

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

2nd SOD

PRINTED: 10/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2015
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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	F 000		
F 242 SS=D	<p>A standard health survey was conducted on 09/01-03/15. Deficient practice was identified with the highest scope and severity at "F" level.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>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 honor resident choices regarding food likes and dislikes for one (1) of fifteen (15) sampled residents (Resident #9). Observations during meal service revealed Resident #9 received items on his/her meal tray that were listed as foods the resident disliked during two (2) meals.</p> <p>The findings include: Review of the facility policy, "Food Preparation," not dated, revealed it was the policy to serve attractive, satisfying, and nutritious meals with consideration given to a resident's food preference.</p> <p>Record review revealed the facility admitted Resident #9 on 07/08/15 with diagnoses that</p>	F 242	Please See Attachment	

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

Debra Tucker RN

TITLE

DON

(X6) DATE

10/14/15

09/25/2015

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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F 242	<p>Continued From page 1</p> <p>included Chronic Airway Obstruction, Anxiety, Depression, and Esophageal Reflux. Review of an initial Minimum Data Set (MDS) assessment dated 07/15/15, revealed the facility assessed Resident #9's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of 1, indicating the resident was not interviewable. Review of a "General Diet Tray Card," not dated, revealed Resident #9 disliked pizza, spaghetti, noodles, pasta, green beans, most meats, and beets.</p> <p>Observation on 09/01/15 at 4:45 PM revealed Resident #9 received green beans on his/her dinner tray. Further observation revealed Resident #9 did not eat the green beans. Resident #9 stated during the observation he/she did not like green beans.</p> <p>Observation on 09/02/15 at 11:30 AM revealed Resident #9 received beets on his her lunch tray. Further observation revealed Resident #9 did not eat the beets. Resident #9 stated during the observation he/she did not like beets.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 09/01/15 at 5:04 PM and SRNA #2 on 09/02/15 at 11:55 AM revealed they assist with passing the meal trays to residents. SRNA #1 and SRNA #2 further stated when passing meal trays the SRNAs are supposed to observe the Resident's General Diet Tray Card to ensure likes and dislikes were honored.</p> <p>Interview with the Dietary Manager on 09/03/15 at 11:20 AM revealed it was the Dietary Aides' as well as the SRNAs' responsibility to ensure the residents' likes and dislikes were honored. The Dietary Manager stated honoring the residents'</p>	F 242			

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F 242	Continued From page 2 likes and dislikes had been an issue in the past but she thought it had improved. The Dietary Manager stated the facility had no "system to ensure accountability" and ensure resident food choices were honored. Interview with the Dietitian on 09/03/15 at 10:06 AM revealed it was her expectation for the facility to serve residents with food that was attractive and satisfying and the facility should honor the residents' likes and dislikes. The Dietitian stated this was important to avoid potential weight loss and to maintain the resident's nutritional status. Interview with the Director of Nursing on 09/03/15 at 3:59 PM revealed it was her expectation for the Dietary Aides and SRNAs to observe and honor the residents' likes and dislikes. The DON stated she was not aware it was a problem. The DON stated it was important to honor residents' food preferences and stated that the nutritional status affected the residents' overall well-being.	F 242			
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328			

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F 328	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure podiatry care (foot care) was provided for three (3) of fifteen (15) sampled residents (Residents #3, #6, and #13). Residents #3, #6, and #13 were observed to have long toenails and record review and interviews with the facility staff revealed the facility failed to ensure the residents received the necessary foot care by staff or a podiatrist.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Podiatry," dated 06/06/14, revealed the facility would contract with an outside Podiatrist to provide care for residents requesting their services.</p> <p>Review of the facility's policy and procedure titled "Nail," not dated, revealed it was the policy of the facility to maintain residents' nails in a clean appropriate manner. Further review revealed toenails were to be trimmed as needed by the State Registered Nursing Assistants (SRNAs) except for diabetic residents. Further review revealed Podiatry would check residents' nails as indicated.</p> <p>1. Record review revealed the facility admitted Resident #3 on 02/25/15 with diagnoses that include Diabetes Mellitus, Hypertension, and Anemia. Review of the 09/15/15 monthly Physician's Orders revealed an order for Podiatry Services as needed. Review of a quarterly Minimum Data Set (MDS) assessment dated 07/23/15, revealed the facility assessed Resident</p>	F 328			

