

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
--	--

(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 conducted 08/19/14 through 08/22/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E".	F 000		
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 observation, interview, record review and review of the facility staff in-service notes, it was determined the facility failed to promote care in a manner that enhances and maintains a resident's dignity and respect related to privacy, for two (2) of fourteen (14) sampled residents (Resident #2 and #6) and one (1) unsampled resident (Resident B). Certified Nurse Aide (CNA) #8 left Resident #2 uncovered during incontinent care while she left the room to obtain extra washcloths leaving the resident exposed and CNA #2 provided incontinent care for Resident B in full view of the resident's roommate by leaving the bathroom and room door open. In addition, staff failed to knock prior to entering Resident #2's and Resident #6's room to provide care. The findings include: Review of facility Staff In-service Notes titled,	F 241	The corrective actions for residents affected by the deficient practice involved educating direct care staff on 08/21/14 regarding the expectation of maintaining resident dignity by knocking prior to entering the resident rooms and by not exposing residents during care. This immediate education was provided on 08/21/14 by both Director of Nursing and Director of Nursing in training. Additional education was provided to nursing department employees by the Director of Nursing in training on 09/08/14 regarding the same. Every resident has the potential to be affected by the deficient practice. Systemic Changes: Every direct care nursing employee will be required to successfully demonstrate clinical competency regarding maintaining a respectful environment and providing care while preserving residents' dignity. On 09/22/14 and 09/23/14, Director of Nursing provided education and required competency demonstration from all nursing staff. Additionally, direct care	10/01/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* DATE *10/08/14*

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: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 241	<p>Continued From page 1</p> <p>Quality of Life/Customer Service, dated 02/24/14, revealed all employees were educated on the Importance of maintaining and enhancing patient dignity and respect, to groom residents as they wish to be groomed, maintain privacy of body, and to respect private space and property by knocking on doors.</p> <p>1. Record review revealed the facility admitted Resident #2 on 03/31/14 with diagnoses which included Pressure Ulcer to Lower Back, Hypertension, Urinary Tract Infection (UTI), and Urinary Device.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 06/12/14, revealed the facility assessed the resident's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15), which indicated the resident was interviewable. The resident required extensive assistance with hygiene and bathing.</p> <p>Observation of catheter care for Resident #2 by CNA #8, on 08/21/14 at 11:00 AM, revealed CNA #8 failed to close the window blinds prior to providing the catheter care. The resident's bed was next to the window facing the garden area on the ground floor of the facility. During the procedure CNA #8 realized she needed more wash cloths. She repositioned the resident on his/her back and left him/her exposed while she left the room to get the supplies.</p> <p>Interview with CNA #8, on 08/22/14 at 10:00 AM, revealed she realized what she had done as soon as she stepped out of the room. She stated she thought about reentering the room to cover the resident but she didn't.</p>	F 241	<p>nursing employees will be required to demonstrate clinical competency as a final step in the orientation process and annually from date of hire. Monitoring performance to ensure solutions are sustained will be performed by the Director of Nursing (DON) and/or Registered Nurse (RN) designee through the performance of unannounced random monthly audits across all three shifts. These audits will include the demonstration of care provision during patient care and toileting. Monthly analysis of the audit findings and continued compliance will be reviewed and discussed to the Internal Quality Assurance (QA) Team. The Internal Quality Assurance (QA) Team members are: Dietary Manager, Director of Nursing, Administrator, Business Manager, Administrative Assistant, RN/Care Plan/MDS Coordinator, Activities Director, Housekeeping/Laundry Supervisor, Social Services Director, Maintenance Supervisor and Medical Records Coordinator. Random audits will continue until 100% compliance for three months has been achieved. The Quality Assurance Committee will determine when consistent compliance has been</p>	1 10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
--	--

(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 241	<p>Continued From page 2</p> <p>2. Observation, on 08/21/14 at 9:50 AM, revealed CNA #2 was in Resident B's room making rounds. CNA #2 assisted Resident B to the bathroom and left the bathroom door open with the resident in view of the roommate.</p> <p>Interview, on 08/22/14 at 3:41 PM with CNA #2, revealed she realized she had not closed the door when Resident B was toileting and stated it was possible the resident's roommate could see him/her. CNA #2 stated this was a privacy concern and dignity issue.</p> <p>3. Observation, on 08/20/14 at 11:00 AM, revealed CNA #2 entered Resident #6's room without knocking. Interview with CNA #2 at that time revealed she did not knock because Resident #6's roommate was usually asleep.</p> <p>4. Observation, on 08/21/14 at 8:35 AM, revealed Registered Nurse (RN) #1 entered Resident #2's room without knocking to provide wound care. Interview with RN #1, on 08/21/14 at 2:00 PM, revealed she was nervous about the procedure and she should have knocked on the doors before entering.</p> <p>Interview with Director of Nursing (DON), on 08/21/14 at 1:15 PM and on 08/22/14 at 3:54 PM, revealed she expected the staff to cover the resident before leaving the room and to close the blinds. She stated at no time should staff invade the resident's privacy without knocking. They have all been trained to knock on doors. The DON revealed she expected the CNAs to provide privacy to all residents at all times.</p>	F 241	<p>attained and the frequency of the monthly audits can be adjusted if deemed appropriate by the Quality Assurance Committee. Quality Assurance Committee members are: Dietary Manager, Director of Nursing, Administrator, Medical Director, Administrative Assistant, Consultant Pharmacist, Occupational Therapist, RN/Care Plan/MDS Coordinator, LaKesha Snow, Housekeeping/Laundry Supervisor and Maintenance Supervisor.</p>	10/01/14
