

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

PRINTED: 06/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2014
NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 06/10/14 and concluded on 06/12/14. Deficiencies were cited with the highest scope and severity cited at an "F".	F 000	Please see attached.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of the facility's policy, it was determined the facility failed to ensure care was provided in a manner to maintain each resident's dignity for one (1) out of ten (10) sampled residents (Resident #9), and two (2) of five (5) Unsampled Residents (Unsampled Residents A and B). Observations of meal service on 06/10/12, revealed Resident #9 and Unsampled Resident B were assisted with meals while staff stood over them while feeding them. Further observation revealed staff wiped Unsampled Resident A's mouth with his/her protective covering, omitting the napkin that was on the resident's tray. In addition, observation of Unsampled Resident A revealed staff "force fed" the resident. Staff was also observed to "call out" to another staff member to obtain a "bib" for Resident #9, instead of a protective covering. Further observation revealed the facility failed to move Resident #9's shadow box (picture box) to his/her room when	F 241		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: LNH/CEO DATE: 7/2/2014

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 241	Continued From page 1 the resident was relocated to a different room. The findings include: Review of the facility's policy, titled "Resident Rights Policy, F151", revised June 2008, revealed the facility protected and promoted the rights of each resident admitted in order to provide a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. The facility would protect and promote the rights of each resident. Review of the facility's policy, titled "Feeding Residents", developed June 2005 and reviewed June 2008, revealed the facility would provide assistance or total feeding for residents who needed assist with nutrition. Staff assigned to assist with feeding the residents would be State Registered Nursing Assistants, licensed nurses, licensed therapists, or other team member trained to assist with meals. Residents would be offered clothing protectors prior to each meal. 1. Record review revealed Resident #9 was admitted by the facility, on 02/17/14, with diagnoses which included Alzheimer's and Advance Dementia. Further record review revealed the facility assessed Resident #9 for cognition on 06/02/14 and the resident was determined to be severely impaired. Observation, on 06/10/14 at approximately 6:12 PM, revealed Licensed Practical Nurse (LPN) #2 yelled out to staff to request a "bib" for Resident #9. Further observation revealed LPN #2 was observed standing over the resident to assist with feeding the resident.	F 241			

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F 241	Continued From page 2 Interview with LPN #2, on 06/10/14 at 6:54 PM, revealed staff should sit down on a stool to assist residents with their meals. She stated she was taught to get eye level with the resident. Continued interview with LPN #2 revealed she should have sat down to assist Resident #9 with feeding. LPN #2 further revealed clothing protectors should not be called "bibs" and this was a dignity issue. She stated she should not have called the clothing protector a "bib". Interview with CNA #2, on 06/10/14 at 6:40 PM, revealed staff should not call the clothing protector a "bib". 2. Observation of Resident #9 (located in room 252), on 06/11/14 at 5:28 PM, revealed Resident #9 was sitting outside of his/her room, seated in a wheelchair, holding his/her teddy bear in his/her hand. Upon leaving the resident's room, to exit the facility, observation revealed Resident #9's shadow box was observed to be posted outside of Resident #4's room (located in room 245). Interview with CNA #7, on 06/12/14 at 10:17 AM, revealed the residents' shadow boxes provided a history of the residents' life. It showed who the residents were and what they did. She added the shadow boxes were also used to help residents remember their rooms, especially those who were confused. Continued interview revealed Resident #9 was moved out of the room he/she shared with Resident #4, due to a disagreement that occurred approximately three (3) weeks ago. Interview with CNA #6, on 06/12/14 at 9:57 AM, revealed the Shadow Boxes outside of the residents' rooms displayed a glimpse of the	F 241			

