

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
---	--

(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 investigating KY20930 was conducted on 11/04/13 through 11/07/13 to determine the facility's compliance with Federal requirements. KY20930 was substantiated with the highest scope and severity of a "G". The facility admitted Resident #1, on 10/29/13 at approximately 7:00 PM; however, they did not complete an assessment of the resident upon admission. The resident had a diagnosis of Esophageal Cancer, with an order for Roxanol (pain medication), every four (4) hours as needed. The facility failed to ensure pain medication was available to administer to the resident in a timely manner. He/she asked for pain medication at approximately 10:00 PM and 4:00 AM the next morning; however, the facility failed to administer the medication to control the resident's pain. The resident left the facility with a family member, on 10/30/13 at 6:45 AM, (approximately twelve (12) hours later), as a result of the facility's failure to provide pain management.	F 000	Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals, who draft or may be discussed in this response of this plan of correct. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment	F 157		12/04/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Zedd W. D. H., NHA TITLE: Administrator (X6) DATE: 11-27-13

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: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
---	--

(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>significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</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 interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to consult with the resident's physician when there was a need to alter treatment for one (1) of three (3) sampled residents (Resident #1). Resident #1 was admitted to the facility on 10/29/13 at approximately 7:00 PM with orders for Total Parenteral Nutrition (TPN). The facility was unable to provide the TPN to Resident #1; however, staff did not notify the physician.</p> <p>The findings include: Review of the facility's Notification of Resident Change in Condition policy, undated, revealed</p>	F 157	<p>F 157</p> <ol style="list-style-type: none"> 1. Resident #1 discharged from the facility on 10-30-13. The resident's physician was notified by the Assistant Director of Nursing that the resident did not receive the TPN as prescribed on 10-30-13. 2. The Director of Nursing, Assistant Director of Nursing or Unit Managers performed an audit of the Medication Administration Record (MAR) to compare against the Medication Cart to ensure that all current residents' medications were available. The audit was completed on 11-21-13. For any residents identified as not having current medications available, the resident's physician was notified and pharmacy delivered the medications. 3. The Director of Nursing, Assistant Director of Nursing or Unit Managers will re-educate all facility licensed staff regarding notification of the physician if they are unable to follow the physician orders to include medications prescribed. This education will be completed by 12-3-2013 with no license staff working after 12-3-2013 without having received the re-education. 	
-------	--	-------	--	--

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
(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 2</p> <p>clinicians would immediately consult with the resident's physician a significant change in the resident's physical, mental, or psychosocial status.</p> <p>Record review revealed the facility admitted Resident #1 on 10/29/13, with diagnoses which included Esophageal Cancer. Review of the Discharge Orders for Nursing Homes, dated 10/29/13 at 4:00 PM, revealed to continue TPN (nutrition provided through a needle directly into the vein), as ordered.</p> <p>Interview with Resident #1 and his/her spouse, on 11/06/13 at 8:20 AM and 8:45 AM, respectively, revealed the resident arrived at the facility with TPN sent from the hospital to ensure no interruption in the resident's nutrition. They stated the nursing staff at the facility was made aware of the TPN orders; however, there were no intravenous (IV) pumps available in the facility. Further interview revealed the Director of Nursing (DON) was present in the facility, and assured them the TPN would be administered as soon as the pumps arrived from the pharmacy.</p> <p>Review of the Nurse's Notes, dated 10/29/13 at 8:20 PM and 9:30 PM; and, on 10/30/13 at 12:30 AM, revealed calls were placed by the DON to the pharmacy requesting the IV pumps to administer the resident's TPN.</p> <p>Interview with the DON, on 11/06/13 at 9:45 AM, revealed she had left the facility on 10/30/13 at approximately 1:00 AM. She informed Licensed Practical Nurse (LPN) #1 to notify her when the IV pumps arrived at the facility, so she could come back to administer the TPN at that time. Further interview with the DON, revealed she did not</p>	F 157	<p>4. The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit all admissions and re-admissions weekly for twelve (12) weeks to ensure all medications are available timely and the physician is notified if there is a delay in following the physician orders.</p> <p>The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee to consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and Social Service Director with the Medical Director attending at least quarterly.</p>	12/04/13	

