

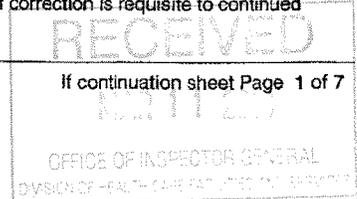
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(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 standard survey was initiated on 02/19-13 and concluded on 02/21/13. A Life Safety Code Survey was conducted on 02/21/13. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed.	F 000	"The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law." F 431	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Plow TITLE: Administrator (X6) DATE: 3/8/13

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.

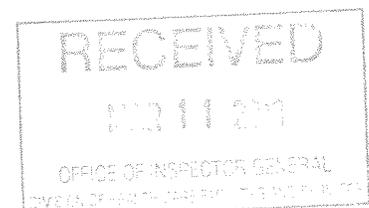


BWB

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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

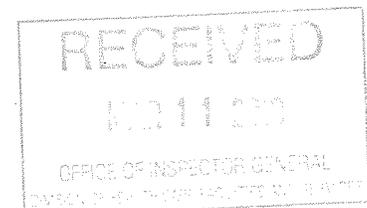
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 1</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to remove drugs and biologicals that had been expired, opened, and not dated. Two (2) of two (2) medication rooms had four (4) Vacutainers used for drawing blood in the Blue Unit Medication Room and one (1) Vacutainer in the Pink Unit Medication Room were expired, and two (2) of two (2) treatment carts on the Blue Unit had four (4) expired suction swabs, one (1) bottle of normal saline, and one (1) bottle of baby oil opened with no name, or date when opened.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Organizational Aspects, dated 01/02/10, revealed Section F. stated specific activities that the consultant pharmacist should perform included, but was not limited to: 4) Checking the medication storage areas at least monthly, and the medication carts at least quarterly, for proper storage and labeling of medications, cleanliness, and removal of expired medications.</p> <p>Review of the Blue Unit Medication Room, on 02/21/13 at 10:30 AM, revealed four (4) small blue top Vacutainers used for drawing blood, which had an expired date of January 2013. In</p>	F 431	<p>unlabeled/expired medications and supplies by 3/13/13. This education will be repeated quarterly for 2 quarters then annually. All newly hired staff will be educated on this practice during orientation and education will be completed by staff development coordinator.</p> <p>4. Medicine and treatment carts will be monitored daily by nursing managers. Audit sheet has been updated to include expired and non labeled and dated medications and supplies. Weekend Nurse Manager has been assigned the responsibility to conduct weekly audits of the Med Carts, treatment carts and Medical Supply Room. Unit Managers will conduct monthly audits for 3 months then quarterly for one year and report all on all audits to the facility QA Committee no less than quarterly for one year, for further recommendations.</p> <p>5. Completion date:</p>	3/15/13	



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

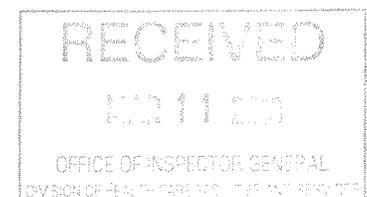
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 2</p> <p>addition, review of the Pink Unit Medication Room revealed one (1) small blue top Vacutainer, which also had an expiration date of January 2013.</p> <p>Review of Treatment Cart #1 on the Blue Unit, on 02/21/13 at 10:45 AM, revealed one (1) bottle of Normal Saline with an expiration date of November 2011, and four (4) suction swabs with an expiration date of November 2012. Treatment Cart #2 contained a bottle of baby oil which was half full with no name, or date when opened.</p> <p>Interview with LPN #1 on the Blue Unit, on 02/21/13 at 11:00 AM, revealed all nurses should be monitoring the treatment carts for expired medications, and should be doing this on a daily basis. The LPN stated the consultant pharmacist comes monthly and reviews each medication cart and drug cart. The LPN stated she was not sure about a policy for checking the carts.</p> <p>Interview with RN #2 on the Blue Unit, on 02/21/13 at 12:00 PM, revealed the treatment carts should be checked daily and any expired medications or supplies discarded. RN #2 stated she had not noticed the baby oil in the treatment cart, and did not know who had used it.</p> <p>Interview with RN #1 on the Pink Unit, on 02/21/13 at 11:00 AM, revealed she was unsure why the small blue top Vacutainer was still there; however, expiration dates should have been checked daily.</p> <p>Interview with the Pharmacy Consultant, on 01/21/13 at 2:30 PM, revealed the consulting pharmacist was responsible for looking at everything, including the treatment carts, and</p>	F 431			