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F 241	Continued From page 3 residents' past life, before coming to the facility. She reported that if a resident had a dementia diagnoses, it would assist with helping the resident to remember what room he/she belonged to. She reported the shadow boxes should not be displayed in front of another resident's room because the residents should be able to recognize their room from that of another resident. She reported that in regards to Resident #9, she would have thought his/her shadow box would have followed him/her to his/her new room. Interview with CNA #7, on 06/12/14 at 10:17 AM, revealed Resident #9's pictures should have followed Resident #9 so he/she could identify his/her new room. CNA #7 stated she believed this would be a dignity issue because Resident #9 did not have a sense of identity for determining his/her room. Interview with the Director of Social Service (DSS), on 06/12/14 at 10:33 AM, revealed the shadow boxes provided a glimpse of the residents' personality. She reported it assisted residents in reminiscing about their past. Continued interview with the DSS revealed that when a resident changed rooms, staff should move the pictures of the resident to the resident's new room. She revealed the shadow box should have followed the resident to his/her new room as this would be a dignity issue. Interview with the Activities Director, on 06/12/14 at approximately 1:15 PM, revealed the shadow boxes were set up to assist residents with dementia. She reported that the shadow boxes sometimes assisted visitors with facilitating conversation when talking to the residents.	F 241		
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F 241	<p>Continued From page 4</p> <p>Continued interview with the Activities Director revealed the shadow box should have been moved with Resident #9 to his/her new room.</p> <p>Interview with the Director of Nursing Services (DON), on 06/12/14 at 2:35 PM, revealed the shadow boxes were used to show the residents as a "whole" person. She stated many of the families would place pictures of the residents in the boxes and noticed the boxes gave the residents a sense of "pride". Further interview revealed Resident #9 was moved from Resident #4's room, temporarily, until a more permanent placement could be located. The DON stated the shadow box should have been moved when Resident #9 was moved out of his/her room.</p> <p>3. Record review for Unsampled Resident B, revealed the resident was admitted by the facility on 05/22/12 with diagnoses which included Dementia with Psychosis Behavior and Depression. Further record review revealed Unsampled Resident B was last assessed on the Quarterly Minimum Data Set (MDS), dated 04/18/14, to have scored a three (3) regarding cognitive skills for daily decision making. This indicated the resident was severely impaired and never/rarely made decisions.</p> <p>Observation, on 06/10/14 at 6:05 PM, revealed CNA #2, stood over Unsampled Resident B to assist him/her with his/her meal.</p> <p>Interview with CNA #2, on 06/10/14 at 6:40 PM, revealed staff should be "eye level" to the resident while assisting with meals. She reported staff should not stand while assisting residents with their meals and this would be a dignity</p>	F 241			

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F 241 Continued From page 5
concern. She further stated she should have
been seated while assisting Unsampld Resident
B with his/her meal.

F 241

Interview with the Director of Nursing Services
(DON), on 06/12/14 at 2:35 PM, revealed it would
be her expectation that staff would sit next to the
resident while assisting him/her with feeding.
She reported staff was to converse with the
residents as if they were at a family meal. She
stated this was important due to respect and
dignity of the resident.

4. Record review revealed Unsampld Resident
A was admitted to the facility on 10/05/07 with a
diagnosis of Cardio Vascular Accident (CVA) with
aphasia. Observation at the evening meal on
06/10/14 at 5:55 PM in the dining room, revealed
LPN #1 was feeding Unsampld Resident A a
pureed diet. LPN #1 took Unsampld Resident
A's clothing protector and wiped Unsampld
Resident A's mouth. Further observation of the
table revealed a napkin was beside the resident's
plate.

Continued observation, on 06/10/14 at 6:00 PM,
revealed LPN #1 was force-feeding the resident.
Unsampld Resident A turned his/her head to the
side and closed his/her mouth. LPN #1 continued
to put the spoon to Unsampld Resident A's
mouth after he/she would close his/her mouth
and turn his/her head. This was observed
several times during the course of the meal.

On 06/10/14 at 6:40 PM, an interviews was
conducted with LPN #1. She revealed she would
wipe a resident's mouth with a napkin, only when
there was not a lot of food on his/her face. She
stated napkins got messy quick. She stated she