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
(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 3</p> <p>receive a phone call until approximately 6:30 AM, when she was informed the resident was leaving the facility against medical advice.</p> <p>Interview with LPN #1, on 11/04/13 at 3:50 PM; and, on 11/05/13 at 1:30 PM, revealed the DON informed her to call the Assistant Director of Nursing (ADON) when the IV pumps arrived from pharmacy. She called the ADON at approximately 1:30 AM; however, she was told the administration of TPN could wait until 7:00 AM, when a Registered Nurse (RN) was in the facility. LPN #1 did not notify the physician the TPN would not be administered per order.</p> <p>Interview with the ADON, on 11/05/13 at 3:40 PM, revealed she received a call from LPN #1 at approximately 1:30 AM on 10/30/13. She stated the IV pumps had arrived at the facility; however, she informed LPN #1 to notify the DON. LPN #1 instructed her that if the DON did not respond, the TPN could wait until the day shift arrived. Further interview with the ADON revealed if the TPN was not given per order, the physician should have been notified.</p> <p>Interview with the resident's Oncologist (cancer doctor), on 11/05/13 at 12:48 PM, revealed he was under the impression the TPN would be initiated immediately upon arrival at the facility. He stated the resident could not eat or drink anything; therefore the TPN was the only way to sustain him/her. Further interview with the Oncologist revealed he would have expected the facility staff to notify him if the TPN could not be administered per order as he would have sent the resident back to the hospital for treatment.</p> <p>Interview with the resident's Primary Physician,</p>	F 157			

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420		
(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	Continued From page 4 on 11/05/13 at 3:15 PM, revealed the TPN should have been administered as soon as possible. If he would have been made aware the facility could not initiate the TPN that night, he would not have discharged the resident from the hospital on 10/29/13. Interview with the DON, on 11/06/13 at 9:45 AM, revealed she expected the nurse to notify the physician if the TPN was not going to be administered per order.	F 157	F 309		
F 309 SS=G	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, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of three (3) sampled residents (Resident #1). The facility admitted Resident #1, on 10/29/13 at approximately 7:00 PM; however, the facility did not complete an assessment of the resident upon admission. The resident had a diagnosis of Esophageal Cancer, and an order for Roxanol	F 309	1. Resident #1 discharged from the facility on 10-30-13. The resident's physician was notified by the Assistant Director of Nursing that the resident's pain medications were not available on 10-30-13. The Physician was notified on 11-27-13 by the Assistant Director of Nursing that an admission assessment was not completed by the admitting nurse at the time of the residents discharge against medical advice. 2. The Director of Nursing, Assistant Director of Nursing or Unit Managers audited all current residents who admitted or re-admitted to the facility within the last thirty (30) days to ensure admission assessments were completed and pain medications were available. The audit was completed on 11-25-13. Any concerns identified were immediately corrected.		

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420	
(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 309	<p>Continued From page 5</p> <p>(pain medication), every four (4) hours, as needed. The facility failed to ensure pain medication was available to administer to the resident in a timely manner. He/she asked for pain medication at approximately 10:00 PM and 4:00 AM the next day; however, he/she did not receive the medication. The resident left the facility with a family member, on 10/30/13 at 6:45 AM, (approximately twelve (12) hours later), as a result of the facility's failure to provide pain management.</p> <p>The findings include:</p> <p>Review of the facility's "Admission To Do List", undated, revealed the following:</p> <ol style="list-style-type: none"> 1. Review discharge orders 2. Call pharmacy and fax over orders and face sheet with room number 3. Complete Pain Assessment 4. Complete Nursing Note <p>Review of the facility's Pain Management Process Policy/Procedure, last revised 06/17/13, revealed the facility recognized that each resident had the right to treatment and services to maintain their quality of life. Upon admission and re-admission, the facility would complete a pain assessment/evaluation. Physician and family would be notified when pain levels were outside normal levels for each individual resident.</p> <p>Record review revealed the facility admitted Resident #1 on 10/29/13, with diagnoses which included Esophageal Cancer. Review of the Admission Data Set, dated 10/29/13, revealed all areas of the admission assessment for Resident #1 were incomplete, including the resident's pain status.</p>	F 309	<p>3. The Director of Nursing, Assistant Director of Nursing or Unit Managers will re-educate all facility licensed staff regarding timely completion of admission assessments and meeting residents' pain needs. The education also included notification of the resident's physician if unable to meet resident's pain control needs. This education will be completed by 12-3-2013 with no licensed staff working after 12-3-2013 without having received this re-education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Managers will audit all new admissions and re-admissions for timely admission assessments and meeting pain control needs weekly for twelve (12) weeks.</p> <p>The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at any time concerns are</p>	