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F 328	<p>Continued From page 4</p> <p>#3's cognitive status as severely impaired with a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident was not interviewable.</p> <p>Observation on 09/03/15 at 11:41 AM revealed Resident #3 had long toenails, which extended past his/her toes.</p> <p>Review of the Podiatry Progress Notes dated 08/20/14 and 04/15/15 revealed the Podiatrist trimmed Resident #3's toenails on 08/20/14 and 04/15/15. Further review revealed the physician noted, "Follow-up in nine (9) weeks."</p> <p>2. Record review revealed the facility admitted Resident #6 on 03/19/09 with diagnoses that included Cerebral Palsy, Anxiety, and Anemia. Review of the Monthly Physician's Orders dated September 2015 revealed orders for Podiatry Services. Review of a quarterly Minimum Data Set (MDS) assessment dated 08/18/15, revealed the facility assessed Resident #6's cognitive status as severely impaired with a Brief Interview for Mental Status (BIMS) score of 0, indicating the resident was not interviewable.</p> <p>Review of the Podiatry Progress Notes dated 08/20/14 and 04/15/15 revealed the Podiatrist trimmed Resident #3's toenails on 08/20/14 and 04/15/15. Further review revealed the physician noted, "Follow-up in nine (9) weeks."</p> <p>Observation on 09/02/15 at 2:17 PM revealed Resident #6's toenails were yellow, thick, and extended beyond the toe.</p> <p>Interview with the Medical Records Director on 09/03/15 at 9:45 AM revealed it was her responsibility to schedule all appointments with</p>	F 328			

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F 328	<p>Continued From page 5</p> <p>the Podiatrist. Further interview revealed she was not sure why the appointments were not scheduled as the physician ordered.</p> <p>Interview with the Podiatrist on 09/03/15 at 9:55 AM, revealed the standard of care for Podiatry was to be evaluated every nine (9) weeks. The Podiatrist stated it was important especially for Resident #6 because his/her nails were dystrophic, thick, and difficult to cut. Further interview revealed the Podiatrist stated he would expect the follow-up appointments would be made according to his recommendations.</p> <p>Interview with the Director of Nursing on 09/03/15, revealed she was not aware the Podiatry visits were not completed as ordered. Further interview revealed she expected all Physician's Orders to be followed.</p> <p>3. Observation on 09/03/15 at 9:10 AM revealed Resident #13 was lying in bed, covered with the sheet. The resident's toenails on both feet were observed to be long and hanging over the toes.</p> <p>Review of the medical record for Resident #13 revealed the facility admitted the resident on 03/26/15 with diagnoses that included Diabetes and Cardiovascular Accident with Hemiparesis. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated 06/24/15 revealed the facility assessed the resident's cognition using the Brief Interview for Mental Status (BIMS). The facility assessed the resident to have a score of 14, indicating that Resident #13 was cognitively intact and interviewable.</p> <p>Review of the most recent Podiatry visit for Resident #13 revealed the podiatrist last saw the</p>	F 328			

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F 328	Continued From page 6 resident on 04/15/15.	F 328			
F 366 SS=D	<p>Interview with Resident #13 on 09/03/15 at 9:10 AM revealed the resident stated his/her toenails get caught on the sheets sometimes.</p> <p>483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE</p> <p>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide food substitutes of similar nutritive value for one (1) of fifteen (15) sampled residents (Resident #9). The menu specified cheese ravioli as the main entree for the evening meal on 09/02/15; however, Resident #9 was served mashed potatoes as a substitute for the entree.</p> <p>The findings include: Review of the facility policy, "Food Substitutions at meals," revised on 03/09/04, revealed one meat and two vegetables would be served as a substitute for meals. Record review revealed the facility admitted Resident #9 on 07/08/15 with diagnoses that included Chronic Airway Obstruction, Anxiety, Depression, and Esophageal Reflux. Review of an initial Minimum Data Set (MDS) assessment dated 07/15/15 revealed the facility assessed Resident #9's cognition as severely impaired with</p>	F 366	Please See Attachment		

