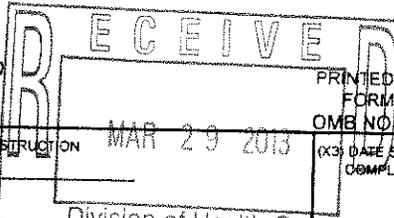


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SOL



PRINTED: 03/19/2013
FORM APPROVED
OMB NO: 0938-0391

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 02/14/2013
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	F 000	THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES 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.	
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the 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</p>	F 225	<p>The former social worker investigated the incidents on resident #9 and resident E and did not feel them reportable. Current social worker will report all incidents to ensure compliance with 483.13 guidelines.</p> <p>All incident reports for past year were reviewed by social worker, DON and Administrator on 2-15-13 and none were found to be reportable.</p> <p>All staff to include the social worker will be in-serviced on 3-7 and 3-8-2013 on abuse and reporting issues by Ombudsman representative Sheila Cornett. A new social worker was employed on 10-29-12. The social worker will also attend additional training on abuse at Hazard Community and Technical College on 3-14-13.</p> <p>All incident reports will be reviewed on occurrence by the social worker, DON/designee and administrator/designee for reporting compliance. Any problem will be referred to QA committee for input.</p> <p>Completion Date:</p>	3-8-13

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

Sheila Cornett

TITLE

Administrator

(X6) DATE

3-27-13

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.

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure allegations of abuse were reported to the appropriate state agencies for one of fifteen sampled residents (Resident #9) and one of seven unsampled residents (Resident #E). Resident #9 had an allegation of verbal abuse; the facility was made aware and investigated but did not notify the proper state agencies. Resident E had an injury of unknown origin; the facility was aware and investigated the incident but did not report the incident to the appropriate state agencies. The findings include: A review of the abuse policy (undated) revealed all alleged incidents involving mistreatment, neglect, or abuse, including injuries of unknown origin and misappropriation of residents' property would be reported immediately to the facility administrator/designee. The state agencies would be notified immediately by the facility administrator or his/her designee. Review of the facility's investigations revealed an allegation of verbal abuse had been made on 07/26/12 that involved Resident #9 and a CNA employed by the facility. Although the facility	F 225		

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F 225	<p>Continued From page 2</p> <p>conducted a thorough investigation of the allegation, the facility failed to notify the appropriate state agencies as required.</p> <p>Further review of the facility's investigations revealed on 04/05/12 it was reported that Resident E had an injury of unknown origin. Continued review of the incident report revealed the facility conducted an investigation of the injury; however, the facility failed to ensure the injury of unknown injury was immediately reported to the appropriate state agencies.</p> <p>An interview with the facility's Social Worker on 02/14/13 at 11:30 AM revealed when the facility became aware of an allegation of abuse, the Administrator or his designee was notified. The Social Worker acknowledged the incidents should have been reported to the appropriate state agencies as required. However, according to the Social Worker, she was not employed by the facility on 04/04/12 or 07/26/12 when the allegations of abuse/injury of unknown origin to Resident #9 and Resident E had occurred.</p> <p>Interview with the Administrator on 02/14/13 at 1:30 PM revealed he had been made aware of the allegations related to Resident #9 and Resident E. The Administrator said the facility looked at every incident/allegation on an individual basis, and the Social Worker or the Administrator would notify the appropriate state agencies. The Administrator acknowledged the facility had failed to ensure the allegation of verbal abuse related to Resident #9 and the injury of unknown origin for Resident E were reported to the appropriate state agencies.</p>	F 225	
F 253	483.15(h)(2) HOUSEKEEPING &	F 253	

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(X4) ID PREFIX TAG F 253 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 253	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 3-8-13
	<p>Continued From page 3 MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's policies, it was determined the facility failed to provide effective maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Two toilets were observed to be loose in the "Team 2" women's hallway bathroom. In addition, the framework of a heater in the women's bathroom was observed to be broken and the heater was slightly pulled away from the wall with no exposed wires.</p> <p>The findings include: A review of the facility's "Maintenance Policy," undated, revealed the Maintenance Department was responsible to provide regular and preventive maintenance. The policy revealed a log would be kept at each nursing station for staff to note areas in need of repair. According to the policy, maintenance staff would be responsible to check the log each morning and provide the repairs which were needed.</p> <p>Observation on 02/12/13, at 12:40 PM, revealed the Team 2 women's hallway bathroom contained two toilets that were loose from the floor. A wall heater was also observed in the bathroom; however, the heater was slightly pulled away from the wall, with no wiring exposed, and the frame of</p>		<p>Floors anchor to secure both toilets in Team 2 women's hallway bathroom were installed on 2-15-13. The heater in this bathroom was also repaired on the same date.</p> <p>Any resident could be affected if the building is not maintained properly. All toilets and heaters were checked by maintenance on 2-15-13 and found to be in good repair.</p> <p>All staff will be in-serviced on 3-7-13, and 3-8-13 on the process for maintaining a sanitary, orderly and comfortable interior. Staff will continue to list any needed repairs on each nurses station with maintenance checking and correcting daily. (See attachment A.)</p> <p>Monitoring for compliance will be done by department heads and administrator during daily duties. Maintenance supervisor will do a monthly walk-through inspection and the administrator/designee will do one quarterly, QA committee will be notified should the need arise.</p> <p>Completion Date:</p>	

