRIVE JACKSON, KY 41339	

(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 A standard health survey was conducted on 04/07-09/15. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DIFICINCIES CITED. HOWEVER, SUBMISSION OF THE PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DIFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAWS.	
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 a review of the facility care plan policy it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for three (3) of seventeen (17) sampled residents (Residents #1, #3, and #7). Resident #1 had care plan interventions for splints to be applied to the bilateral lower extremities. Observations revealed the splints were not applied on 04/07/15 and 04/08/15. Residents #3 and #7 utilized a Foley catheter (a tube to drain urine from the bladder). Observations of these residents on 04/07/15 at 3:07 PM and 04/08/15 at 11:15 AM revealed the catheters were not secured to prevent trauma in accordance with the written plan of care. The findings include: A review of the facility policy titled "Certified Nurse Aide Care Plan In-service," (not dated) revealed the nursing care plan provided guidelines of care for specific residents. According to the policy, the	F 282	The Care Plans of residents 1-3-7 were reviewed by DON, Supervisor and Restorative Nurse. Any deficient practices were corrected as 4-10-15 by DON, Supervisor and Restorative Nurse. As of 4-15-15 100% of all residents were checked by DON, Supervisor, MDS Nurse and Restorative Nurse-To ensure their Care Plan matched the current MDS, Physician Orders and Policies of NHGC. Any deficient practice were corrected by DON, Supervisor, MDS Nurse and Restorative Nurse. 100% of Care Plans will be checked weekly by DON, Supervisor or designee for implementation of all ordered interventions and quality of care given. Nursing staff was in-serviced by Nursing Supervisor and MDS Nurse on 4-21-15 on updating and following each residents plan of care. 20% of all staff will be audited weekly by Nursing Supervisor, Restorative Supervisor and MDS Nurse for their knowledge and Compliance of interventions of Care Plans (see A-I). All results will be reviewed monthly at QA meeting.	4-24-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Phillip Fitterer
TITLE: Administrator
(X6) DATE: 4-30-15

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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	185112		04/09/2015

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F 282	Continued From page 1 care plan followed a specific set of needs for each resident and the purpose of the care plan was to provide any caregiver the knowledge of a specific resident. Further review revealed the care plans were read after walking rounds and followed throughout resident care. Review of the facility's policy titled "Catheterization of the Urinary Bladder," (not dated) revealed the catheter tubing would be taped to the resident's thigh to prevent trauma. 1. A review of the medical record revealed Resident #1 was admitted to the facility on 11/03/14 with diagnoses that included history of Toe Fractures, Difficulty Walking, Muscular Wasting, Osteoarthritis, and Peripheral Vascular Disease. A review of the comprehensive admission Minimum Data Set (MDS) assessment dated 11/15/14 revealed Resident #1 was assessed to have limited range of motion to both lower extremities. Further review of the MDS assessment revealed the resident was assessed to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. A review of the comprehensive care plan developed for Resident #1 with a revision date of 03/17/15 revealed the resident had a need for restorative splints due to foot drop prevention with interventions for staff to apply and remove the splints. Further review of the plan of care revealed the resident was scheduled to have the splints applied to both feet for two hours and removed for two hours starting at 7:00 AM and ending at 11:00 PM daily. Observations of Resident #1 conducted hourly on 04/07/15 from 11:00 AM to 5:55 PM and on	F 282		

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F 282	Continued From page 2 04/08/15 from 9:15 AM to 3:00 PM revealed the resident's splints were not applied to the resident's bilateral feet as scheduled/planned. Interview with Resident #1 conducted on 04/08/15 at 3:00 PM revealed facility staff was supposed to apply the splints to the resident's feet for two hours and then the splints would be off for two hours. Further interview with the resident revealed the resident would often have to remind staff to apply the splints because they would forget. Interview conducted with Certified Nurse Aide (CNA) #2 on 04/09/15 at 10:05 AM revealed the CNA was assigned to provide care for Resident #1 on 04/07/15 and did not apply the splints because she forgot to apply the splints. An interview with CNA #1 conducted on 04/08/15 at 3:05 PM revealed the CNA was assigned to care for Resident #1 on 04/08/15, and forgot to apply the splints to the resident's feet as care planned. An interview with Registered Nurse (RN) #1 conducted on 04/08/15 at 3:15 PM revealed the RN was assigned to provide care to Resident #1 on 04/07/15 and 04/08/15. The RN stated she made rounds to check Resident #1 at least every two hours on 04/07/15 and 04/08/15 and had not noticed that Resident #1's splints were not applied. An interview conducted with the Director of Nursing (DON) on 04/09/15 at 1:30 PM revealed residents that received Level 3 restorative services were to be provided the services by nursing staff according to a care plan developed	F 282		