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F 366	Continued From page 7 a Brief Interview for Mental Status (BIMS) score of 1, indicating the resident was not interviewable. Review of a "General Diet Tray Card," not dated, revealed Resident #9 disliked pizza, spaghetti, noodles, pasta, green beans, most meats, and beets. Observation of the facility's menu for the evening meal on 09/02/15 revealed cheese ravioli was the main course. Further observation on 09/02/15 at 5:20 PM revealed Resident #9 was served Brussels sprouts, mashed potatoes, breadstick, and fruit cocktail but was not served a protein food item. Interview with Dietary Aide #3 on 09/22/15 at 5:22 PM revealed the mashed potatoes were served to Resident #9 as a substitute for the main course of ravioli since Resident #9 did not like pasta. Further interview revealed Dietary Aide #3 stated the Brussels sprouts were the protein and the ravioli was a starch. Additional interview revealed the Dietary Aide stated she was not aware Brussels sprouts did not have protein. Interview with the Dietary Manager on 09/03/15 at 11:20 AM revealed she was not aware Resident #9 was served mashed potatoes as a substitute for the ravioli. She stated an alternate protein such as a chicken patty should have been prepared as a substitute for the main course. Interview with the Dietitian on 09/03/15 at 10:06 AM revealed the Dietary Manager was responsible for ensuring all residents were served a protein and two sides.	F 366			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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F 371	<p>Continued From page 8</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, review of staff training, and review of facility policy, it was determined the facility failed to store, prepare, and serve food under sanitary conditions. Observations in the kitchen on 09/01/15 and 09/02/15 revealed the following: staff was not wearing hair nets while in the kitchen, floor mats in the kitchen were sticky, raw meat was thawing in a pan of water in the sink, and dish washing temperatures did not reach an adequate temperature according to policy to prevent foodborne illness. In addition, staff was observed to touch the lid of the garbage can with clean hands to dispose of paper towels.</p> <p>The findings include:</p> <p>1. Review of the facility policy regarding Food Preparation, undated, revealed all dietary employees must wear a hair net when involved in food preparation in the kitchen.</p> <p>Observation on 09/01/15 at 4:16 PM revealed the</p>	F 371			

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F 371	<p>Continued From page 9</p> <p>Dietary Manager sitting at a desk in the kitchen area without a hair net. Further observations on 09/02/15 at 10:50 AM revealed the Dietary Manager got up from the desk and proceeded across the kitchen to retrieve a tray from the tray line without a hair net. Further observations revealed the floor mats were sticky, and behind the food prep table the floor mat had food debris in two of the holes on the mat.</p> <p>Observation on 09/02/15 at 11:00 AM revealed Dietary Aide #1 walked through the kitchen to the sink area without a hair net to retrieve a hair net. She proceeded to wash her hands and then touch the garbage can lid with her clean hands to dispose of the paper towels used to dry her hands.</p> <p>Observation on 09/02/15 at 11:20 AM revealed dietary staff working the tray line tracked a black wet substance from the floor mat to the floor.</p> <p>Interview with Dietary Aide #2 on 09/02/15 at 1:30 PM revealed Maintenance was responsible to clean the mats every week on Thursday.</p> <p>Interview with Maintenance staff on 09/02/15 at 2:00 PM revealed he tried to clean the mats every week by taking them outside and using degreaser. He stated kitchen staff was to remove the mats every night and mop the floors.</p> <p>Interview with the Dietary Manager on 09/02/15 at 2:30 PM revealed she had not been instructed to wear a hair net in the kitchen. She stated she usually just sat at the desk in the kitchen but acknowledged there was a potential for hair to get in the food if she had to walk through the kitchen to retrieve items for other staff. She stated there</p>	F 371		