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F 253	Continued From page 4 the wall heater was broken. Resident G was observed to enter the Team 2 women's hallway bathroom at 2:35 PM on 02/12/13. An interview conducted with Resident G on 02/12/13, at 2:40 PM, revealed the resident used the hallway bathroom "every now and then." The resident also stated the toilet was a "little loose." An interview conducted with the Maintenance Supervisor on 02/14/13 at 10:50 AM, revealed he had not been aware the toilets were loose in the Team 2 women's hallway bathroom or that the heater was slightly loose from the wall and the frame broken. The Maintenance Supervisor stated he checked the repair logs at the nursing stations every morning and then again before leaving for the day. The Maintenance Supervisor stated he does a weekly preventive maintenance round, but he does not check the toilets unless someone has identified a problem with them. An interview conducted with the Administrator on 02/14/13, at 11:10 AM, revealed he had not been made aware of the loose toilets, or loose heater with the broken frame, in the Team 2 women's hallway bathroom. The Administrator revealed staff was required to document any issues in need of repair on the repair log and the Maintenance Department was required to check every day and provide the repairs.	F 253		
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.	F 281	Resident #'s 1 and 5, O ₂ settings were corrected immediately on 2-13-13 by nursing staff. The Don/nursing supervisor/ MDS staff	

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F 281	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for two of fifteen sampled residents (Residents #1 and #5). Residents #1 and #5 had physician's orders for oxygen to be administered at 4 liters per minute; however, observations conducted on 02/12/13 and 02/13/13 revealed facility staff failed to ensure the oxygen was administered as ordered by the physician. The findings include: A review of the facility policy related to following physician's orders (no date) revealed all nursing staff was responsible to follow the physician's orders as written. The policy further noted the nurse would be responsible to verify the implementation of the physician's orders prior to documentation. A review of the medical record revealed the facility admitted Resident #5 on 08/08/08 with diagnoses that included Non-Insulin Dependent Diabetes Mellitus, Congestive Heart Failure, Asphyxia, Advanced Alzheimer's, and Chronic Obstructive Pulmonary Disease. A review of the February 2013 physician's orders revealed the physician ordered oxygen to be administered at 4 liters per nasal cannula for Resident #5. Observations conducted on 02/12/13 at 2:30 PM, 3:20 PM, 4:15 PM, 5:40 PM, and 6:15 PM	F 281	audited 100% of all residents physicians orders by observing residents for compliance. This audit was completed on 2/ 18 /13, 2/ 19 /13 and 2/20/13. Every resident receiving O ₂ was assessed for correct setting on 2/15/13 by the DON/Nurse supervisor/MDS staff. No other residents was found to be affected. Floor nurses will check all assigned residents their shift for implementation of physician orders from information obtained from MARS/TARS. Nurse aides will check their assigned residents for C.N.A. Care plan compliance every two hours during rounds. In-service will be held on 3/7/2013 and 3/8/2013 by DON/Nurse Supervisor/ Designee on following Physician orders (see attachment B1 and B2.) Physician orders in 30% of all resident charts will be reviewed and resident observed for order compliance. This will be conducted monthly by DON/Nurse Supervisor/Designee/MDS Staff. QA committee will be consulted for input if needed. Completion Date:	3-8-13

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F 281	<p>Continued From page 6</p> <p>revealed Resident #5 was lying in bed and oxygen was being administered at 2 liters per nasal cannula. On 02/13/13 at 9:00 AM, the resident was observed to continue be receiving oxygen at 2 liters per nasal cannula.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #2 on 02/13/13, at 9:05 AM, revealed she was assigned to Resident #5 on 02/13/13. LPN #2 stated nurses were responsible to check the resident's oxygen setting at least one time during a shift and acknowledged she had not checked Resident #5's oxygen since reporting to work at 7:00 AM on 02/13/13. LPN #2 stated she did not know what the physician had prescribed for the oxygen setting for Resident #5.</p> <p>Interview conducted with LPN #3 on 02/13/13, at 9:10 AM, revealed she had been assigned to Resident #5 on 02/12/13. The LPN stated she had not checked the resident's oxygen setting to ensure the correct amount was administered to the resident.</p> <p>Interview with the Director of Nurses (DON) on 02/14/13, at 1:10 PM revealed the nurses were responsible to check the resident's oxygen setting at least once per shift prior to documenting on the resident's treatment administration record to ensure oxygen was administered as ordered by the physician.</p> <p>2. A review of the medical record for Resident #1 revealed the resident was admitted by the facility on 12/14/11 with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Congestive Heart Failure, and Coronary Artery</p>	F 281		

