

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

PRINTED: 04/21/2014
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 R 04/11/2014
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 A Revisit Survey was conducted 04/11/14 and determined the facility was back in compliance on 03/14/14 as alleged in the acceptable POC.	{F 000}			

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

TITLE

(X6) DATE

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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FORM APPROVED
OMB NO. 0936-0391

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 02/21/2014
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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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F 000	INITIAL COMMENTS A Recertification Survey and an Abbreviated Survey (#KY21318,) was conducted on 02/18/14 through 02/21/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for Federal recertification with the highest scope and severity of "D." #KY21318 was unsubstantiated with no regulatory violations identified.	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	1. LPN # 5 abuse registry check was completed by the former Human Resource personnel on 2/18/14 and noted that LPN # 5	03/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>D. Edward Foley</i>	TITLE <i>Interim administrator</i>	(X6) DATE <i>03/17/14</i>
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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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F 225	<p>Continued From page 1 investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, personnel record review and review of the Nurse Aide Abuse Registry (NAAR) Online Validation Results and the facility's Abuse and Neglect Policy, it was determined the facility failed to ensure the Nurse Aide Abuse Registry (NAAR) checks were requested upon hire for four (4) of five (5) personnel records reviewed.</p> <p>The findings include:</p> <p>Review of the facility policy "Abuse and Neglect; Screening of Staff," undated, revealed all potential employees will be screened as part of the application process to determine if there is a history of abuse, neglect or mistreatment of individuals. Screening will include checking with the appropriate licensing boards and registries.</p> <p>Review of the Personnel Record for Licensed Practical Nurse (LPN) #5, revealed the employee's hire date was 01/21/14 and the NAAR check was not completed until 02/18/14; twenty-eight (28) days after hire.</p> <p>Review of the Personnel Record for Registered</p>	F 225	<p>was not listed on the abuse registry, RN # 3 abuse registry check was completed on 2/11/14 by the former Human Resources personal and RN # 3 was not listed on the abuse registry, RN # 4 abuse registry check was completed on 12/20/13 by the former human resource personal and RN # 4 was not listed on the abuse registry. The Assistant Director of Nursing abuse registry check was completed on 2/19/14 by the former Human Resource personnel and noted the ADON was not listed on the abuse registry.</p> <p>2. An audit of all current employee files was completed on 02/26/2014 by the current Human Resource Personal to assure all current employees have had an abuse registry check completed and that none are listed on the abuse registry. Any noted as not having had this abuse registry check will have an abuse registry check ran, any listed on the abuse registry will be immediately suspended pending evaluation of the abuse registry. This will be completed by 02/26/2014</p> <p>3. The Administrator re-educated the Human Resource Manager on the requirement to complete an abuse registry check prior to start of employment. This was completed on 02/26/2014.</p> <p>4. The Administrator will review all new hires weekly for twelve (12) weeks to validate that the abuse registry check was completed timely. Results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems resolved. If at any time concerns are identified the Quality Assurance Committee</p>	
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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 225	Continued From page 2 Nurse (RN) #3, revealed the employee's hire date was 02/04/14 and the NAAR check was not completed until 02/11/14; seven (7) days after hire. Review of the Personnel Record for RN #4, revealed the employee's hire date was 12/13/13 and the NAAR check was not completed until 12/20/13; seven (7) days after hire. Review of the Personnel Records for the Assistant Director of Nursing (ADON), revealed the employee's hire date was 01/24/14 and the NAAR check, was not completed until 02/19/14; twenty-six days (26) after hire. Interview with the Human Resources Coordinator, on 02/21/14 at 10:48 AM, revealed she had only been in this position for one (1) week but the NAAR checks should have been done prior to hiring the staff. Interview with the Regional Administrator, who was in charge during the Administrator's absence, on 02/21/14 at 10:53 AM, revealed he was not aware the NAAR checks had not been completed prior to hiring the staff. He stated the NAAR checks were overlooked during the transition in staff members, and should have been completed prior to hiring any employee.	F 225	will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, MDS nurse, Dietary Service Manager, Activity Director and Maintenance Director with the Medical Director attending at least Quarterly.		
F 281 SS=D	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	F 281	F281- 1. RN # 3 was removed from the medication cart on 02/20/2014 and was provided additional training on medication administration in the facilities electronic training system (Silverchair). The Assistant Director of Nursing observed medication administration to resident A on 02/24/2014 and noted that medications were administered timely per physician order. The physician was notified of resident A's medication administration times on 2/18/14, this notification was made by Unit Manager with no further direction given. 2. On 02/24/2014 an observation of medication administration by the Assistant Director of Nursing noted that medications were administered timely. 3. On 3/1/14 the facility altered the medication administration time to allow more time after receiving report from the off going shift. The medication administration time change was approved by the Quality	03/14/14	