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

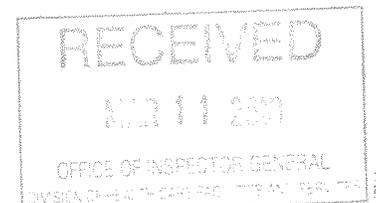
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	Continued From page 3 removing any expired medications that were found. The consultant pharmacist then submits a written report for each cart reviewed. The pharmacist stated, according to policy, the treatment carts should be checked at least quarterly. Review of the pharmacy inspection sheets revealed a consult date of 02/05/13 with several items found expired or not dated when opened, on the Blue Unit Treatment carts. Interview with the Administrator, on 02/21/13 at 1:20 PM, revealed nurses should be checking the medication rooms and treatment carts daily, according to the pharmacy policy, and would expect this to be done. The administrator stated the facility used the Lippincott Nursing Manual for standard of practice for checking expired medications, which included the same practice as the policy for labeling and expired medications. In addition, the Administrator stated there was a daily medication cart cleaning log which was completed by 11-7 nurses daily, and checked off and signed; however, stated the log did not direct the staff to check for expired medications.	F 431			
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 -	F 441	F 441 1. On 2/21/13, CNA #1 was re-educated on Infection Control, perineal care and hand washing by the Interim DON. On 2/20/13 and 2/27/13, skin assessments were completed on resident #7 for any signs or symptoms of infection or skin irritation that may be related to SRNA #1		



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

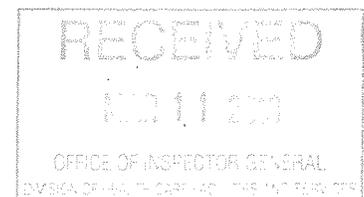
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(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 4 (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 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's policy, it was determined the facility failed to maintain their Infection Control Program to prevent transmission of disease and infection (related to proper perineal care and incontinent care) for one (1) of nineteen (19) sampled residents. Observation of incontinent care for Resident #7 revealed Certified Nursing Assistant	F 441	not changing gloves per facility protocol. No new areas or signs and symptoms of infection were noted. 2. Skin audits, 24 hour reports, and lab results will be reviewed for all residents on 3/4/13 by the Unit Managers for the past 30 days to identify any resident with signs or symptoms of infection or irritation that may be the result of failure to follow the infection control policy. 3. Nursing staff will be re-educated on the Infection Control Policy, perineal care and hand washing by the SDC, Unit Managers and Interim DON. This education will be completed by 3/15/13. This education will put emphasis on appropriate glove changing protocol and complete perineal care. Perineal care skills test will be performed by the SDC and Unit Managers. These will be completed by 3/15/13. Any deficient practice will be addressed by the Unit Mangers/Interim DON immediately. SRNA skills checklist and the infection control policy will be reviewed with all nursing employees upon hire and no less than annually thereafter.		