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F 371	<p>Continued From page 10</p> <p>was a potential for contamination of clean hands when staff touched the garbage can lid to open the garbage can. The Dietary Manager stated the Dietitian also had concerns with the garbage can because staff had to touch the lid to open the can.</p> <p>2. Review of the facility policy titled "Dishwasher Policy," undated, revealed when mechanical dishwashers were used the rinse cycle should reach a sanitizing temperature of 180 degrees. Observation on 09/02/15 at 2:15 PM revealed Dietary Aide #3 was operating the mechanical dishwasher. Observations revealed the wash temperatures reached 168 degrees; however, the rinse cycle only reached 170 degrees.</p> <p>Interview with Dietary Aide #3 on 09/02/15 at 2:15 PM revealed she was not aware of the requirement for dishwashing/rinsing temperatures.</p> <p>3. Review of the facility policy regarding Thawing Meat, undated, revealed meat would be kept in the freezer until time of use. The policy stated that meat would be thawed by either placing it in the sink under running water until thawed or placed in the refrigerator until thawed.</p> <p>Observation on 09/02/15 at 4:40 PM revealed a roast in plastic wrap sitting in a pan of water in the sink without the water running.</p> <p>Interview on 09/02/15 at 4:42 PM with Dietary Aide #1 revealed she did not know who had placed the roast in the sink. She stated she was not aware of the proper thawing process for meat. She proceeded to turn the water on to run over the meat.</p>	F 371			

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F 371	<p>Continued From page 11</p> <p>Interview on 09/03/15 at 10:05 AM with the Dietitian revealed she was a consultant and her responsibilities were to complete initial, annual, and significant change assessments as required. She stated she had completed audits monthly and had completed an audit on 08/31/15, but did not find any of the concerns identified. She stated the Dietary Manager had worn a hair net in the past, but had stopped and she was unsure why. She stated the Director of Nursing and Administrator were responsible to oversee the Dietary Manager. She stated she had informed the Dietary Manager she did not like the garbage can, but did not follow up about it and did not put it in writing. She stated there was a risk for contamination when staff had to push the lid to dispose of trash. She stated staff should know the proper thawing and dishwashing policy and procedure and attributed their lack of knowledge to being nervous.</p> <p>Interview with the Dietary Manager on 09/03/15 at 11:19 AM revealed staff had been trained on sanitation and thawing of food. She stated she did random audits and "toss up questions" and staff knew the answers. She stated she had not documented any training or audits she had completed. She did provide staff training records for Dietary Aides #1, #2, and #3 that indicated staff had been trained upon hire regarding the dishwasher temperatures, sanitation, and policies and procedures.</p> <p>Interview with the Director of Nursing on 09/03/15 at 3:59 PM revealed she was unaware of any concerns in the kitchen. She stated she depended on the Dietary Manager and Dietitian to oversee the kitchen.</p>	F 371			

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2015
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(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 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 431	Please See Attachment		

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NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(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 431	<p>Continued From page 13</p> <p>by:</p> <p>Based on observation, interview, and facility policy review, it was determined the facility failed to store all drugs and biologicals in locked compartments on two (2) of four (4) medication carts. Observations on 09/02/15 and 09/03/15 revealed bottles of insulin were not locked in two (2) medication carts when staff was not present.</p> <p>The findings include:</p> <p>Review of facility policy titled "Medication Storage," dated 03/15/15, revealed residents' medications would be stored in locked medication carts.</p> <p>Observations of medication cart A, left unattended next to room 21 on 09/02/15 from 11:00 AM until 11:12 AM, revealed 20 bottles of insulin that were labeled for residents and lying on top of the medication cart.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 09/02/15 at 11:12 AM, revealed she always left the insulin bottles on top of the medication cart because there was no place on the cart to lock them.</p> <p>Observations of medication cart B, left unattended next to nurses' station B on 09/03/15 from 11:55 AM until 12:10 PM, revealed 14 bottles containing insulin labeled for residents and not locked but on top of the medication cart.</p> <p>Interview with LPN #2 on 09/03/15 at 12:10 PM, revealed insulin or any medication should never be left unattended on top of the medication cart.</p> <p>Interview with the Assistant Director of Nursing</p>	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2015
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(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 431	Continued From page 14 (ADON) on 09/03/15 at 3:00 PM, revealed she would expect all medications to be locked in the medication cart, including insulin, when staff was not present at the medication cart. Interview with the Director of Nursing (DON) on 09/03/15 at 3:45 PM, revealed she would expect insulin and all medications to be locked in the medication cart when staff was not at the medication cart.	F 431			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures it was determined the facility failed to ensure two (2) of two (2) restrooms that were available for resident use were equipped to receive calls through a communication system. Observations revealed restrooms in the lobby area of the facility were unlocked and available for resident use, but were not equipped with an emergency communication system. The findings include: Review of the facility's policy and procedure titled "Call Light Policy," not dated, revealed it was the policy of the facility to maintain a call light system	F 463			