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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420
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F 281	<p>Continued From page 3</p> <p>by:</p> <p>Based on observation, record review, interview and review of the facility's policy and procedure, it was determined the facility failed to ensure staff administered medication within the appropriate timeframe per the facility's policy for one (1) unsampled resident (Resident A). Registered Nurse (RN) #3 administered two (2) of Resident A's medications fifty-five minutes after the facility's allotted timeframe for medication administration.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Medication Administration", not dated, revealed the center strives to provide safe administration of all medications. The licensed nurse and/or medication assistant will administer medication according to state specific regulation. The licensed nurse and/or medication assistant will check the following to administer medication:</p> <ul style="list-style-type: none"> a. Right medication b. Right dose c. Right dosage form d. Right route e. Right resident f. Right time <p>1. Review of Resident A's February 2014 Physician Orders, revealed orders for the following medications to be administered at 8:00 AM: Glucophage (hypoglycemic medication) 500 milligrams (mg) three (3) times a day (tid) and Metoprolol (hypertension) 25 mg tid.</p> <p>Observation of a medication pass, on 02/18/14 at 9:20 AM, revealed RN #3 administered the above</p>	F 281	<p>Assurance Committee and Medical Director on 02/28/2014</p> <p>4. The Director of Nursing or Assistant Director of Nursing will observe medication administration times three (3) times per week for twelve (12) weeks to assure medications are administered timely. Results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems resolved. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, MDS nurse, Dietary Service Manager, Activity Director and Maintenance Director with the Medical Director attending at least Quarterly</p> <p>F332</p> <p>1. RN # 3 was removed from the medication cart on 02/20/2014 and was provided additional training on medication administration in the facilities electronic training system (Silverchair). The Assistant Director of Nursing observed medication administration to resident A on 02/24/2014 and noted that medications were administered timely per physician order. The physician was notified of resident A's medication administration times on 2/18/14, this notification was made by Unit Manager with no further direction given.</p> <p>2. On 02/24/2014 an observation of medication administration by the Assistant</p>	03/14/14
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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 281	<p>Continued From page 4</p> <p>medications at 9:55 AM which was fifty-five (55) minutes after the facility's allotted time frame.</p> <p>Interview with RN #3, on 02/18/14 at 10:15 AM, revealed medication administration pass was allowed one (1) hour before to one (1) hour after the scheduled medication times. She explained the reason she was passing 8:00 AM medications at 10:15 AM was because she had asked the Unit Manager (RN#1) on Hall 1 for assistance a minimum of five (5) times with medication administration but did not receive any help.</p> <p>Interview with Unit Manger/RN #1, on 02/18/14 at 11:40 AM, revealed RN #3 came to her and told her she needed help with the medication pass and she only asked one (1) time. She stated it was part of her job duties to assist with any help needed on the floor but the other Unit Manager (LPN #2) came from Hall II to assist RN #3 with finishing the medication pass. Additionally, she revealed she was assisting the Director of Nursing (DON) with obtaining information for the survey team; therefore, she did not provide assistance to RN #3.</p> <p>Interview with LPN #2, on 02/18/14 at 11:40 AM, revealed there had been issues with RN #1 not wanting to assist the nurses working on the floor in the past.</p> <p>Interview with the DON and the Administrator, on 02/20/14 at 4:40 PM, revealed it was not acceptable practice to fail to follow the facility's policy on medication administration.</p>	F 281	<p>Director of Nursing noted that medications were administered timely.</p> <p>3. On 3/1/14 the facility altered the medication administration times to allow more time after receiving report from the off going shift. The medication administration time change was approved by the Quality Assurance Committee and Medical Director on 02/28/2014. All Licensed staff were re-educated on Medication Administration in the facility electronic training system (silverchair) with no Licensed staff working after 03/12/2014 without having received this re-education.</p> <p>4. The Director of Nursing or Assistant Director of Nursing will observe medication administration times three (3) times per week for twelve (12) weeks to assure medications are administered timely. Results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems resolved. If at any time concerns are identified the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, MDS nurse, Dietary Service Manager, Activity Director and Maintenance Director with the Medical Director attending at least Quarterly</p>		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332			

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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420		
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F 332	<p>Continued From page 5</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on observation, interview, record review and review of the facility policy and procedure, it was determined the facility failed to ensure it was free of a medication error rate of 5% or greater. Observation of a medication pass revealed there were thirty-two (32) opportunities with two medication errors which resulted in a 6 percent medication error rate. Resident #1 was administered two medication at the wrong time.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Medication Administration", not dated, revealed the center strives to provide safe administration of all medications. The licensed nurse and/or medication assistant will administer medication according to state specific regulation. The licensed nurse and/or medication assistant will check the following to administer medication:</p> <ul style="list-style-type: none"> a. Right medication b. Right dose c. Right dosage form d. Right route e. Right resident f. Right time <p>Observation of a medication pass, on 02/18/14 at 9:20 AM, revealed thirty two medications administered to four (4) residents.</p>	F 332			

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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 NORTH ELM ST. HENDERSON, KY 42420		
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F 332	<p>Continued From page 6</p> <p>Review of Resident A's February 2014 Physician Orders revealed orders for Glucophage (hypoglycemic medication) 500 milligrams (mg) three times a day (tid) and Metoprolol (anti-hypertension) 25 mg tid.</p> <p>Observation of a medication pass, on 02/18/14 at 9:20 AM, revealed RN #3 administered the above medications at 9:55 AM which was fifty-five minutes after the facility's allotted time frame which resulted in two medication errors.</p> <p>Interview with RN #3 who was still passing the 8:00 AM medications, on 02/18/14 at 10:15 AM, revealed medication administration pass was allowed one (1) hour before to one (1) hour after the scheduled medication times.</p> <p>Interview with the Director of Nursing and the Administrator, on 02/20/14 at 4:40 PM, revealed it was not acceptable practice to fail to follow the facility's policy on medication administration.</p>	F 332			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2014
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
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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: 1967.</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 installed in 1967, with 28 smoke detectors and 197 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator with unknown installation date. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/20/14. Henderson Nursing and Rehabilitation Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		

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