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F 282	Continued From page 3 by Therapy and the Restorative Nurse. Further interview revealed the CNAs assigned to residents on the floor were responsible to apply splints to residents according to the plan of care and nurses were required to monitor residents every two hours to ensure interventions were provided in accordance with the plan of care. The DON was not aware Resident #1's splints were not being applied as care planned until the surveyor questioned staff on 04/08/15. 2. Review of Resident #3's medical record revealed the facility admitted the resident on 11/23/11 with diagnoses of Acute Renal Failure, Dysphagia, Dementia, Urinary Retention, Depression, Psychosis, and Mood Problems. Review of the Quarterly Minimum Data Set (MDS) assessment dated 03/05/15 revealed Resident #3 continued to require an indwelling urinary catheter. Review of the Comprehensive Care Plan revealed interventions for care for the indwelling urinary catheter were to be done "per facility policy." Observation of Resident #3 on 04/08/15 at 11:15 AM, during catheter care, revealed the catheter was attached to a bedside drainage bag, but the tubing was not secured to the resident's leg as required by the facility's policy. 3. Review of Resident #7's medical record revealed the facility admitted the resident on 01/05/07 with diagnoses of Urinary Retention, Senile Dementia, Anemia, Paralysis, and Depression. Review of the Minimum Data Set (MDS) dated 03/17/15 revealed Resident #7 continued to need an indwelling Foley catheter. Review of the Comprehensive Care Plan revealed interventions for care for the indwelling	F 282		

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F 282	Continued From page 4 urinary catheter were to be done "per facility policy." Observation of Resident #7 on 04/07/15 at 2:50 PM, during catheter care done by CNA #3, revealed the catheter was observed attached to a bedside drainage bag, but the tubing was not secured to the resident's leg as required by the facility's policy. Interview on 04/08/15 at 3:30 PM with CNA #3 revealed she was trained to anchor the catheter tubing with a leg strap but just forgot. Interview with the Director of Nursing on 04/09/15 at 3:40 PM revealed the care plans were prepared by the MDS Nurse and were monitored regularly to ensure staff was providing the interventions on the care plan. He further stated no concerns had been identified with the staff following the care plans.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the	F 315	On 4-10-15 resident #3 and #7 were assessed by DON, Restorative Nurse and Nursing Supervisor to ensure Foley Catheters were anchored and secured with catheter strap and care planned correctly. On 4-10-15 100% of all residents were assessed by DON, Restorative nurse and supervisor to ensure there was a clinical need for Foley catheter and that they were anchored, secured and catheter strap and care planned correctly. (A) All residents will be assessed by nursing staff on admission/re-admission, quarterly and significant change to ensure a Foley catheter is clinically necessary, that is care planned and that care is being implemented per policy (B-I). (B) All incontinent residents are assessed 7-14 days after admission by floor nurse for the need	