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420		
(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 309	Continued From page 6 Interview with Licensed Practical Nurse (LPN) #1, on 11/05/13 at 1:30 PM, revealed she did not complete the resident's admission assessment as it should have been completed by the previous nurse. However, interview with the Director of Nursing (DON), on 11/06/13 at 9:45 AM, revealed she expected LPN #1 to complete the admission paperwork and assessment of the resident. She revealed the admission process should be completed as quickly as possible. Review of Resident #1's Physician Discharge Orders for Nursing Homes, dated 10/29/13 at 4:00 PM, revealed the following orders: 1. Duragesic (pain) Patch 50 micrograms (mcg) every seventy-two (72) hours 2. Morphine 2 milligrams (mg) as needed for pain, every two (2) hours Review of Resident #1's facility Physician's Orders, dated 10/29/13, revealed the above orders were faxed to the pharmacy at 9:15 PM; however, the Morphine was not listed. Review of the updated Physician Discharge Orders, dated 10/29/13, revealed to change the Morphine Sulfate to Roxanol Sublingual (SL) 20 mg per milliliter (ml); give 0.5 ml every four (4) hours, as needed. Interview with the Director of Nursing (DON), on 11/06/13 at 9:45 AM, revealed the updated orders were brought in with the resident upon admission, at approximately 7:00 PM. However, she could not provide documented evidence that the orders were faxed to the pharmacy. Interview with the spouse of Resident #1, on 11/06/13 at 8:20 AM, revealed he/she brought the	F 309	identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee to consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and Social Service Director with the Medical Director attending at least quarterly.	12/04/13	

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420		
(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 309	<p>Continued From page 7</p> <p>resident to the facility, on 10/29/13 at approximately 7:00 PM, with orders from the hospital. The Spouse indicated at approximately 10:30 PM, the resident complained of pain due to the swelling of hi/her esophagus. The Spouse stated the staff indicated the medication had not arrived from pharmacy at that time. Further interview with the Spouse revealed he/she went home shortly afterwards; however, the resident called him/her at approximately 4:30 AM, indicating he/she was "sick" and "hurting so bad." The Spouse stated when he/she arrived at the facility, the orders brought with the resident were still sealed at the nurse's desk.</p> <p>Interview with Resident #1, on 11/06/13 at 8:45 AM, revealed it was reported at approximately 10:00 PM that he/she was "hurting really bad," with a hand on his/her chest. The resident reported he/she "cat napped" throughout the night. Between 3:30 AM-4:00 AM, an aide came in and brought some ice into his/her room. The resident informed the aide of the need for pain medication, as he/she was hurting about an "8 or 9" on a pain scale of 0-10. The aide indicated she would check on it; however, the aide never came back into the resident's room. The resident stated at approximately 4:30 AM, he/she contacted a family member indicating he/she was in pain and "could not stand it any longer". The resident was discharged from the facility later that morning. Further interview with the resident verified the paperwork brought in from the hospital was still unopened at the nurse's desk.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 11/05/13 at 8:30 AM, revealed she was the aide taking care of Resident #1, on 10/29/13 from 11:00 PM to 7:00 AM on 10/30/13. She stated the</p>	F 309			

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420		
(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 309	<p>Continued From page 8</p> <p>resident put on his/her call light sometime between 3:00 AM and 5:00 AM, asking for pain medication. CNA #5 revealed LPN #1 was made aware of the resident's request for pain medication. However, she was informed the resident's medications had not been received from the pharmacy.</p> <p>Interview with LPN #1, on 11/04/13 at 3:50 PM; on 11/05/13 at 1:30 PM; and, on 11/06/13 at 4:00 PM, revealed she did not receive any paperwork upon the resident's admission to the facility. LPN #1 stated she was not aware of the updated orders from the hospital, and verified she did not fax any orders to the pharmacy. Further interview with LPN#1 revealed she was the resident's nurse from 7:00 PM to 7:00 AM; however, the resident never indicated he/she was in pain. She stated she did not have any reports of the resident's pain made during the shift.</p> <p>Interview with the DON, on 11/06/13 at 9:45 AM, revealed LPN #1 should have faxed the updated pain medication orders to the pharmacy, to ensure arrival at the facility that night.</p>	F 309			