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 280	<p>Continued From page 3</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedures it was determined the facility failed to develop a care plan that addressed the assessed needs of the resident for one (1) of fourteen sampled residents (Resident #9). The facility assessed Resident #9 to require the extensive assistance of (2) two staff for bed mobility and bathing; however, the care plan stated one-two staff was required for bed mobility and bathing. On 03/05/14, Certified Nurse Aide (CNA) #11 provided a bed bath and changed linens for Resident #9 by herself when the resident slid from the bed on to the floor and</p>	F 280	<p>The corrective action for resident #9 was to update the care plan and to indicate the need for two assist with bed mobility. The Director of Nursing in training identified other residents having the potential to be affected by the same practice as those residents having the same ambiguous ADL care interventions listed on the care plan as "1-2 assist". After identifying residents who might be affected, the Director of Nursing in training updated their respective care plan interventions to indicate how many persons are required for assistance in each category of ADL's. Updated interventions were completed by 09/19/14. Systemic changes required to ensure this practice does not recur: The care plan library from which the care plan is written was updated by the Director of Nursing in training on 09/19/14 so that the "1-2 assist" choice as an intervention was eliminated. The revised care plan library requires the licensed nurse to choose whether or not the resident requires assistance of 1 with the performance of ADLs or requires the assistance 2 for ADL care. Licensed nurses and state registered nurse aides were educated on these changes on 09/22/14 and 09/23/14 by the Director of Nursing. Nurse Aides will be instructed to report any variance from the policy to the charge nurse for clarification prior to performing</p>	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 280	Continued From page 4 sustained an abrasion above the left eyebrow. The findings include: Review of the facility's policy and procedure titled, "Comprehensive Care Plan", not dated, revealed it was the policy of the facility to develop a Comprehensive Care Plan for each patient, that included measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The care plan must describe the following: 1. The services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being and 2. Any services that would otherwise be required but were not provided due to the resident's exercise of rights, including the right to refuse treatment. The staff responsible for this was Licensed Nurses, Social Services Director, and as applicable: a Therapy Representative. Record Review revealed the facility admitted Resident #9 on 06/04/12 with diagnoses which included Hemiplegia right side, Depressive Disorder, Hypertension (HTN), Hypothyroidism, Hypertrophy of Prostate, Degenerative Disc Disease, Seborrheic Dermatitis, Vitamin D Deficiency, Trigeminal Neuralgia, and Osteoarthritis. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 02/14/14, revealed the facility assessed Resident #9 as extensive assistance of two (2) staff for bed mobility and dependent on two (2) staff for bathing; however, review of the Comprehensive Care Plan for Activities of Daily Living (ADL) Performance	F 280	care. In order to monitor performance of the solution the Director of Nursing or RN designee will perform weekly audits of all ADL care interventions until 100% compliance is achieved for three consecutive months. The purpose of the audits is to ensure ADL care interventions are not ambiguous on the care plan. After 100% compliance is achieved for three consecutive months, the audits will be performed monthly. Monthly analysis of the audit findings and continued compliance will be reviewed and discussed to the Internal Quality Assurance (QA) Team. Random monthly audits will continue until 100% compliance for three months has been achieved. The Quality Assurance (QA) committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted as deemed appropriate by the Quality Assurance (QA) Committee.	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 280	<p>Continued From page 5</p> <p>Deficit, related to Hemiplegia, functional decline, weakness and possible contractures of the knees, initiated 06/19/14, revealed an intervention that was initiated on 08/03/12 for 1-2 staff member assistance for bed mobility and the amount of assistance needed for bathing was not addressed.</p> <p>Review of a Fall Investigation Report, dated 03/05/14, revealed Resident #9 was found on the floor naked, on the right side between the two (2) beds, facing the window and there was soiled bedding on the bed. The report revealed Resident #9 stated he/she "Did not know what happened". Further review revealed Resident #9 was assessed for injury and found to be bleeding from the forehead, above the left eyebrow. Resident #9 was then assisted back to bed via Maxi Lift and after cleaning the injured area, a scratch was found. Further review of the report revealed Resident #9 was receiving care at the time by staff due to the resident's bedding being soiled.</p> <p>Further review of the Comprehensive Care Plan, dated 03/05/14, revealed there were no revisions made to the care plan after the fall to address how many staff needed to assist the resident with bed mobility and bathing.</p> <p>Interview with CNA #11, on 08/22/14 at 10:20 AM, revealed CNA #11 was washing Resident #9 and changing the resident's soiled gown and sheet. She stated she rolled the resident away from her, lost her grip of the resident and the resident tensed up into a fetal position and the lower part of the resident's body fell off the bed. She revealed she did not know how Resident #9 sustained the injury to above the left eyebrow.</p>	F 280			

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 280	<p>Continued From page 6</p> <p>CNA #11 revealed there were two (2) aides and one (1) nurse on the hall that night.</p> <p>Interview with Licensed Practical Nurse (LPN) #11, on 08/21/14 at 3:15 PM, revealed CNA #11 was changing Resident #9, rolled the resident away from her, lost her grip of the resident and the resident fell out of the bed. LPN #11 stated the cut above the left eyebrow was not very deep and did not require any stitches or hospitalization.</p> <p>Interview, on 08/22/14 at 3:30 PM with MDS Coordinator, revealed the care plan was generated when the resident was first admitted to the facility. She stated some of the care plan was automatically generated and sometimes the person admitting the resident will add to the care plan. The MDS Coordinator stated she updates the care plan and it was not in the "Scope of Practice" for CNAs to make decisions about whether to have one or two staff assistance. She revealed at the time of the fall it would have been better to have had another staff member assisting to ensure Resident #9 did not sustain a fall and injury.</p> <p>Interview with Director of Nursing (DON), on 08/22/14 at 9:52 AM revealed fall assessments were completed on all residents on admission. She stated the facility has a falls committee which consists of the Maintenance Supervisor, Housekeeper Supervisor, MDS Coordinator, DON, Social Services, Activities Director and Physical Therapy. She revealed the falls committee was responsible for conducting a Root Cause Analysis of each fall and if the resident was meeting goals and interventions were working, no changes are made.</p>	F 280			