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F 315	Continued From page 5 facility failed to provide appropriate treatment and services to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging of the catheter for two (2) of seventeen (17) sampled residents (Residents #3 and #7). Observations on 04/07/15 of Resident #7 and on 04/08/15 of Resident #3 revealed the facility failed to ensure the catheter was secured to the resident's leg as directed by the facility policy. The findings Include: Review of the facility's policy entitled "Catheterization of the Urinary Bladder," (not dated) revealed the catheter tubing would be taped to the resident's thigh to prevent trauma. 1. Review of Resident #3's medical record revealed the facility admitted the resident on 11/23/11 with diagnoses that included Acute Renal Failure, Dysphagia, Dementia, Urinary Retention, Depression, Psychosis, and Mood Problems. Review of the Annual Minimum Data Set (MDS) assessments dated 12/09/14 and 12/18/13 revealed Resident #3 used a urinary indwelling catheter for over two years secondary to Renal Insufficiency and Chronic Kidney Disease. Review of the Comprehensive Care Plan revealed interventions for care for the indwelling urinary catheter were to be done per the facility's policy. Observation of Resident #3 on 04/08/15 at 11:15 AM, during a skin assessment and catheter care, revealed the catheter was observed attached to a bedside drainage bag, but the tubing was not secured to the resident's leg as required by the facility's policy.	F 315	of a bladder retraining program (B-II). The results are forwarded to Restorative Program for implementation of appropriate programs. All nurses were in-serviced on 4-21-15 by Nursing Supervisor, Restorative Nurse and MDS Nurse on compliance on use of Foley catheters. (A) 20% of all residents with a Foley catheter will be assessed and monitored by DON/Supervisor/ designee every week to ensure they are anchored, using catheter straps and are care planned per facility policy (B-III). All reports will be reviewed by QA monthly. (B) 100% of all new admissions will be assessed by DON/Supervisor/designee after 14 days for any incontinence needs and implementation of programs. All results will be reported to QA monthly. (B-IV) Date:	4-24-15

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F 315	Continued From page 6 2. Review of Resident #7's medical record revealed the facility admitted the resident on 01/05/07 with diagnoses that included Urinary Retention, Senile Dementia, Anemia, Paralysis, and Depression. Further review of the medical record revealed Resident #7 was admitted to the hospital in February 2015 with severe Peripheral Vascular Disease, which caused Resident #7 to have an Above Knee Amputation on the right leg. Resident #7 was discharged from the hospital with an indwelling Foley catheter, secondary to Urinary Retention. Review of the MDS revealed on 03/17/15, Resident #7 continued to need an indwelling Foley catheter. Review of the Comprehensive Care Plan revealed interventions for care for the indwelling urinary catheter were to be done per the facility's policy. Observation of Resident #7 on 04/07/15 at 2:50 PM, during catheter care done by Certified Nurse Aide (CNA) #3, revealed the catheter was observed attached to a bedside drainage bag, but the tubing was not secured to the resident's leg as required by the facility's policy. Interview with CNA #3 on 04/08/15 at 3:30 PM revealed she was trained to anchor the tubing to the leg but she forgot to do so. Interview with Registered Nurse #1 revealed she was not aware if the facility policy regarding catheter care said to anchor the catheter tubing; however, she stated it was best to anchor catheter tubing if the residents would allow it. Interview with the Director of Nursing on 04/09/15 at 3:40 PM revealed he did not think the CNAs were trained to anchor the catheter tubing. He further revealed he makes rounds and has	F 315		

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F 315	Continued From page 7 checked to see if the catheter bag was anchored, but not the catheter tubing.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility policy for range of motion it was determined the facility failed to ensure one (1) of seventeen (17) sampled residents (Resident #1) who had limited range of motion received appropriate treatment and services to increase range of motion and prevent further decrease in range of motion. Resident #1 required splints to the bilateral lower extremities. The splints were to be on for two hours and off for two hours per a schedule every day from 7:00 AM to 11:00 PM. The facility failed to assure the splints were applied as ordered and Resident #1 was observed to not have the splints applied to the lower extremities on 04/07/15 and 04/08/15. The findings include: A review of the facility policy for range of motion titled "Range of Motion/Contracture Care," dated 2003, revealed Therapy staff screened residents, and a program was developed based on a	F 318	The deficient practice was corrected on 4-9-15. Resident #1 splints were applied per restorative care plan by CNA and Nurse. 100% of all residents were assessed by therapy department and restorative nurse for needed splints and appropriate restorative programs by 4-24-15. No problems were found. Restorative and nursing department will maintain a master listing of all restorative care they are receiving. The restorative CNA's will monitor 20% of residents for correct implementation weekly (C - I and II).On 4-21-15 the Nursing Supervisor, Restorative Nurse and MDS Nurse held an in-service for Nursing Department on resident range of motion compliance. 20% of all residents receiving restorative care will be audited for compliance monthly by DON, Restorative Nurse, Supervisor or designee. QA committee will be consulted for input if necessary. Date:	4-24-15