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

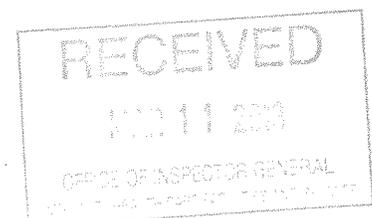
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(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 5</p> <p>(CNA #1) failed to change gloves when the gloves became soiled with feces. The CNA touched the resident's clothing, pillow, bed linens, and furniture with the soiled gloves.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Briefs/Under Pads, dated 11/01/12, revealed guidelines for proper handing of briefs. The procedure instructed staff to remove gloves, wash and dry hands thoroughly, and then reposition bed covers. Interview with the Interim Director of Nursing (DON), on 02/21/13 at 2:30 PM, revealed the facility used the Lippincott manual for perineal care guidelines. On page 123 of the manual, instructions were given to provide perineal care after urination and bowel movements. The Lippincott gave specific instruction for perineal care of a male patient that included cleaning the penis.</p> <p>Observation of a skin assessment for Resident #7, on 02/20/13 at 1:25 PM, revealed the resident was having a bowel movement when the incontinent brief was removed. The incontinent brief was slightly wet with urine. Continued observation revealed CNA #1 used several disposable wipes to clean the feces off the resident's buttocks. Some of the feces got onto CNA#1's disposable gloves. She took a disposable wipe and wiped the glove and continued to clean the resident. Again, feces got on the left disposable glove. The CNA again wiped the glove with a disposable wipe. After she clean the feces from the resident, she applied a clean incontinent brief (with the help of CNA #2). Then CNA #1 pulled the resident's pants up and</p>	F 441	<p>4. UM/Staff Nurses/SDC will observe no less than 3 residents per day receiving perineal care x 2 weeks, then will observe no less than 10 residents per month x 2 months, then observe no less than 10 residents quarterly. All observations will be presented to facility QA Committee no less than quarterly for one year for further recommendations</p> <p>5. Completion date:</p>	<p>3/15/13 3-10-13 pnm gloves by PB 3-15-13</p>	



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(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 6</p> <p>pulled the sheets over the resident. She then touched the resident's pillow, bed covers, and furniture (chest) with the same soiled gloves. Perineal care was not provided. The CNAs then removed their gloves and washed their hands.</p> <p>Interview with CNA #1 and CNA #2, on 02/20/13 at 1:30 PM, revealed both had received training on Perineal care that included when to change soiled gloves. CNA #1 stated she should have changed her gloves when they became soiled with feces instead of wiping them with a disposable wipe. She stated she had been trained to change her gloves but she just didn't think about it. She indicated perineal care should have been provided but she was focused on cleaning the feces and forgot to clean the resident's penis. She said she usually cleaned the resident's penis and buttocks whenever the resident was incontinent of bladder. She just didn't think.</p> <p>Interview with the Interim DON, on 02/21/13 at 2:30 PM, revealed all nursing staff had been trained on proper perineal care. She said anytime gloves are soiled, they are to stop and change their gloves.</p> <p>Review of the training records revealed CNA #1 and CNA #2 attended training on Perineal care in September 2012. Review of the training's content revealed proper perineal care was included.</p>	F 441			



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

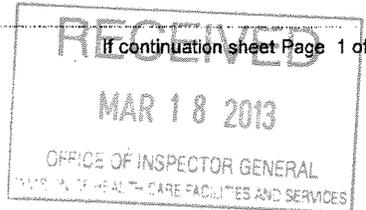
PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: one (1) story, Type II (111)</p> <p>SMOKE COMPARTMENTS: five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/21/13. Hart County Health Care Center was found to be not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for one hundred four (104) beds with a census of ninety eight (98) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X Michelle Brown* TITLE *X Administrator* (X6) DATE *X 3/15/13*

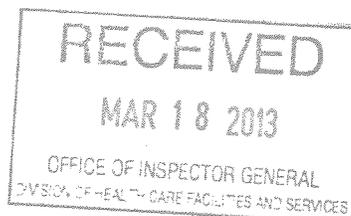
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

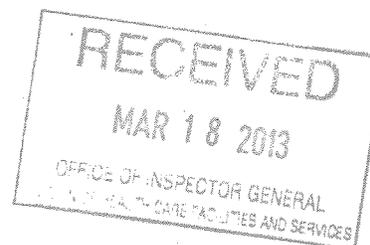
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility has one hundred four (104) certified beds with a census of ninety eight (98) on the day of the survey. The findings include: Observation, on 02/21/13 at 12:56 PM, with the	K 029	1. The Director of Maintenance contacted Cave City Construction and Countrycrest Enterprises to bid the install of a drop ceiling in boiler rooms on 200 and 500 hall. Administrator awarded bid to Countrycrest Enterprises and work was completed on 3/6/13. 2. Director of Maintenance checked all other storage areas of the building to ensure a ceiling was in place. 3. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 3/11/13 and provide a current copy of the standard . 4. The Administrator will check that the ceiling installation is complete and report on completion to the facility QA Committee. Maintenance Supervisor will inspect ceiling quarterly x 3 and report findings to QA. 5. Compliance Date:	3/12/13