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 281 F 281 SS=D	Continued From page 7 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) unsampled resident (Resident C). Resident C had a physician's order for a No Added Salt (NAS) Diet, however, Certified Nurse Aide (CNA) #3 was observed to add salt to the resident's food during the noon meal on 08/21/14. The findings include: Review of the facility's policy titled, "Policy for Dietary Requests Not in Accordance with Physician Ordered Diet", dated 10/19/13, revealed if a resident requested food or drink not in accordance with their physician-ordered diet, and continue with the request after being provided and an explanation of why they are not to have a certain food or drink item, then the charge nurse should be notified so that risks can further be articulated to the resident. The resident's request should be denied unless the physician had ordered liberalization in addition to a mechanically altered diet. The policy further stated, staff, volunteers, and anyone representing the facility were not to deviate from a physician ordered diet unless the physician has made allowances through an order and the resident's right to choice does not apply to choosing a food	F 281 F 281	Corrective actions taken for the resident affected by the practice involved instruction by the Director of Nursing in training to the State Registered Nurse Aides and licensed nurses on 09/08/14 to follow the physician's diet orders for every resident and to call the physician if the resident would benefit or requested a diet change. All direct care nursing staff were re-educated regarding these policies and procedures during an in-service on 09/08/14 by the Director of Nursing in training. All other residents with physician ordered dietary restrictions have the potential to be affected by the same practice. The following measures and systemic changes have been put into place in order to prevent the practice from recurring: Following physician's orders regarding dietary restrictions and what to do if the resident requests items outside those restrictions will be emphasized during the orientation process. All direct care nursing employees will be educated regarding this policy and procedure on a quarterly basis. The Director of Nursing or RN designee will perform random weekly observations of tray delivery and set up involving all three meals for the adherence to physician ordered diets. The observations will continue weekly until 100% compliance is achieved for three consecutive months and then will	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 281	<p>Continued From page 8 or drink that contradict the physician's diet order.</p> <p>Record review revealed the facility admitted Resident C on 04/24/10 with diagnoses which included Presenile Dementia, Congestive Heart Failure, Edema, unspecified Essential Hypertension, Esophageal Reflux and Anxiety State.</p> <p>Review of the Physician orders, dated 04/15/14, revealed Resident #C was ordered a NAS Diet.</p> <p>Observation during the noon meal, on 08/21/14 at 12:08 PM, revealed Resident C was in his/her room with Certified Nurse Aide (CNA) #3 assisting the resident with his/her meal. The residents plate contained ham, macaroni and cheese, one (1) slice of bread, lima beans and blackberry cobbler, tea and cranberry juice. CNA #3 opened a salt packet and sprinkled salt on the ham, macaroni and cheese and lima beans. CNA#3 then proceeded to serve Resident #C the food items she sprinkled with salt. Review of the Diet card on the tray revealed the resident was on Regular NAS diet.</p> <p>Interview, on 08/21/14 at 12:32 PM with CNA #3, revealed she sprinkled salt on the resident's food because he/she likes it that way. CNA #3 stated she was aware of the physician's order for the NAS diet but the resident likes it "so I put it on there"</p> <p>Interview, on 08/22/14 at 3:49 PM with Director of Nursing (DON) #1, revealed she expected the staff to follow the physician's order related to the resident's diet.</p>	F 281	<p>decrease in frequency to monthly. The Director of Nursing will review and discuss a summary of the observation findings to the Internal Quality Assurance (QA) Team monthly. Random monthly audits will continue until 100% compliance for three months has been achieved. The Quality Assurance (QA) Committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted as deemed appropriate by the Quality Assurance (QA) Committee.</p>	10/01/14	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282			

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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)	(X6) COMPLETION DATE	
F 282 SS=D	<p>Continued From page 9 PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility 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, record review, and review of the facility policy and procedure it was determined the facility failed to follow the care plan for one (1) of fourteen (14) sampled residents (Resident #7) in regards to not properly positioning Resident #7 who was receiving an enteral feeding via Gastric Tube (GT).</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Comprehensive Care Plan", not dated, revealed it was the policy of the facility for the care plan to describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.</p> <p>Record review revealed the facility admitted Resident #7 on 08/25/13 with diagnoses to include Dysphagia due to Cerebrovascular Disease, Esophageal Reflux, Aphasia due to Cerebrovascular Disease, and Polyneuropathy in Diabetes.