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F 281	<p>Continued From page 7</p> <p>Disease. The medical record revealed a physician's order dated 01/01/13, for oxygen therapy to be administered to the resident at 4 liters per minute by nasal cannula.</p> <p>Observation of Resident #1 on 02/12/13, at 2:30 PM, 3:30 PM, 4:30 PM, 5:15 PM, and 6:10 PM, revealed the resident was receiving oxygen therapy by nasal cannula at a rate of 4.5 liters per minute.</p> <p>An interview with Registered Nurse (RN) #1 on 02/13/13, at 2:40 PM, revealed she had been assigned and provided care to Resident #1 on the 7:00 AM to 7:00 PM shift on 02/12/13. The RN stated she was responsible for ensuring the residents received oxygen at the rate specified by the physician. The RN stated she made rounds on the residents every two hours and had failed to identify that the rate of oxygen administration for Resident #1 was incorrect until the end of her shift on 02/12/13.</p> <p>An interview with the DON on 02/14/13, at 12:40 PM, revealed he made rounds daily to ensure the residents were provided the care they require. The DON stated the nurses were responsible for monitoring the residents to ensure they receive appropriate care which included the provision of oxygen at the rate prescribed by the physician. In addition, according to the DON, staff was required to document the rate of oxygen administration for each resident on the Treatment Administration Record (TAR).</p>	F 281	
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility</p>	F 282	Resident #4 call light was corrected immediately on 2-14-13 and resident #13 hipsters were applied on 2-14-13.

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F 282	<p>Continued From page 8</p> <p>must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care plan interventions were implemented according to the resident's comprehensive care plan for two of fifteen sampled residents (Residents #4 and #13). Resident #4 had a care plan intervention to keep the resident's call light within reach and Resident #13 had interventions to have bilateral "hipsters" (pads to prevent injury to the hips as a result of falls) in place at all times. However, observations conducted during the survey on 02/12/13, 02/13/13, and 02/14/13 revealed the facility failed to implement the interventions as directed by the resident's plan of care.</p> <p>The findings include:</p> <p>A review of the facility Care Plan policy (no date) revealed facility staff was responsible to verify the care plan interventions were implemented or in place prior to documenting either on the back of the Certified Nursing Assistant (CNA) care plan, the Medication Administration Record (MAR), or the Treatment Administration Record (TAR).</p> <p>1. Review of the medical record revealed the facility admitted Resident #13 on 01/21/10 with diagnoses including Coronary Artery Disease, Senile Dementia, Parkinson's Disease, and</p>	F 282	<p>Any resident could be affected if services are not provided or arranged by a qualified person in accordance with resident care plan. A list of interventions compiled from physician orders was compared to resident for compliance by DON/NURSE Supervisor/MDS. An audit of all resident call lights and safety interventions were completed on 2-15-13 by DON and Supervisors and no other residents were found to be affected.</p> <p>Care plan interventions will be checked by CNA's when they do 2 hour resident rounds. Nurses will do checks during shift from TAR's to ensure compliance of all interventions. MDS workers will update care interventions quarterly and PRN. In-service on implementing care plan intervention was held on 3-7 and 3-8-2013 by DON/Nurse Supervisor. (See attachments B1 and B2.)</p> <p>10% of care plan interventions will be checked monthly by DON/Nurse Supervisor/designee by comparing physician orders to CNA care plan/TARs/MARs, to verify compliance with individual resident. QA committee will be notified if needed.</p> <p>Completion Date:</p>
			<p>(X5) COMPLETION DATE</p> <p>3-8-13</p>