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

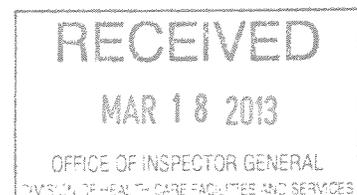
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(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 029	Continued From page 2 Maintenance Director revealed the mechanical room located in the 200, and 500 Hall did not have a ceiling leaving the room open to the attic. Interview, on 02/21/13 at 12:56 PM, with the Maintenance Director revealed he was not aware the room was required to be rated. Interview, on 02/21/13 at 3:00 PM, with the Administrator revealed she was not aware the room was required to be rated. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²),	K 029		



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

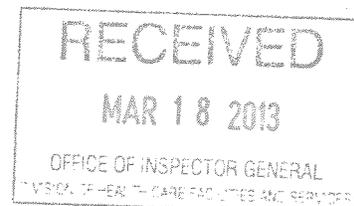
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(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 029	Continued From page 3 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred four (104) beds with a census of ninety eight (98) on the day of the survey. The findings include: Observation, on 02/21/13 at 1:10 PM, with the Maintenance Director revealed an exterior exit with only one light bulb outside to light the egress	K 045	K045 1. The Director of Maintenance contacted Gerald's Electric, A&B Electric, and County Crest Enterprises to submit bid to add two way light fixtures to each exit on 200, 300, 500 and 600 halls. Administrator awarded bid to A&B Electric and completed on 3/6/13. 2. Director of Maintenance checked all outside light fixtures to ensure all are 2 bulb.	



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

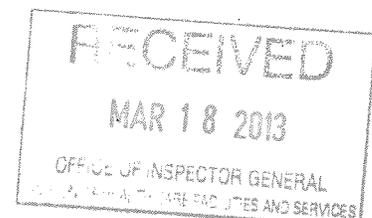
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(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 045	<p>Continued From page 4</p> <p>path. The exit with only one light was located at the end of the 200, 300, 500, and 600 Hall.</p> <p>Interview, on 02/21/13 at 1:10 PM, with the Maintenance Director revealed he was not aware the exits did not have the required illumination for egress lighting.</p> <p>Interview, on 02/21/13 at 3:00 PM, with the Administrator revealed she was not aware the exit did not have the required illumination for egress lighting.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of</p>	K 045	<p>3. This upgrade will resolve all exterior light requirements. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 3/11/13 and provide a current copy of the standard .</p> <p>4. These exterior lights will be reviewed on the TELS maintenance schedule to be conducted and repaired on a monthly basis. These checks will be recorded in the TELS program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.</p> <p>5. Compliance Date</p>	3/12/13	



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

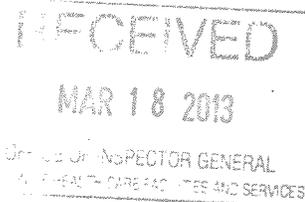
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(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 045	Continued From page 5 occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or	K 066		



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

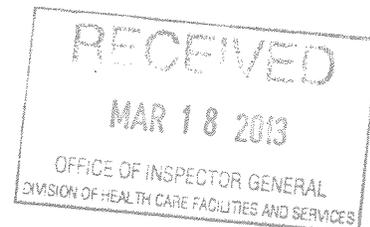
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(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 066	<p>Continued From page 6</p> <p>compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for one hundred four (104) beds with a census of ninety eight (98) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays.</p> <p>The findings include:</p> <p>Observation, on 02/21/13 at 1:57 PM, with the</p>	K 066	<p>K 066</p> <ol style="list-style-type: none"> Housekeeping Supervisor ordered self-closing container from Direct Supply on 3/5/13. Container was delivered and installed in smoking areas on 3/14/13. Housekeeping Director checked all designated smoking areas to ensure the appropriate self-closing container for ashes was available on 3/5/13 Housekeeping employees was educated on emptying ashtrays in self-closing container by the Housekeeping and Maintenance Supervisor by 3/15/13 Director of Housekeeping to check the designated smoking areas and self-closing containers during routine rounds but no less than monthly to ensure that the containers are present and ashtrays are emptied. Director of Housekeeping to report on rounds no less than quarterly to facility QA committee. Compliance date: 3/16/13