</p> <p>Review of the Comprehensive Care Plan for "Attention to Tube Feeding", dated 06/17/14, revealed an intervention to elevate the head of bed thirty (30) degrees related to tube feeding;</p>	F 282	<p>Direct care nursing employees were educated on 08/21/14 by the Director of Nursing and Director of Nursing in training that a nurse aide is not to push, hold, start or stop on an enteral feeding pump at any time. Additionally, the aides were instructed to notify the licensed nurse that the head of the bed may need to be lowered for the provision of care. In turn the licensed nurses are to make the determination whether or not the tube feeding should be held and/or the head of the bed lowered if it is in the best interest of the resident. All other residents receiving enteral feedings may be affected by the same practice. The following measures/systemic changes have been put into practice: On 09/08/14 the Director of Nursing in training educated licensed nurses about making rounds every two hours to monitor that the head of bed is elevated on all residents receiving enteral feeding. The Title of the Training is "Deficiency Corrections related to G-tube policy, procedures and nurse expectations." The licensed nurse will document the results of the rounds and corrective action for any noncompliance. The licensed nurse will also document whether or not any enteral feedings were noted to be placed on hold without the prior determination as appropriate by the licensed nurse.</p>	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 10 however, observation of Certified Nursing Assistant (CNA) #1 providing care for Resident #7, on 08/19/14 at 10:40 AM, revealed Resident #7 was lying in the bed with the head of the bed in the flat down/flat position and the feeding pump running. Interview with CNA #1, on 08/21/14 at 12:25 PM, revealed she would normally push "hold" on the feeding pump when providing care and when care was completed raise the head of the bed and turn the pump back on to running. CNA #1 stated she would raise the head of the bed to forty-five (45) degrees when the pump was running. CNA #1 revealed she was nervous and was focused on completing the task and several other tasks she was assigned.	F 282	Monitoring for compliance will be performed by the Director of Nursing through random weekly visual observations of all residents receiving enteral feeding and via monitoring the daily documentation of the charge nurses for compliance with the policy. After 100% compliance is achieved for three consecutive months, the audits frequency will be changed to monthly. The Director of Nursing will review and discuss a summary of the observation findings to the Internal Quality Assurance (QA) Team monthly. The Quality Assurance (QA) Committee will determine when consistent compliance	10/01/14	
F 323 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy, it was determined the facility failed to ensure adequate supervision necessary to prevent accidents for three (3) of fourteen (14) sampled residents (Resident #8, Resident #9 and Resident #11). Observations revealed there were three (3) unlocked storage	F 323	The following corrective actions were taken at the time the potential hazards were identified: On the evening of 08/19/14 all personal care items, including the items containing flammable and alcohol ingredients, were removed from around the residents' vanities and placed in closets. The night of 08/19/14 a designated person was given the specific and only task of monitoring the halls and storage closets for residents that may wander into the storage rooms or other resident rooms. On 08/20/14 the three storage rooms were locked with Keypad Cam Electronic Door Locks. Staff were educated on 08/20/14 to	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 323	<p>Continued From page 11</p> <p>rooms and twenty-two (22) out of thirty-one (31) resident rooms, containing flammable and alcohol based hygiene products. Resident #8 and Resident #11 were noted wandering in and out of resident rooms and Resident #11 was noted to have been pulling on the storage room door handle. Resident #9 was assessed to need the supervision of two (2) staff for bed mobility and bathing; however, one CNA provided a bed bath and turning of the resident in bed and the resident's upper body slid from the bed and the resident sustained an abrasion above the left eye. In addition, Resident #9 was observed to have been calling-out for help, without a response from staff members for fifteen (15) minutes, during an episode of shortness of breath, resulting in the need for a nebulizer treatment.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Record Review revealed the facility admitted Resident #9 on 06/04/12 with diagnoses which included Hemiplegia right side, Depressive Disorder, Hypertension (HTN), Hypothyroidism, Hypertrophy of Prostate, Degenerative Disc Disease, Seborrheic Dermatitis, Vitamin D Deficiency, Trigeminal Neuralgia, and Osteoarthritis. <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 02/14/14, revealed the facility assessed Resident #9 as extensive assistance of two (2) staff for bed mobility and dependent on two (2) staff for bathing.</p> <p>Review of the Comprehensive Care Plan for Activities of Daily Living (ADL) Performance Deficit, related to Hemiplegia, functional decline, weakness and possible contractures of the</p>	F 323	<p>to put all items away in closets and to remove aerosols or other potentially harmful substances from residents' rooms. This education on 08/20/14 was provided to all nursing staff by the Director of Nursing and Director of Nursing in training. This same education on 08/20/14 was provided to Housekeeping/Laundry and Maintenance staff by Housekeeping/Laundry Supervisor and Maintenance Supervisor. On 08/25/14, the Administrator reiterated the education by providing written material to all nursing staff that included the same educational information as provided on 08/20/14. On 09/04/14, the Administrator educated the Internal Quality Assurance (QA) Team that included the same educational information as provided on 08/20/14. Documentation obtained during walking rounds was added to the Internal Quality Assurance (QA) Team responsibilities for the purpose of noted compliance; if non-compliance is found there will be immediate education and documentation. On 09/08/14, Administrator instructed nursing, housekeeping, laundry, maintenance, dietary, activities, social services and administrative staff of the same material at an all-staff in-service. Other residents that wander in and out of residents' rooms and closets may have the potential to be</p>	10/01/14

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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)	(X6) COMPLETION DATE	