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: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/03/2015
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(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 463	<p>Continued From page 15</p> <p>for each resident's use. Additional review revealed call lights would be maintained in each bathroom that was accessible for resident use.</p> <p>Observations during the environmental tour on 09/03/15 at 2:15 PM revealed two (2) restrooms in the front lobby that were unlocked and available for resident use. Further observation revealed the restrooms were not equipped with an emergency communication system. Further observation revealed both bathrooms were unlocked and available for resident use.</p> <p>Interview with the Maintenance Director on 09/03/15 at 2:30 PM revealed both restrooms were accessible to residents. Further interview revealed he was not aware that the restrooms needed an emergency communication system.</p>	F 463			

F242

Please accept our credible allegation of compliance:

Resident # 9 food preferences have been reviewed & the meal tray card updated to include resident # 9 food dislikes. Dietary staff has been in serviced on reading resident # 9 diet card & substituting foods as indicated. (See attachment # 1)
SRNA's will be in serviced on monitoring resident # 9 meal tray with each meal to ensure resident # 9 is not served foods listed on resident # 9 dislike list. SRNA's will be in serviced on returning resident # 9 meal tray to dietary if foods have been placed on the meal tray that is listed on resident # 9 dislike list for substitutions.

Chart audits will be completed by the Dietary Supervisor on all residents to determine that all current residents have a current food preferences form on their medical record and these food preferences are reflected on the residents' tray cards. (See attachment # 2).

The Dietary Staff has been in serviced on reading diet cards correctly and honoring requests.(See attachment #1 and #2).

SRNA's will be in serviced on comparing residents meal cards with the food served as they pass meal trays to ensure residents are not served foods they dislike. SRNA's will be in serviced on returning meal trays to dietary for replacement of foods found on residents trays that are listed as disliked foods.

Admission & quarterly dietary profile have been reviewed & revised to include resident's food likes & dislikes. (See attachments # 13 & 14) Policies & procedures relating to resident's food preferences have been reviewed & updated as indicated. (See attachment #15)

The dietary supervisor will be in-serviced on the new assessment forms. Dietary staff will be in-serviced on the revised food preference policy & procedure. (See attachment # 3)

Dietary will utilize the CQI tool monthly to ensure residents are not served foods listed on their dislike list. The CQI tool utilized for tray accuracy has been revised to include monitoring for residents being served foods that are listed on their dislike list. (See attachment # 16)

The CQI indicator for the monitoring of resident tray accuracy, including the provision of meals honoring resident identified likes/disliked, will be utilized monthly under the supervision of the DM/RD. Results of the completed tool will be reviewed monthly in the facility CQI meetings. (See attachment # 4)

Quality Assurance will monitor ten (10) meal trays monthly to ensure residents are not served foods that are listed on their meal cards as foods that are disliked.(See attachment # 17)

10-19-2015

F328

Please accept our credible allegation of compliance:

Appointments have been made for residents # 3, 6, & 13 to be provided with podiatry services. Nursing staff will trim resident # 3, 6 & 13 toe nails as indicated prior to the podiatry appointment.

An audit has been completed to determine residents in need of podiatry services. All residents toe nails will be checked by staff and trimmed as indicated.

Policy & procedure on nail care has been reviewed & revised as indicated. (See attachment # 8)

The podiatrist office has been contacted in regards to our residents and arrangements are in progress for the podiatrist &/or his assistant to visit the facility on a routine basis or as indicated to provide proper podiatric treatment and care. The Medical Records Director has received in-service education on the need to monitor the visits by the Podiatrist quarterly, and to notify him 30 days in advance of when residents must be seen. (See attachment # 7 & # 12)

The Quality Assurance nurse will review the Podiatry visit monitoring with the Medical Records Director quarterly to determine compliance is maintained with these services. (See attachment # 9)

10-3-2015

F366

Dietary staff will be in-serviced on providing resident # 9 with appropriate meal substitutes which will meet his dietary requirements as requested.
(See attachment # 1)

All residents are provided appropriate meal substitutes which meet their dietary requirements, as requested, as determined by meal service observations performed quarterly by the RD.

Policies on appropriate meal substitutes have been reviewed & revised. (See attachment # 3).