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F 318	Continued From page 8 resident's unique risk. Further review revealed Level 3 restorative care involved Certified Nurse Aides (CNAs) from the nursing unit and Level 3 restorative care was provided to maintain function, or attain a higher level of functioning, and the program included contracture care. Further review of the policy revealed if splints were a part of the resident's contracture care the splints would be applied per a schedule and followed according to the care plan seven days a week. A review of the record for Resident #1 revealed the facility admitted Resident #1 on 11/03/14 with diagnoses that included history of Toe Fractures, Difficulty Walking, Muscular Wasting, Osteoarthritis, and Peripheral Vascular Disease. A review of the comprehensive admission Minimum Data Set (MDS) assessment dated 11/15/14 and the resident's most recent quarterly MDS assessment revealed the resident was assessed to have limited range of motion to both lower extremities and a care plan developed to include interventions for bilateral splints to be applied to the bilateral feet to prevent foot drop (extension contractures to the feet). Additional Review of the MDS assessment revealed Resident #1 was assessed to have a Brief Interview for Mental Status (BIMS) score of 15, which is cognitively intact. Observations of Resident #1 conducted hourly on 04/07/15 from 11:00 AM to 5:55 PM and on 04/08/15 from 9:15 AM to 3:00 PM revealed the resident's splints were not applied to the resident's bilateral feet as scheduled/planned. Interview conducted with Resident #1 on 04/08/15 at 3:00 PM, revealed the staff was supposed to	F 318		

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F 318	Continued From page 9 apply splints to the resident's feet for two hours and then the splints would be off for two hours. Further interview with the resident revealed the resident would often have to remind staff to apply the splints because they would forget. An interview conducted with CNA #2 on 04/09/15 at 10:05 AM, revealed the CNA was assigned to provide care for Resident #1 on 04/07/15 and did not apply the splints because she forgot. An interview conducted with CNA #1 on 04/08/15 at 3:05 PM, revealed the CNA was assigned to care for Resident #1 on 04/08/15, and forgot to apply the splints to the resident's feet as directed by the plan of care. An interview conducted with Registered Nurse (RN) #1 on 04/08/15 at 3:15 PM, revealed the RN was assigned to provide care to Resident #1 on 04/07/15 and 04/08/15. RN #1 stated she had made rounds to check Resident #1 at least every two hours on 04/07/15 and 04/08/15, and had not noticed Resident #1's splints were not applied. An interview conducted with the Director of Nursing (DON) on 04/09/15 at 1:30 PM, revealed residents who received Level 3 restorative services were to be provided the services by nursing staff according to a plan developed by Therapy and the Restorative Nurse. Further interview revealed the CNAs assigned to residents on the floor were responsible to apply splints to residents according to the plan of care and nurses were required to monitor the application of splints for concerns during nursing rounds at least every two hours. The DON was not aware Resident #1's splints were not being applied as planned on 04/07/15 and 04/08/15.	F 318		

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339	

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (000) SMOKE COMPARTMENTS: Six COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 04/07/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DIFICIENCIES CITED. HOWEVER, SUBMISSION OF THE PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY. THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAWS. No specific resident was identified as being affected by this deficiency.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144	All residents could be affected should the generator not function properly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Phillip Litteral
TITLE: Administrator
(X6) DATE: 4-30-15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185112		04/07/2015

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K 144	Continued From page 1 accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to ensure a weekly written maintenance schedule was being performed on the emergency generator. This deficient practice affected six (6) of six (6) smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 81 on the day of the survey. The findings include: The life safety code tour was conducted on 04/07/15 at 11:50 AM. Review of the generator record was conducted during the tour. An interview with the Director of Maintenance (DOM) at the time of the record review revealed the generator was not being maintained on a weekly basis as required. The DOM stated he was not aware a routine weekly maintenance schedule was required to maintain the emergency generator. The findings were revealed to the Administrator upon exit. Reference: NFPA 110 (1999 Edition).	K 144	The maintenance supervisor was in-serviced by the administrator on 4/13/15 on requirements for generator maintenance, which included weekly inspections, according to NFPA 3.4.4.1 . A weekly generator inspection was conducted by the maintenance supervisor on 04/15/15 and no problems were identified. The Administrator will do monthly inspections of generator maintenance records for required maintenance to ensure compliance with NFPA guidelines. He will also check weekly maintenance. Q.A. Committee will be consulted when necessary.	04/15/2015

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K 144	Continued From page 2 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144		