F 323	<p>Continued From page 12</p> <p>knees, initiated 06/19/14, revealed an intervention that was initiated on 08/03/12 for 1-2 staff member assistance for bed mobility and the amount of assistance needed for bathing was not addressed.</p> <p>Review of a Fall Investigation Report, dated 03/05/14, revealed Resident #9 was found on the floor naked, on the right side between the two (2) beds, facing the window and there was soiled bedding on the bed. Further review revealed Resident #9 was assessed for injury and found to be bleeding from a scratch on the forehead, above the left eyebrow.</p> <p>Further review of the Comprehensive Care Plan, dated 03/05/14, revealed there were no revisions made to the care plan after the fall to address how many staff needed to assist the resident with bed mobility and bathing.</p> <p>Interview with CNA #11, on 08/22/14 at 10:20 AM, revealed CNA #11 was washing Resident #9 and changing the resident's soiled gown and sheet. She stated she rolled the resident away from her, lost her grip of the resident and the resident tensed up into a fetal position and the lower part of the resident's body fell off the bed. She revealed she did not know how Resident #9 sustained the injury to above the left eyebrow. CNA #11 revealed there were two (2) aides and one (1) nurse on the hall that night.</p> <p>Interview with Licensed Practical Nurse (LPN) #11, on 08/21/14 at 3:15 PM, revealed CNA #11 was changing Resident #9, rolled the resident away from her, lost her grip of the resident and the resident fell out of the bed. LPN #11 stated the cut above the left eyebrow was not very deep</p>	F 323	<p>affected by this practice. Additional measures/systemic changes implemented to ensure the deficient practice does not recur included the following: On 09/08/14 all employees were notified of the requirement to put all personal items in the residents' closets and/or drawers and not to leave these items out around the sink. They were also instructed to remove any aerosol can such as shaving cream, etc. that may be found in a resident's room. The education was provided to all staff, all departments on 09/08/14 by the Administrator and to nursing, dietary, housekeeping/laundry and maintenance department the same day, 09/08/14 by the Director of Nursing in training, Dietary Manager, Housekeeping/Laundry Supervisor and Maintenance Supervisor, respectively. The department leaders make facility rounds at various times and frequencies in order to monitor the residents' rooms for personal items out in the room or around the sink. The department leaders are to remove any aerosols if found and to put the personal care objects in closets if left out. The results of these rounds/observations and interventions are documented, and given to the Administrator or Administrative Assistant. A compilation of result will be presented to the Internal</p>	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 13 and did not require any stitches or hospitalization.</p> <p>Interview, on 08/22/14 at 3:30 PM with MDS Coordinator, revealed at the time of the fall it would have been better to have had another staff member assisting to ensure Resident #9 did not sustain a fall and injury.</p> <p>In addition, while working in the Conference Room with the door closed, surveyors heard a resident calling out to staff. The resident was located approximately thirty (30) feet away from the Conference Room. Observation of Resident #9, on 08/20/14 at 12:15 PM, revealed an unkempt resident, lying in bed and calling out loudly and upon entering the resident's room, the resident shouted "get out of my room," yet the resident continued to call out to staff.</p> <p>Observation, on 08/20/14 at 12:20 PM, revealed Resident #9 calling out. The resident continued to intermittently call out, with no staff responding. There was no staff in sight on this hall (Hall 200). Observation for the next fifteen (15) minutes revealed no staff responded to the resident so the surveyor went to get help. Registered Nurse (RN) #1 came into the resident's room and assessed the resident and determined the resident's oxygen saturation (O2 Sat.) was 97% and pulse was 85 beats per minute (bpm). Further observation revealed Resident #9 was given a breathing treatment. Further observation at 2:00 PM and 3:00 PM, revealed the resident was in bed. When attempted to speak to the resident, the resident only made sounds with no discernable speech. The resident's call light was in reach but when the resident was asked to push the call light, the resident was unable to do so.</p>	F 323	<p>Quality Assurance (QA) Team for review, discussion and direction for taking necessary action. Monitoring for ongoing compliance to ensure the systemic changes are maintained will be accomplished through department leaders' observation rounds and monthly reports to the Internal Quality Assurance (QA) Team by the Administrator or Administrative Assistant. The Quality Assurance (QA) Committee will review compliance Quarterly and provide instructions regarding changes or additions to procedures. The corrective action for resident #9 was performed on 03/05/14. Charge Nurse Supervisor/LPN and included staff education regarding turning the resident toward the caregiver and not away from the caregiver and to get assistance when needed. Other residents identified as potentially affected by the practice are all residents requiring the assistance of two during ADL care. Systemic changes and measures put into place in order to ensure the practice does not recur include the following: care plan interventions and directions for nurse aides were updated for all residents by 09/19/14 by Director of Nursing. All nursing staff were educated on both 09/22/14 and 09/23/14 by the Director of Nursing to review the plan of care for the amount of assistance required for each resident prior to providing care. Licensed nurses and state registered nurse aides were</p>	10/01/14
-------	--	-------	--	----------

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 323	Continued From page 14 Interview with the Director of Nursing (DON) #1, on 08/21/14 at 12:52 PM, revealed she had assigned someone to hall 200 and the Dietary Manager had pulled one of her staff to help pass trays in the dining room. She stated this left one Certified Nurse Aide (CNA) on Hall 200 and the CNA (CNA #5) was in a resident's room with the door closed while feeding the resident. She revealed CNA #5 could not hear Resident #9 hollering. Interview with CNA #5, on 08/22/14 at 9:55 AM, revealed she was feeding a resident in room #205 (Resident #9 is in room 206), and had the door closed, as the resident liked to have the door closed, and did not hear anyone hollering. She stated the other two (2) CNAs were on the other halls feeding residents. 