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F 241	Continued From page 6 would tell a staff member to use a napkin instead of the clothing protector because it could embarrass the resident especially with other residents sharing his/her table. She stated it would be a dignity issue for the resident. Continue interview with LPN #1 revealed Unsampld Resident A usually did not eat supper. He/she liked to take bird bites and was not verbal; it was hard to know when he/she did not want to eat. She stated she did not see Unsampld Resident A turn his/her head, but did see him/her close his/her mouth several times. She said it would be appropriate to watch for signs the resident did not wish to finish his/her meal. On 06/10/14 at 6:50 PM, interview with the DON revealed she did not approve of staff using residents' clothing protectors to wipe the residents' mouths. She stated staff was supposed to use napkins and they were available. She said if that napkin got soiled staff members were to get another napkin. She further stated she did not expect a staff member to force-feed a resident, they were to look for cues, if the resident was non-verbal. She expected staff to respond to residents' needs and this was definitely a dignity issue for the resident.	F 241			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the residents' environment was free from accidental hazards by not placing a "caution/safety" sign over a soiled area on the floor after the floor was mopped. The findings include: Review of the facility's policy titled, "Policies and Procedures, Cleaning Patient Rooms", revised 02/01/11, revealed the purpose of the Environmental Service Department was to implement the Quality Assurance program as approved by the Facility's Board, Administration and its Medical Staff. Further review of the policy revealed the procedure (under section 9) for cleaning the floor involved placing a wet floor sign at the entrance. Observation, on 06/10/14 at approximately 1:35 PM, revealed the floor was soiled in the residents' dining room, located to the far end of the dining room, adjacent to the residents' scale. Interview with Certified Nursing Assistant (CNA) #5, on 06/10/14 at 1:40 PM, revealed the floor was just mopped by Environmental Service Worker #5. She reported a yellow "caution" sign should have been placed over the soiled spot for the safety of the residents. She stated a resident could have fallen and injured himself/herself. Interview with Environmental Service Worker #5, on 06/10/14 at approximately 1:45 PM, revealed she had mopped the floor after a resident had	F 323			

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F 323	Continued From page 8 urinated on the floor after being weighed. She reported she thought she had placed a sign at the front entrance of the door. She stated it was important to place a sign so that no one slipped and fell. Continued interview with Environmental Service Worker #5 revealed she should have placed the sign up near the soiled area of the floor to prevent any falls or injuries. Interview with the Maintenance Director, on 06/11/14 at 3:00 PM, revealed the Environmental Service Department was cautious of the floor being wet because residents could injure themselves if they slipped on the floor. He stated it would be his expectation that the caution sign would be placed on the floor after being mopped and/or placed back in position if moved by a staff member. Interview with the Environmental Service Coordinator, on 06/12/14 at 1:55 PM, revealed she stressed to staff the importance of placing the safety sign on the floor when the floor was wet. She reported she also stressed to staff to pick the safety sign back up when the floor was dry because this too increased the safety concern. She reported placing the safety sign on the floor when the floor was wet and picking it up when it was dry was very important because someone could fall, trip over the sign, or slip. She revealed this was important because someone could hurt themselves.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

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F 371	Continued From page 10 Assignments", not dated revealed all staff have responsibility to observe and record the walk-in and refrigerator temperatures. AM and PM Dietary Aides monitor and record the old walk-in and new walk-in temperatures and AM and PM Cooks monitor and record the reach in refrigerators temperatures. The policy stated the acceptable temperature range for the refrigerators 40 degrees Fahrenheit or below and if the temperatures were not within range staff must notify the person in charge or maintenance. Observation, on 06/10/14 at 4:45 PM, of the kitchen during the evening meal service revealed review of refrigerator temperature log dated June 2014, temperatures were not recorded for June 3rd, 4th, 5th, 6th, 7th and 8th. Refrigerator temperatures recorded for June 1st, 2nd, 9th and 10th were 40 degrees Fahrenheit or below. Interview, on 06/11/14 at 9:27 AM, with Dietary Aide #2 revealed she looked at and recorded the temperatures for the dishwasher only. She further revealed she did notice the temperatures for the refrigerator and did not record the temperatures. Dietary Aide #2 stated the refrigerator temperature should be 32 degrees Fahrenheit. Interview, on 06/11/14 at 11:10 AM, Dietary Aide/Cook #1 revealed it was the responsibility of the cook to check the equipment temperatures and record the temperatures. If the temperatures were not within normal limits they should contact the Dietary Manager, House Supervisor and Maintenance. Dietary Aide/Cook #2 stated refrigerator temperatures should be 42 degrees Fahrenheit. Interview, on 06/11/14 at 9:40 AM, with the	F 371		

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F 371	Continued From page 11 Dietary Manager revealed the responsibility for monitoring equipment temperatures was hers. She further revealed she did not check the temperature log weekly. She stated the danger of not recording refrigerator temperatures was bacteria growth, spoiled food and making residents sick. The dietary aides and cooks on each shift had the responsibility to check and record the temperatures of the refrigerators. She further revealed she did not know why the refrigerator temperatures were not recorded, possibly due to shortage of staff and training of new employees. In addition, she stated if the temperatures were not in range staff should notify the Dietary Manager and maintenance.	F 371		
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined the facility failed to ensure there was adequate spacing in the dining room to accommodate residents during dining. Observation revealed staff displayed difficulty passing out trays to residents and bumped into Unsampled Resident D, pushing his/her abdomen against the table. Subsequently, residents who ate in the dining room expressed	F 464		