Dietary staff will be in-serviced on appropriate meal substitutes by the RD on 9-23-2015. (See attachment # 1)

In-services will be held monthly x's 12 months on providing appropriate substitutes to residents at meals.

The dietary supervisor will perform meal service observations weekly x's two (2) months then monthly to determine that meal substitutes are provided in accordance with dietary requirements. (See attachment # 4). Results of these observations will be reported to the Administrator & Director of Nursing. Any dietary staff found to not be serving meal substitutes according to policy will be retrained in this area.
Quality Assurance will monitor meals monthly to ensure food substitutions served at meals are of the same nutrient value as the food they are being substituted for.
(See attachment # 18)
10-16-2015

F371

Please accept our credible allegation of compliance:

Floor mats in the kitchen has been replaced with solid mats that can be swept & mopped daily.

Meat is now being thawed according to acceptable standards.

The dish washer has been fixed to maintain appropriate temperatures.

Hair nets are located in a area accessible to dietary staff so they can be applied prior to entering the kitchen area.

The trash can in question has been replaced with a type that is foot operated to prevent dietary staff from having to touch the lid.

An audit will be completed of the kitchen and meal service by the Dietary Supervisor to identify any dietary sanitation issues. All identified issues will be addressed as indicated.

In-services were held with the dietary staff on 9-23-2015 on preparing, distributing and serving food under sanitary conditions. (See attachment # 1)

Provide monthly in-service education to dietary staff on preparing & serving residents food in a safe sanitary manner and environment x's 12 months then quarterly.

In-service all new dietary employees at the time of hire on the preparing, distributing and serving of food under sanitary conditions.

The CQI indicator for the monitoring of dietary sanitation, including but not limited to dish rinse water temperatures, thawing of meat, floor mat cleanliness, and hand washing/glove use, will be utilized monthly by the dietary supervisor. (See attachment # 5)

The Quality Assurance nurse will monitor dietary sanitation monthly & report her findings to the QA Committee, Director of Nursing & Administrator. (See attachment # 6)

All deficient practice noted with dietary sanitation will be handled by the QA Committee.

10-3-2015

F431
N314

Please accept our credible allegation of compliance:

All bottles of insulin are now kept locked in medication carts at all times unless being accessed to give residents insulin.

Licensed Practical Nurses (LPN's) will be in-serviced on keeping insulin bottles locked in the medication cart when they are not in direct line of sight.

All medications have been checked to ensure they are kept locked in medication carts at all times.

Licensed staff that deals with resident's medications will be in-serviced to keep all medications locked in the medication cart when the cart is not in direct view of the individual passing medications. Dates of in service were _____.
(See attachment # _____)

Medication carts will be checked to ensure there is space for insulin bottles and all other medications to be safely locked when not in direct line of sight of the individual passing medications. Room has been made in all medication carts for the locked storage of insulin and all other medications that may have been affected by this deficient practice.

The CQI indicator for the monitoring of medication storage in compliance with the regulations will be utilized monthly x 2 months and then quarterly thereafter. This form will be completed by the QA nurse or her designee. Information from the CQI indicator will be reported to the Director of Nursing, Administrator and Quality Assurance Committee with any deficient practice being dealt with by administration. (See attachment # 10)

Quality Assurance will monitor monthly the storage of insulin to ensure it is kept locked in medication carts. (See attachment # _____)

10-16-2015

F463

Please accept our credible allegation of compliance.

The two (2) public restrooms which did not have emergency call systems have had their locks replaced and are now accessible by key only. Keys to these restrooms are available by request from the front office & A-side nurses' station.

All restrooms accessible for resident use have been inspected to ensure each restroom has access to an emergency call system.

Instructions on keeping the two (2) public accessible restrooms with no emergency call system locked at all times and the locations of the keys to these restrooms have been posted for all employees & visitors.

The public accessible restrooms with no emergency call system will be monitored by maintenance weekly to determine that they are kept locked.

10-3-2015

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185298	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/01/2015
NAME OF PROVIDER OR SUPPLIER HICKS GOLDEN YEARS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (200)</p> <p>SMOKE COMPARTMENTS: 5</p> <p>FIRE ALARM: Complete automatic fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II propane generator.</p> <p>A life safety code survey was initiated and concluded on 09/01/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 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.