2. Review of the facility's policy titled, "Accident Prevention and Investigation Policy and Procedures", dated 03/22/13, revealed the facility should provide a safe environment that optimizes patient independence and reduces the risk of accidents. The policy further revealed it was the responsibility of all employees to monitor the environment for safety hazards that may place patients and others at risk of accidents and take appropriate action to reduce or eliminate hazards. A tour of the 100 hall, on 08/19/14 at 10:00 AM, revealed three (3) unlocked storage rooms that were readily accessible to all residents and/or visitors. Tour of resident rooms on the 100 hallway revealed five (5) out of eight (8) rooms contained multiple cans of shaving cream, alcohol based after shave lotion, and multiple containers of hygiene products found sitting out	F 323	educated on these changes on both 09/22/14 and 09/23/14. Nurse Aides were instructed to report any variance from the policy to the charge nurse for clarification prior to performing care. In order to monitor performance of the solution the Director of Nursing or RN designee will perform weekly audits of all ADL care plan interventions in order to ensure interventions stating "1-2 assist" have not been added to any plan of care. The care plan audits will continue weekly until 100% compliance is sustained for three months then the audit will decrease in frequency to monthly. Additionally, the Director of Nursing or RN designee will perform monthly visual competency evaluations randomly and across all three shifts to ensure nursing employees are performing ADL care with the amount of assistance required as directed by the individual plan of care. The Director of Nursing will review and discuss the monthly compliance delivery of care with the Internal Quality Assurance (QA) Team. These competency evaluations will be ongoing. There will be ongoing reports provided to the Quality Assurance (QA) Committee for additional instructions regarding changes or additions if necessary. The corrective action for resident #9 was performed on 08/20/14 when the RN responded to the needs of the resident by assessing and providing a nebulizer treatment. Additionally, the nurse aide on	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 15</p> <p>on the counter beside the sink inside the resident rooms.</p> <p>Further investigation of the unlocked storage rooms, on 08/19/14 at 4:00 PM, revealed wound care supplies, thirteen (13) bottles of tube feeding, oxygen tanks, crash cart and emergency equipment. The supply closet was found to have sixteen (16) bottles of mouth wash, seven (7) cans of shaving cream, eleven (11) bottles of shampoo/body wash, and seventeen (17) bottles of body moisturizer. Further review of the contents revealed warning labels on the mouthwash to include if swallowed contact poison control, review of the shaving cream revealed a list of ingredients to include propane and butane, and the body moisturizing lotion label stated for external use only avoid contact with eyes.</p> <p>Observation, on 08/19/14 at 2:45 PM, revealed Resident #8 had one bottle of alcohol based after shave and four (4) cans of shaving cream on the sink located in the room.</p> <p>Observation, on 08/21/14 at 9:45 AM, revealed Resident #11 was in a wheelchair by the nurse's station pulling on the supply closet door then trying to open a shower door at 10:05 AM.</p> <p>Interview with Housekeeping Supervisor, on 08/19/14 at 4:25 PM, revealed she made room rounds weekly and monitored for aerosol products on her rounds. She stated that each resident had their own personal supplies and had been allowed to keep them at their bedside and not in a locked container.</p> <p>Interview with Licensed Practical Nurse (#3), on 08/19/14 at 4:45 PM, revealed the facility has two</p>	F 323	<p>the floor was instructed on 08/20/14 by the Director of Nursing in training to not close the resident's room door whenever she was assigned to monitor the hall during meal time. Other residents having the potential to be affected by the same practice would be any resident that is unable to use the call light system and requires assistance during meal times. Measures/systemic changes put in place include ongoing nursing employee education. On 09/22/14 and 09/23/14, Director of Nursing re-educated all nursing employees on the need for a nursing employee to be available on each hall during meals in order to respond to calls for assistance. To ensure the above solution is sustained, the Director of Nursing or RN designee will perform random weekly observations of all three meals for staff availability to hear and respond to residents calling. These observations will continue weekly until 100% compliance is achieved for three months then the frequency of the observations will decrease to monthly. The shift assignment sheets will be reviewed by the Director of Nursing or RN designee at the same frequency as the meal observations in order to ensure the hall monitoring has been assigned during meal times. The monthly observations and reviews will be ongoing.</p>	10/01/14
-------	---	-------	---	----------

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 323	Continued From page 16 (2) residents that have wandering as a behavior. She stated Resident #8 was a wandering resident and resided on the 100 hall. Interview with LPN #2, on 08/21/14 at 3:59 PM, revealed Resident #8 wanders in other residents' rooms looking for various things when confused and Resident #11 goes in other residents' rooms also. LPN #2 stated she did not know why there were four (4) cans of shaving cream in Resident #8's room. Interview with DON #2, on 08/19/14 at 4:20 PM, revealed she did not personally see anything the residents could get into. She stated the doors have never been locked and she has never been told to keep them locked. She stated she did not know the contents of the personal hygiene supplies stored in the supply room and was surprised to see propane and butane listed as an ingredient in shaving cream. Interview with the Administrator, on 08/19/14 at 4:30 PM, revealed she was not aware of the warnings on the hygiene supplies and did not realize the shaving cream contained butane and propane, She indicated that the supplies should not be available for wandering residents and the facility was not safe with the supply room doors unlocked and with all residents having access to personal care supplies at their bedsides.	F 323	The Director of Nursing or RN designee will present monthly compliance reports for review and discussion to the Internal Quality Assurance (QA) Team monthly. The Quality Assurance (QA) Committee will review and discuss at least quarterly each component of this correction. The Quality Assurance (QA) Committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted as deemed appropriate by the Quality Assurance (QA) Committee.	10/01/14	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328	Direct care nursing employees were educated on 08/21/14 by Director of Nursing and Director of Nursing in training that nurse aides are not to push hold on the enteral feeding pump at any time. The aide is to	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 328	<p>Continued From page 17</p> <p>Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy, it was determined the facility failed to ensure one (1) of fourteen (14) sampled residents (Resident #7), who required a Gastric Tube (GT) for nutritional needs, received the proper care and positioning required to prevent aspiration, related to the failure to turn off the feeding pump, prior to laying the resident flat in bed for incontinent care.