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F 282	<p>Continued From page 9</p> <p>Osteoarthritis.</p> <p>Review of the quarterly assessment with a reference date of 12/30/12 revealed the facility assessed Resident #13 to require extensive assistance of staff for bed mobility, transfers, and toileting. The resident was also assessed to have experienced falls since the previous assessment on 10/01/12. Resident #13 was assessed to have a BIMS (Brief Interview for Mental Status) score of 3 and was not interviewable.</p> <p>Review of the comprehensive care plan revealed facility staff had reviewed the care plan on 12/30/12 and had identified Resident #13 to have a history of multiple falls. Care Plan interventions included to keep the resident's call light within reach at all times, to keep the resident's bed in the lowest position when care was not being provided, to keep mats at the bedside, and to apply "hipsters" at all times. A review of the February 2013 CNA care plan revealed "hipsters" were to be used at all times for Resident #5.</p> <p>Resident #13 was observed on 02/14/13, at 8:50 AM, to be lying in bed with bilateral fall mats in use. At 9:50 AM, the resident remained in the same position in bed and LPN #3 was asked to verify the use of hipsters. Observations revealed no hipsters were in place. The LPN also searched the resident's room but was unable to locate the hipsters.</p> <p>Interview conducted on 02/14/13, at 9:55 AM with Licensed Practical Nurse (LPN) #3 revealed CNAs were responsible to ensure the hipsters were in place at all times. LPN #3 stated the nurses were supposed to check on the residents</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>during their assigned shift to ensure the care plan interventions were implemented and acknowledged she had failed to ensure the "hipsters" were in place for Resident #13.</p> <p>Interview conducted with CNA #14 on 02/14/13, at 10:00 AM, revealed she was aware Resident #13 was at high risk for falls. CNA #14 stated the CNAs were responsible to follow the care plan interventions identified on the CNA care plan and to initial the back of the CNA care plan daily to indicate the interventions had been implemented during the CNA's assigned shift. CNA #14 stated she was aware the resident was to have the hipsters in place to protect the resident's hips during a possible fall; however, CNA #14 stated she "forgot" to apply the "hipsters" for Resident#13 on 02/14/13.</p> <p>An interview conducted on 02/14/13, at 1:10 PM, with the Director of Nursing (DON) confirmed CNAs were responsible to follow the CNA care plan interventions for each resident. The DON stated the nurses were responsible to monitor the residents each time they went into each resident's room to ensure care plan interventions were implemented consistently and in accordance with each resident's individual plan of care.</p> <p>2. A review of the comprehensive care plan dated 04/06/12 for Resident #4 revealed the resident required limited to total assistance with activities of daily living. Review of the comprehensive care plan interventions revealed the call light was to be within reach at all times. In addition, another intervention was to remind/encourage the resident to pull the call light when requiring assistance from staff.</p>	F 282	
(X5) COMPLETION DATE			

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

PRINTED: 03/19/2013
FORM APPROVED
OMB NO. 0938-0391

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 02/14/2013
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 282	<p>Continued From page 11</p> <p>Observations of Resident #4 on 02/12/13 at 2:25 PM, 3:35 PM, 4:25 PM, and 5:05 PM, revealed the resident was lying in bed with no call light observed to be within reach of the resident. Each time the surveyor observed Resident #4, the resident's call light was attached to a recliner in the corner of the resident's room out of reach of the resident.</p> <p>An interview was conducted with Certified Nursing Assistant (CNA) #16 at 6:20 PM on 02/12/13. The CNA stated she assisted Resident #4 out of bed and to the dining room for the evening meal. The CNA stated, "I thought" the call bell was within reach of Resident #4 at the time the CNA had gotten the resident out of bed. However, the CNA accompanied the surveyor to Resident #4's room, and the call light remained attached to the recliner. The CNA stated she thought the call light cord near Resident #4's bed was for the resident. However, the call light cord near Resident #4's bed was for the roommate's call light. The CNA stated she was not aware Resident #4's call light was attached to the recliner and out of reach of the resident.</p> <p>An interview was conducted with Registered Nurse (RN) #2 at 6:30 PM on 02/12/13. The RN stated she would expect the CNAs to check the call lights every two hours to assure call lights were within reach of the residents. RN #2 stated she was not aware the call light was out of Resident #4's reach for the extended time.</p> <p>Interview with the Director of Nursing (DON) at 11:05 AM on 02/14/13 revealed the nurses were responsible to monitor the residents each time</p>	F 282		

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

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FORM APPROVED
OMB NO. 0938-0391

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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	
(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 282	Continued From page 12 they went into the resident's room to ensure the care plan interventions were implemented according to the resident's plan of care. According to the DON, nurses were expected to assess each resident when they entered the room to provide care; however, the DON did not specify how often the nurses were to assess each resident.	F 282		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	Staff was in-serviced on 2-15-13 by Nursing supervisor on infection control related to linen storage and meal services. The floor of the linen room was cleansed on 2-14-13 and linen in contact with floor removed. Rounds were done by DON/Supervisor on 2-15-13 concerning infection control related to linen storage and meal delivery. No other compliance issues were identified. In-service on 3-7 and 3-8-13 on policy and procedure on serving meals and linen storage by DON/supervisor. (See attachments C1 and C2.) To maintain an effective Infection Control Program and to ensure compliance, the DON/Supervisor/Designee will visibly observe meal passes in the dining room and on the floor. Linen processing and storage areas will be visibly inspected for the same purpose. These compliance rounds will be done weekly with the use of environmental infection compliance forms (see attached.) Any other infection control issues during environmental rounds will be observed for	