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F 464	<p>Continued From page 12</p> <p>some concern about the spacing in the dining area during the group interview.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 06/11/14 at 3:00 PM, revealed there was no policy related to dining room spacing/accomodation for residents.</p> <p>Record review of Unsampled Resident C revealed the resident was admitted by the facility on 01/27/14 with diagnoses which included Cerebral Palsey, Parkinson's, Paralysis, Functional Decline, and Arthritis. Review of the resident's Quarterly Minimum Data Set (MDS), dated 04/28/14, revealed the resident had a Brief Interview of Mental Status Score (BIMS) of fifteen (15), which indicated the resident was cognitively intact.</p> <p>Record review of Unsampled Resident D revealed the resident was admitted by the facility on 08/15/12 with diagnoses which included Alzheimer's, Psychosis, Depression, and Atherosclerosis. Review of residents Quarterly MDS, dated 04/22/14, revealed resident had a BIMS of zero (00), which was indicative of severe impairment.</p> <p>Review of Unsampled Resident E's record revealed the resident was admitted by the facility on 01/22/14 with diagnoses which included Depression and Anxiety. Review of the residents Quarterly MDS, dated 04/28/14, revealed the resident had a BIMS score of eleven (11), which indicated the resident was cognitively intact.</p> <p>Observation, on 06//10/14 at 12:30 PM, revealed</p>	F 464			

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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330		
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F 464	<p>Continued From page 13</p> <p>Licensed Practical Nurse (LPN) #2 was observed during meal service having difficulty passing out the residents trays. LPN #2 was observed to walk between two (2) feeder tables with residents seated in wheelchairs at the table. As she moved to give a resident his/her tray, she bumped into Unsampld Resident D, who was seated in a Gerichair. His/Her abdomen was observed to be pushed against the dining table. At that moment, Unsampld Resident D expressed discomfort by screaming out profanity.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/10/14 at 6:54 PM, revealed there was a crowding concern in the dining area. She stated it was difficult to set-up trays for the residents with the wheelchairs and Gerichairs taking up a lot of the space in the dining room. She reported the safety concern would be if there was a fire or tornado it would be difficult to get the residents out. Continued interview with LPN #2 revealed she accidentally bumped into Unsampld Resident D and he/she used profanity when anyone bumped into him/her. She admitted her bumping into the resident was because of a crowding issue.</p> <p>Group interview with Unsampld Residents C and E, on 06/10/14 at 3:07 PM, revealed the dining room was too small for dining. Unsampld Resident C reported he/she did not have enough room to move his/her motor chair around during dining.</p> <p>Interview with Certified Nursing Assistance (CNA) #1, on 06/11/14 at 10:16 AM, revealed the dining room was crowded at times. She reported that sometimes staff bumped into residents while assisting with tray set-up. Continued interview</p>	F 464			

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F 464	<p>Continued From page 14</p> <p>with CNA #1 revealed they were in close quarters and did not have enough space to get the resident's out of the dining area. She reported staff have had to move resident's out of the dining room to move another resident out of the area. She revealed that staff would sometimes bump into Unsampld Resident D, because of the crowding concern, and he/she would curse and upset the other residents. Further interview CNA #1 revealed that if there was an emergency, staff would not be able to get the residents out of the dining area quick enough, which was a safety concern.</p> <p>Interview with CNA #3, on 06/11/14 at 11:10 AM, revealed there was not sufficient space for the residents. She reported it depended upon who came to the dining room to eat. She stated that if all the facility's residents came to the dining area to eat, then there was not enough space to accommodate all of the residents. She stated she has had to remove some of the residents out of the dining area to assist another resident with toileting or for a family member who came to visit a resident. CNA #3 stated that if in the event of a fire or tornado, staff would not be able to move the residents out of the dining room all at once, which increased the safety concern for the residents.</p> <p>Interview with the Activities Director, on 06/12/14 at approximately 1:15 PM, revealed the dining area was crowded. She revealed they had more residents who were in Gerichairs and wheelchairs. She reported the spacing in the dining room was a safety concern and "dangerous" for the residents. She stated it would be difficult to provide quick access to residents and when it was crowded, it was more</p>	F 464			