</p> <p>The findings include:</p> <p>Review of facility policy titled, "Medication Administration via Enteral Tube", dated 07/08/14, revealed to place the resident in a proper position with head of bed elevated to 45 degrees.</p> <p>Record review revealed the facility admitted Resident #7 on 06/25/13 with diagnoses which included Dysphagia due to Cerebrovascular Disease, Esophageal Reflux, Aphasia due to Cerebrovascular Disease, and Polyneuropathy in Diabetes.</p> <p>Review of the Comprehensive Care Plan for attention to Tube Feeding, dated 06/17/14, revealed an intervention to elevate the head of bed thirty (30) degrees related to the tube</p>	F 328	<p>notify the licensed nurse that the head of the bed may need to be lowered for the provision of care so the licensed nurse can make the determination whether or not the tube feeding should be held or if it is in the best interest of the patient to lower the head of the bed for the provision of care. All other residents receiving enteral feeding may be affected by the same practice. Director of Nursing in training educated nurses on both 09/08/14 and 09/18/14 about the following measures/systemic changes. The Title of the Training is "Deficiency Corrections related to G-tube policy, procedures and nurse expectations." The following measures/systemic changes were fully implemented on 09/18/14: The charge nurses on duty will monitor and document compliance of keeping the head of bed elevated unless requested by the nurse aide to evaluate whether or not the head of the bed should be lowered. The charge nurse will also document whether or not any enteral feedings were noted to be placed on hold without the prior determination as appropriate by the licensed nurse. Monitoring for compliance will be performed by the Director of Nursing or RN designee through random weekly visual audits and via monitoring the daily documentation of</p>	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 328	Continued From page 18 feeding. Observation of Certified Nursing Assistant (CNA) #1 providing care for Resident #7, on 08/19/14 at 10:40 AM, revealed Resident #7's head of bed was in the flat position while the CNA was providing incontinent care and the feeding pump was running. Interview with CNA #1, on 08/21/14 at 12:25 PM, revealed she normally would push the "hold" button on the feeding pump when providing care and when care was completed she would raise the resident's head of bed to 45 degrees then release the hold on the pump so the feeding would start again.	F 328	the charge nurses for compliance with the policy. The Director of Nursing will present monthly compliance report for review and discussion to the Internal Quality Assurance (QA) Team. The Quality Assurance (QA) Committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted as deemed appropriate by the Quality Assurance (QA) Committee.	10/01/14	
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined the facility failed ensure food was stored, prepared, distributed and served under sanitary conditions. Observations on 08/19/14 and 08/21/14 revealed the ice maker was in need of cleaning, unboxed and undated	F 371	Corrective action for this deficiency was cleaning the ice maker on 09/30/14. All residents, employees, and visitors served meals from the kitchen have the potential to be affected by the practice. Systemic changes include an increase in scheduled cleaning requirements from every six months to every three months. The Dietary Manager will monitor the ice maker monthly in order to ensure cleaning every three months is sufficient. Cleaning schedules will be increased in frequency as needed. The ice maker cleanliness monitoring will be ongoing. The Dietary Manager will report to the Internal Quality Assurance (QA) Team monthly regarding the status of the ice maker cleanliness. There will be ongoing reports to the Quality Assurance (QA) Committee which will provide instructions regarding changes or additions.	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 371	<p>Continued From page 19</p> <p>food items were noted in the freezer, the sanitizer bucket test reading was below the accepted range of 50 Parts per Million (PPM,) mops were stored on the floor, and the dishwasher rinse cycle was below the accepted temperature range.</p> <p>A review of the facility census for 08/19/14, revealed there were three (3) residents who received tube feedings and did not utilize the kitchen amenities.</p> <p>The findings include:</p> <p>1. Observation of the kitchen, on 08/19/14 at 2:30 PM revealed the following:</p> <p>A. Review of a facility policy titled, "Cleaning Ice Machine", undated, revealed the ice machine was scheduled to have been cleaned every six (6) months and was last cleaned on 03/12/14 and was due to be cleaned again in September 2014.</p> <p>Observation of the drip plate above the ice in the ice machine revealed a dark cream colored, filmy substance, that removed easily with a gloved finger.</p> <p>Interview with the Dietary Manager at the time of the observation revealed she was not aware the drip plate had not been cleaned during this process and stated if it was, the ice machine cleaning should have been completed more often than every six months.</p> <p>B. Review of a facility policy titled, "Policy and Procedure for Boxes Opened Up", dated 07/12/2012, revealed "Procedure: When a box is opened up, plastic bags are to be dated."</p>	F 371	<p>Corrective action for the unlabeled packages of food in the freezer; all the unlabeled and outdated food was removed from the freezer and thrown away. All residents, employees, and visitors served meals from the kitchen have the potential to be affected by the practice. Systemic changes and measure implemented to prevent the practice from recurring included the dietary employee education on 08/22/14 by the Dietary Manager related to the proper labeling of opened boxes to include the dating of all bags regardless of whether or not the bag was opened. To ensure the above solutions are sustained, the Dietary Manager will monitor the freezer twice a week for properly dated and/or outdated food items. Freezer monitoring by the Dietary Manager will be ongoing. The Dietary Manager will report monthly the results and ongoing compliance to the Internal Quality Assurance (QA) Team. The Quality Assurance (QA) Committee will review and discuss at least quarterly each component of this correction.