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

PRINTED: 03/19/2013
FORM APPROVED
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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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F 441	Continued From page 13 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy it was determined the facility failed to maintain an effective infection control program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection. Observation of the clean linen storage area on the hallway of the "Team 2" nursing unit during the environmental tour on 02/12/13 revealed the floor was dirty and staff had placed clean linens directly on the floor. In addition, observation of the evening meal on 02/12/13 revealed staff touched the bread for three of seven unsampled residents (Residents B, C, and D) with their bare hands when they held the bread to apply condiments (butter) to the bread. The findings include: 1. A review of the facility's policy titled, "Clean Linen Storage," which contained no date, revealed clean linen would be delivered into the building by the facility Laundry Department from the laundry building and placed into the linen closets of the nursing units. The policy revealed once the linen was placed on the shelves clean	F 441	compliance. QA will be consulted if needed. Completion Date:	3-8-13	

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

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OMB NO. 0938-0391

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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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F 441	Continued From page 14 sheets would be draped over the clean linen on the shelves. The policy also revealed Certified Nursing Assistants (CNAs) were responsible for the organization of linens. Observation of the clean linen storage area on the hallway of "Team 2" on 02/14/13, at 10:10 AM, revealed dirt/debris on the floor. In addition, a clean bed sheet which had been placed over a shelf of linen was observed to be in contact with the soiled floor and three clean blankets were observed on the dirty floor. An interview conducted with Laundry Worker #1 on 02/14/13 at 10:40 AM revealed she was responsible for delivering linen to the nursing units, and to ensure the linens were placed on the shelves of the clean linen storage room and covered with a clean bed sheet. The Laundry Worker stated she had not observed the clean blankets on the floor of the clean linen room that morning nor had she observed the floor of the clean linen room to be soiled with dirt/debris. An interview conducted with Housekeeper #2 on 02/14/13, at 12:30 PM, revealed she was responsible for mopping the floor in the linen room but had not checked the linen room for several days. The housekeeper stated she had not been told to check the linen room every day and was unsure of the date she had last checked the linen room. The housekeeper stated she had not been aware of the dirt on the floor. An interview conducted with Certified Nursing Assistant (CNA) #10 on 02/14/13, at 12:55 PM, revealed she was responsible for ensuring the linen room was maintained during her shift. The	F 441		

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

PRINTED: 03/19/2013
FORM APPROVED
OMB NO 0938-0391

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F 441	<p>Continued From page 15</p> <p>CNA stated the linen was supposed to be covered with the sheet, and the sheet should not have come into contact with the floor. The CNA also stated the clean blankets should not have been on the floor. The CNA stated she was required to notify Housekeeping to mop the floor any time she observed the floor dirty/soiled but was not aware the floor was dirty/soiled.</p> <p>An interview conducted with the Administrator on 02/14/13, at 11:10 AM, revealed the facility did not currently have a Housekeeping Supervisor and he was currently supervising the housekeeping staff to ensure cleaning was being done until the facility could replace the previous supervisor. The Administrator stated linen should not have been on the floor and housekeeping staff was required to mop the floor in the linen room every day. The Administrator stated he had not been aware the housekeeper had not been mopping the linen room every day.</p> <p>2. Review of the facility policy entitled "Meal Tray Pass" (undated) revealed the policy did not include directions to staff related to handling residents' food when passing meal trays. However, a review of the Food and Drug Administration's (FDA's) 2009 Food Code in the employee health and personal hygiene handbook states, "Handwashing alone might not always successfully remove pathogens from heavily contaminated hands, and infected food employees may not always be identified and removed from food preparation activities." "No Bare Hand Contact" is the practice of preventing direct contact with bare hands while handling RTE (ready to eat) foods. This practice provides a secondary protection against the contamination</p>	F 441		

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

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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	
(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 441	<p>Continued From page 16</p> <p>of foods that do not require further cooking with microbial pathogens from the hands of ill food employees."</p> <p>Observation of the evening meal in the dining room on 02/12/13 at 5:30 PM revealed CNA #5 obtained a slice of wheat bread from a wax paper bag with her bare hands and placed the bread on Resident B's meal tray. However, Resident B refused the wheat bread that had been handled by the employee's bare hands and requested a slice of white bread.</p> <p>Interview with Resident B on 02/12/13 at 5:30 PM revealed although the resident did not like staff to touch his/her bread, the resident was hungry and ate the bread.</p> <p>At 5:33 PM, CNA #5 proceeded to obtain a corn bread muffin from a wax paper bag with her bare hands, removed the paper liner from the muffin, touched the muffin with her bare hands, and then placed the muffin on Resident C's meal tray.</p> <p>An attempt to interview Resident C on 02/12/13, at 5:35 PM was unsuccessful related to the resident's cognitive status.</p> <p>Continued observation during the evening meal on 02/12/13 revealed CNA #5 delivered Resident D's meal tray to the resident at 5:35 PM and arranged the food items on the tray. CNA #5 was again observed to take a corn bread muffin from a wax paper bag with her bare hands, remove the paper liner from the muffin, and apply butter to the muffin. CNA #5 was observed to serve the muffin to Resident D.</p>	F 441	