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F 464	Continued From page 15 challenging. Interview with the Ombudsman, on 06/12/14 at 12:34 PM, revealed she had heard some of the residents state they ate in their rooms due to the condition (spacing) of the dining room. Interview with the Director of Nursing (DON), on 06/12/14 at 2:35 PM, revealed the residents that were in Gerichairs took up a lot of room. She reported the facility's dining area was limited on space; however, staff should have planned better for meals by rearranging some tables and they should have used the staff stools to sit on to save on the space. Continued interview with the DON revealed the safety concern for having all the residents in the dining area, with limited space, could be any number of things.	F 464			
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514			

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F 514	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete and accurate. The Physician's orders were not updated accurately on the monthly orders for one (1) of ten (10) sampled residents (Resident #2). The facility failed to ensure Resident #2's diet order was updated correctly on the Physician's monthly orders in May 2014 and June 2014.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing on 06/11/14 at 5:30 PM revealed, the facility did not have a policy specific for updating monthly Physician's orders.</p> <p>Record review revealed, Resident #2 was admitted to the facility on 04/08/13 with diagnoses which included Type II Diabetes, Hypertension, Cerebral Vascular Accident, Dysphasia, Coronary Artery Disease, Anxiety, Urinary Retention, and Rectocele Repair. Review of the Annual Minimum Data Set (MDS) Assessment dated 04/04/14, revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was cognitively intact.</p> <p>Record review revealed a telephone order on 04/14/14 for a Regular Diet with No Concentrated Sweets. However, review of the monthly Physician orders for May 2014 and June 2014 revealed a sixteen hundred (1600) calorie diet. Further review of the medical record revealed, there were no diet order changes after 04/14/14.</p>	F 514			

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F 514	Continued From page 17 Interview, on 06/10/14 at 1:35 PM, with Dietary Manager revealed, it was the nursing department's responsibility to notify the dietary department of new orders or changes. Interview, on 6/10/14 at 3:23 PM, with Registered Nurse (RN) #1 revealed, the orders on the monthly Physician's order sheet were to be checked against the written and verbal orders to ensure orders were correct. RN #1 further revealed, it was a mistake and an oversight, that the order did not get transcribed onto the following month orders. Interview, on 6/10/14 at 2:40 PM, with Director of Nursing (DON) revealed the sixteen hundred (1600) calorie diet on the monthly order sheet was incorrect and should have been a Regular Diet with no concentrated sweets and it was a nursing responsibility to make the necessary order changes into the computer.	F 514		

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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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K 000

INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1947, 1962, 1978, 1986

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: Second Floor wing of a
two story, Type I Unprotected

SMOKE COMPARTMENTS: Four smoke
compartments

FIRE ALARM: Complete fire alarm system with
heat and smoke detectors

SPRINKLER SYSTEM: Complete automatic wet
sprinkler system

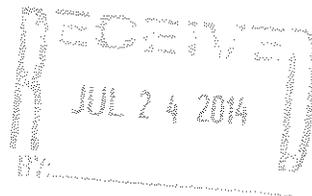
GENERATOR: Type I generator installed in 1982,
fuel source is diesel

A standard Life Safety Code survey was
conducted on 06/10/14. The James B Haggin
Memorial Hospital was found not to be in
compliance with the requirements for participation
in Medicare and Medicaid. The facility is licensed
for thirty- four (34) beds. The census the day of
the survey was thirty three (33)

The findings that follow demonstrate
noncompliance with Title 42, Code of Federal
Regulations, 483.70(a) et seq. (Life Safety from
Fire)

K 000

Please see attached.



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

TITLE

(X6) DATE

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

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K 000	Continued From page 1	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of doors, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, fourteen (14) residents, staff and visitors.</p>	K 018		

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K 018

Continued From page 2
The findings include:

Observation on 06/10/2014 at 2:10 PM with the Director of Physical Plant, revealed a chair blocking the door of resident room 251 from closing. Interview, with the Maintenance Director revealed staff are trained to not allow objects to block resident room doors, but the resident insisted the chair stay in the location blocking the door from closing.

The census of thirty three (34) was verified by the Administrator on 06/10/14. The findings were acknowledged by the Administrator and verified by the Director of Physical Plant at the exit interview on 06/10/14.

Reference: NFPA 101 (2000 edition)
19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.

A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.

K 018