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

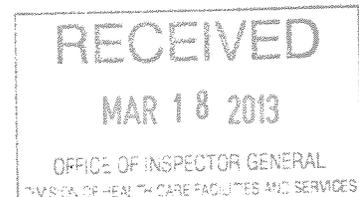
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(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 066	Continued From page 7 Maintenance Director revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the three (3) designated smoking areas. Interview, on 02/21/13 at 2:07 PM, with the Maintenance Director revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Interview, on 02/21/13 at 3:00 PM, with the Administrator revealed she was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the cooking appliances were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred four (104) beds with a census of ninety eight (98) on the day of the survey.	K 069			
			K069 1. Splash guard was installed by Maintenance on 3/8/13 to ensure cooking appliances are within accordance with NFPA standards.		



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

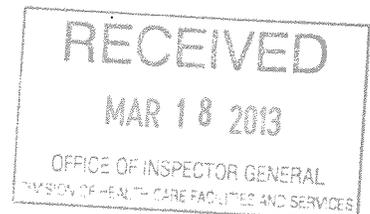
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(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 069	Continued From page 8 The findings include: Observation, on 02/21/13 at 2:05 PM, with the Maintenance Director revealed the deep fryer was located four (4) inches away from the open flame on the stove. Interview, on 02/21/13 at 2:05 PM, with the Maintenance Director revealed he was not aware of the requirement. Interview, on 02/21/13 at 2:05 PM, with the Dietary Manager revealed a new stove was installed and to fit the space, the appliances were moved. The new stove is sitting where the oven use to be located. Reference: NFPA 101 (2000 edition) 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K 069	2. There are no other stoves to check for the deficient practice . 3. This addition will resolve the cooking appliances practice. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 3/11/13 and provide a current copy of the standard. 4. The Administrator will check that the splash guard is installed and report on completion to the facility QA Committee. Maintenance Supervisor will inspect splash guard quarterly x 3 and report findings to QA. 5. Compliance date:	3/12/13	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144			



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

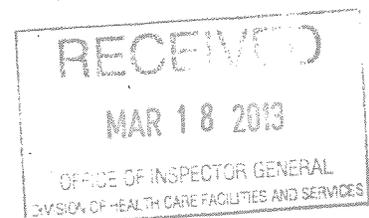
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(X4) ID PREFIX TAG K 144	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 144	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 144
	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on observation, generator testing record review, and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred four (104) beds with a census of ninety eight (98) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/21/13 at 1:57 PM, with the Maintenance Director revealed the battery charger for the facilities emergency generator was connected directly to the generator battery.</p> <p>Interview, on 02/21/13 at 1:57 PM, with the Maintenance Director revealed he was not aware of the requirement.</p> <p>Interview, on 02/21/13 at 3:00 PM, with the Administrator revealed she was not aware of the requirement.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be</p>		<p>1. The Director of Maintenance contacted A&B Electric and County Crest Enterprises to submit bid to re-route the wiring of the generator battery. Administrator awarded bid to Countrycrest Enterprises and completed on 3/7/13.</p> <p>2. There are no other generators to check for the deficient practice.</p> <p>3. This upgrade will resolve the generator wiring deficient practice. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 3/11/13 and provide a current copy of the standard .</p> <p>4. The Administrator will check that the generator wiring is complete and report on completion to the facility QA Committee. Maintenance Supervisor will generator wiring quarterly x 3 and report findings to QA.</p> <p>5. Compliance Date: 3/12/13</p>



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(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 10 sized to minimize voltage drop in accordance with the manufacturers ' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals. Reference: NFPA 99 (1999 Edition) Actual NFPA Standard: NFPA 99, 3-5.4.1.1 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 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 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. Actual Standard: NFPA 99, 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	K 144		



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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749		
(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	<p>Continued From page 11</p> <p>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.</p> <p>(b) Inspection and Testing.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p>	K 144		