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

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FORM APPROVED
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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	
(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 441	Continued From page 17 Interview with Resident D on 02/12/13 at 5:35 PM revealed the resident did not like staff to touch the bread with bare hands. CNA #5 acknowledged in an interview conducted on 02/12/13 at 5:40 PM that she "did use my hands, I know I'm not supposed to, but I use my bare hands for the bread." The CNA stated she had been trained not to touch food with her bare hands but could not remember when the last training had been and stated, "It has been a long time since we were trained." CNA #5 said, "I should have used a utensil or the wax paper to handle the bread instead of my bare hands." Interview with the Registered Dietitian (RD) on 02/12/13 at 6:00 PM revealed the Nursing Department was responsible for making sure CNAs were trained. The RD said she observed meal passes once a month in the kitchen area and the Dietary Manager observed meal services in the kitchen area as well. The RD stated she thought it was acceptable for the staff to touch food in the dining room with their bare hands if the staff used hand sanitizer before and after handling the food. An interview conducted with the Director of Nursing (DON) on 02/14/13, at 12:40 PM, revealed he had not been aware staff could not touch food with their bare hands and had thought as long as staff was using handwashing or hand sanitizer prior to touching food that it would be acceptable.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The	F 502	A vitamin D level was obtained on 2-3-13 for resident #5 and M.D. notified of results being within normal limits.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

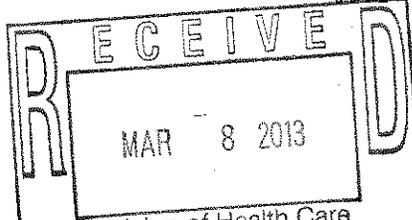
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41338	
(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 502	Continued From page 18 facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policy, the facility failed to ensure laboratory services were provided for one of fifteen sampled residents (Resident #5). Resident #5 had a physician's order dated 09/14/12 for a Vitamin D level to be obtained in three months (December 2012). However, a review of documentation conducted on 02/14/12, revealed the laboratory test had not been obtained in December 2012. The findings include: Review of the facility Laboratory policy/procedure (no date) revealed physician's orders would be followed for obtaining laboratory tests. A review of the medical record revealed the facility admitted Resident #5 on 08/08/08, with diagnoses of Non-Insulin Dependent Diabetes Mellitus, Congestive Heart Failure, Paralysis Agitans, Parkinson's Disease, and Anemia. Review of the physician's orders revealed on 09/14/12 the physician requested facility staff to administer 50,000 units of Vitamin D-3 to Resident #5 on a weekly basis and to obtain a Serum Vitamin D level in three months (December 2012). However, a review of the laboratory tests revealed no evidence the Serum Vitamin D level had been obtained in December	F 502	A lab audit was completed by DON and Supervisors on 100% of the residents on 2-15-13 and no other resident was found to be affected. The facility's policy was updated for obtaining non-routine labs (see attached). This will include placing new orders for non-routine labs on the lab card and lab calendar at the time the order is received. Nursing in-service will be held on 3-7 and 3-8 by DON/Supervisor to ensure compliance. (See attachment D.) The DON/Supervisor/designee will check lab orders at the end of the month while scheduling routine labs on the calendar for the next month. QA committee will be consulted as needed. Completion Date:	3-8-13

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

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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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F 502	<p>Continued From page 19</p> <p>2012 as ordered. Continued review of the medical record revealed the physician continued to prescribe 50,000 units of Vitamin D-3 on a weekly basis for Resident #5 in January 2013.</p> <p>Interview conducted with Registered Nurse (RN) #2 on 02/13/13, at 3:30 PM, revealed laboratory tests requested by the physician were written on a "lab card" at the time of the request and the day shift nursing staff was responsible to ensure the lab requests were written on the "lab calendar." In addition, the interview revealed the night shift nurse was responsible to review the "lab calendar" and complete the lab request forms. The RN stated the night shift nurse was also responsible to obtain the blood specimens for the lab tests. RN #2 acknowledged the laboratory test for Resident #5's Vitamin D level had not been added to the December calendar and was not obtained as ordered by the physician for Resident #5.</p> <p>Interview with the Director of Nursing (DON) on 02/14/13, at 1:10 PM, revealed nursing staff was responsible to check the residents' charts on a monthly basis to ensure the residents' lab tests had been obtained as ordered by the physician. The DON stated no concerns had been identified during the chart reviews.</p>	F 502		



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

Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X2) SURVEY TYPE / COMPLIANT 02112013
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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41338
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 5413.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (000)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II, natural gas generator.</p> <p>A life safety code survey was initiated and concluded on 02/12/13. 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.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p>This plan of correction constitutes my written allegation of compliance for the deficiencies 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 by state and federal laws.</p>	
K 144 SS-F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised</p>	K 144	<p>No resident was identified as being affected by the failure to do the monthly generator</p>	

LABORATORY DIRECTOR'S OR FACILITY OR SUPPLIER REPRESENTATIVE'S SIGNATURE: *Phillip J. Fernald* TITLE: *Administrator* (X6) DATE: *3-8-13*

Any deficiency statement ending with an asterisk (*) denotes a deficiency when 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 60 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

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 430 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)	OR COMPLETION DATE	
K 144	<p>Continued From page 1</p> <p>under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 120 beds with a census of 70 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 02/12/13 at 1:30 PM, an interview and record review with the Director of Maintenance (DOM) revealed the generator transfer switch had not been manually tested on a monthly basis. This testing helps ensure the transfer switch is operating as intended.</p> <p>The DOM stated he was not aware that he should be manually testing the generator transfer switch on a monthly basis as required.</p> <p>The findings were reviewed to the Administrator upon exit.</p>	K 144	<p>Manual transfer switch test. On 2-15-13 maintenance supervisor performed manual test and switch worked properly.</p> <p>Any resident could be affected should the generator fail due to required test not being performed by maintenance personnel.</p> <p>Maintenance supervisor was in-serviced on NFPA 110 (6-4.5) on 2-15-13 by the Administrator. Also a copy of the regulation was given to supervisor for future reference. A monthly generator maintenance check list has been implemented to ensure compliance. (See attachment E1 and E2.)</p> <p>Administrator/designee will monitor generator inspection reports monthly for 3 months and then quarterly if compliance is met. The QA committee will be advised of any compliance problems.</p> <p>Completion Date:</p>	2-15-13	

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

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FORM APPROVED
CMS NO. 0536-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURSET COMPLETE 02/12/2013
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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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(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 144	Continued From page 2 Reference: NFPA 110 (1999 Edition). 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		

NFPA 99, 1999 Edition

3-4.1.1.15 Alarm Annunciator. A remote annunciator, storage battery-powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12). The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:

- (a) Individual visual signals shall indicate the following:
 - 1. When the emergency or auxiliary power source is operating to supply power to load
 - 2. When the battery charger is malfunctioning
- (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:
 - 1. Low lubricating oil pressure
 - 2. Low water temperature (below those required in 3-4.1.1.9)
 - 3. Excessive water temperature
 - 4. Low fuel — when the main fuel storage tank contains less than a 3-hour operating supply
 - 5. Overcrank (failed to start)
 - 6. Overspeed

Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [10: 3-5.5.2]

E 1

Many standby power users are switching over to conductance and/or impedance testers. The way they function is fairly simple, most of the units send a small ac signal thru the battery and measure the return signal for the conductance of the battery or the resistance that the signal encountered. This test has a high 80's/low 90's percentile of accuracy in the automotive field. The accuracy in a standby system can vary greatly. I would like to point out the pros and cons of both the hydrometer test and the conductance/impedance testers. In looking at the JCAHO 2.10.4 code that you mentioned as well as the JCAHO EC.1.7 it would appear that a good deal of the maintenance decisions are left up to individual interpretation.

The hydrometer test (specific gravity) remains one of the best battery tests to date. The test is very simple; it takes a weight measurement of the electrolyte to see what percentage of acid is in the water. Since the acid quantity is a constant value (unless the battery is spilled, overfilled or overcharged) you can look at a hydrometer test result in two ways. When charging a battery you can use the test to determine when a battery has reached a full state of charge. In the case of standby application you can draw a correlation between a loss in acid from the electrolyte and a loss of capacity. In a float application a reading below a 100% state of charge would indicate a charging problem or more commonly a loss of capacity (acid that was in paste material that has shed or hardened). I will be happy to forward materials concerning hydrometer testing to you for a better explanation. A hydrometer may not reflect overheat/overcharge conditions and a hydrometer cannot show a weak connection inside a cell that can pass the float current, but will fail when put under a load.

Use of the proper conductance tester for standby applications should include a system for repeated monitoring of the system (monthly or quarterly). A single test result by itself is of little value. The conductance tester in this type of system should be used to compare data over a period of time. Typically you would check the conductance values of a set of batteries at the time of installation. You would then do follow up tests on a regular interval and look for abnormalities. When a single battery falls below 70% capacity of the rest of the battery group, it is a sign that the battery is failing or when the entire group can only function at 70% of the original capacity, it would be time to change out that group of batteries. When a load tester creates heat or smoke at a connection we know that the connection is weak or we have not connected the tester adequately, you will not have these warning signs with a conductance/impedance tester. In noisy UPS systems some of the conductance/impedance testers do not function well and your results can be all over the board (lack of repeatability). Most of the UPS conductance/impedance testers on the market do not load the circuit, so they may also fail to find a weak connection in a battery (a weak weld or strap).

Many critical standby power systems for the government require a routine capacity test. The capacity test reading can give you a very high accuracy rate on how long the battery(s) will function under a given load. The problem is that for most businesses, this is cost prohibitive. Even with the addition of a conductance/impedance test in lieu of a capacity test, I would still periodically check the specific gravity readings of the batteries. It adds little extra time to the water level check that you would continue to do anyway.

Jim Powell
 Technical trainer
 Interstate Batteries

Reference: NFPA 99 1999 edition

Type 2 Generator set

3-4.4.1 Maintenance and Testing of Essential Electrical System.

3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.

a. Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.

b. Inspection and Testing.

1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.

2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.

3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.

Reference: NFPA 110 1999 edition

6-1 General.

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.

6-1.2

Consideration shall be given to temporarily providing a portable or alternate source whenever the emergency generator is out of service.

6-2* Manuals, Special Tools, and Spare Parts.

6-2.1

At least two sets of instruction manuals for all major components of the EPSS shall be supplied by the manufacturer(s) of the EPSS and shall contain the following:

- a. A detailed explanation of the operation of the system
- b. Instructions for routine maintenance
- c. Detailed instructions for repair of the EPS and other major components of the EPSS
- d. An illustrated parts list and part numbers
- e. Illustrated and schematic drawings of electrical wiring systems, including operating and safety devices, control panels, instrumentation, and annunciators

6-2.2

For Level 1 systems, one set of instruction manuals shall be kept in a secure, convenient location near the equipment. The other set shall be kept in a different secure location.

6-2.3

Special tools and testing devices required for routine maintenance shall be available for use when needed.

6-2.4

Replacement for parts identified by experience as high mortality items shall be maintained in a secure location(s) on the premises. Consideration shall be given to stocking spare parts as recommended by the manufacturer.

6-3 Maintenance and Operational Testing.

6-3.1*

The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class.

6-3.2

A routine maintenance and operational testing program shall be initiated immediately after the EPSS has passed acceptance tests or after completion of repairs that impact the operational reliability of the system.

6-3.3

A written schedule for routine maintenance and operational testing of the EPSS shall be established.

6-3.4

A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following:

- a. The date of the maintenance report
- b. Identification of the servicing personnel
- c. Notation of any unsatisfactory condition and the corrective action taken, including parts replaced
- d. Testing of any repair for the appropriate time as recommended by the manufacturer

6-3.5*

Transfer switches shall be subjected to a maintenance program including connections, inspection or testing for evidence of overheating and excessive contact erosion, removal of dust and dirt, and replacement of contacts when required.

6-3.6*

Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects.

6-4 Operational Inspection and Testing.

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.

Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.

6-4.2*

Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:

- a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating
- b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer

The date and time of day for required testing shall be decided by the owner, based on facility operations.

6-4.2.1

Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source.

6-4.2.2

Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.

6-4.3

Load tests of generator sets shall include complete cold starts.

6-4.4

Time delays shall be set as follows:

- a. Time delay on start: 1 second minimum
Exception: Gas turbine cycle: 0.5 second minimum.
- b. Time delay on transfer to emergency: no minimum required
- c. Time delay on restoration to normal: 5 minutes minimum (see A-4-2.4.7)
- d. Time delay on shutdown: 5 minutes minimum

6-4.5

Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.

6-4.6*

EPSS circuit breakers for Level 1 system usage, including main and feed breakers between the EPS and the transfer switch load terminals, shall be exercised annually with the EPS in the off position.

Exception: Medium- and high-voltage circuit breakers for Level 1 system usage shall be exercised every 6 months and tested under simulated overload conditions every 2 years.

6-4.7

The routine maintenance and operational testing program shall be overseen by a properly instructed individual.

Generator Maintenance Checklist (Monthly)

Monthly Checklist	Date <u>2-15-13</u>
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- Clean and check battery and connections 2-15-13
- Check for proper belt alignment and tensions 2-15-13
- Check hoses and clamps 2-15-13
- Check fluid levels 2-15-13
- Check battery charger for proper operation 2-15-13
- Check no load voltage 2-15-13
- Check automatic transfer switch for proper orientation under a simulated power failure by manually operating switch 2-15-13
- Clean automatic transfer switch cabinet 2-15-13

Checked by
Dwight Smith

Generator Maintenance Checklist (Monthly)

Monthly Checklist	Date <u>2-15-13</u>
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- Clean and check battery and connections 2-15-13
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- Check fluid levels 2-15-13
- Check battery charger for proper operation 2-15-13
- Check no load voltage 2-15-13
- Check automatic transfer switch for proper orientation under a simulated power failure by manually operating switch 2-15-13
- Clean automatic transfer switch cabinet 2-15-13

Checked by Wendell Smith

E 2

Nim Henson Geriatric Center

Guidelines for Generator Maintenance

In-service by Administrator Phillip Litteral 2-15-13.

Signature *Wendell Smith*