</p> <p>Corrective action for the mops stored on the floor was to hang the mops on the wall with hooks. All residents, employees, and visitors served meals from the kitchen have the potential to be affected by the practice. Systemic changes implemented to ensure the mops are not stored on the floor included a mop storage</p>	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 371	<p>Continued From page 20</p> <p>Observation of the freezer revealed unboxed and unlabeled packages of frozen donuts, bags of Peanut Butter Cookies, Blueberry Cobbler and bags of Waffle Fries, Sweet Potato Fries, Riblets, Fish and Zucchini Sticks. Observation of the small reach in refrigerator revealed containers of pre-poured juice which had thickener added. One of the containers had no date or label and one had a date of 08/26/13 which was eighteen (18) days after it had been labeled and placed into the refrigerator.</p> <p>Interview with the Dietary Manager at the time of the observation revealed the dietary staff were aware of the policy but she would need to re-inservice the staff.</p> <p>C. Review of a facility policy titled, "Dietary Policies and Procedures", dated 05/14/10, revealed the sanitizer solution would be at the recommended strength and changed each shift or as needed. The procedure was to prepare the sanitizer bucket to equal 100 parts per million (PPM) by having used a one-eighth (1/8) teaspoon of bleach to thirty-two (32) ounces of warm water, test for strength using chlorine test strips and the cloths were to have been stored in the solution, when not in use.</p> <p>Observation of the sanitizer bucket tested less than 50 PPM.</p> <p>Interview with the Dietary Manager at the time of the observation revealed the sanitizer bucket had been prepared at approximately 11:00 AM and should have measured 50-100 PPM.</p> <p>D. Review of a facility policy titled, "Policy and Procedures for Sanitation," dated July 2010,</p>	F 371	<p>policy revision and education for the housekeeping and dietary employee on 09/10/14 given by Dietary Manager, Housekeeping/Laundry Supervisor and Maintenance Supervisor. The mop heads will be removed after each use and the dirty mops will be placed in laundry. The mop handle and the broom will be stored on the hooks in the dietary department. The Dietary, Housekeeping, and Maintenance Supervisors will monitor compliance with the policy for mop head storage at least three times a week until 100% compliance is sustained for three months. The frequency of mop head storage will then decrease to weekly. Monthly analysis of the audit findings and continued compliance will be presented for review and discussion to the Internal Quality Assurance (QA) Team. The Quality Assurance (QA) Committee will determine when consistent compliance has been attained and the frequency of the weekly audits can be adjusted if deemed appropriate.</p> <p>Corrective action for the sanitizer solution was to empty the solution and mix up the correct ppm. All residents, employees, and visitors served meals from the kitchen have the potential to be affected by the practice. Systemic changes and measures implemented to ensure the practice does not reoccur include the following: the dietary employees were educated on 08/22/14 by</p>	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 371	Continued From page 21 revealed "All mops and brooms will be hung-up after each use." Observation of the storage closet in the kitchen, revealed a mop stored on the floor. Interview with the Dietary Manager at the time of the observation revealed there was a broom and mop storage hanger on the wall, but the handle holders were sprung and unusable. E. Interview with the Dietary Manager at the time of the kitchen observation revealed there was no specific policy for the Dishwasher Temperatures but she had not been told they were not acceptable and would have called someone to assess the problem. Three different observations of the dishwasher temperatures revealed rinse temperatures from 130 to 172 degrees Fahrenheit (F.) A review of the temperature logs for August 2014 revealed three dishwasher rinse temperatures were recorded at 120 twice and 130 degrees F.	F 371	the Dietary Manager regarding the policy revision which requires the sanitizer solution to be changed every four hours. Additionally the sanitizing solution will be tested with chlorine strips every two hours and the water changed if not at the correct ppm. The employees will document the results of the chlorine test strip and will be reviewed by the Dietary Manager at least three times a week for compliance. The Dietary Manager will monitor and document compliance with the policy for the sanitizing solution at least three times a week until 100% compliance is sustained for three months then the frequency will be decreased to bi-weekly. Monthly analysis of the audit findings and continued compliance will be reviewed and discussed by the Internal Quality Assurance (QA) Team. The Quality Assurance (QA) Committee will determine when consistent compliance has been attained and the frequency of the audits can be adjusted. Corrective action for the dishwasher rinse cycle temperatures: On 08/21/14 the temperature relay switch was adjusted so the rinse water would be at the correct temperature. Measures put into place in order to ensure the rinse water would be at the right temperature in the future was to replace the relay switch which was completed 08/23/14. The dietary employees were educated on 08/22/14 by the Dietary Manager to	10/01/14	
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;	F 441			

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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)	(X6) COMPLETION DATE	
F 441	<p>Continued From page 22</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy, it was determined the facility failed to ensure infection control procedures were followed for three (3) of fourteen (14) sampled residents (Resident #1, Resident #2 and Resident #6). Staff failed to remove gloves and wash hands during wound care for Resident #2 and incontinent care for Resident #6. In addition, the facility failed to ensure oxygen (O2) tubing was stored in a bag when not in use per the facility's policy for Resident #1.</p>	F 441	<p>report outlying temperatures to the Dietary Manager immediately. The Dietary Manager will monitor the dish washer temperature logs three times a week until compliance is maintained for three months at which time the frequency of monitoring the logs will change to weekly. Monthly analysis of the audit findings and continued compliance will be presented for review and discussion to the Internal Quality Assurance (QA) Team. The Quality Assurance (QA) Committee will determine when consistent compliance has been attained and the frequency of the monthly audits can be adjusted if deemed appropriate.</p> <p>The corrective actions for the following infection control measures were as follows: For resident #1, the nebulizer set up and oxygen tubing were placed in a bag; for resident #2 and resident #6 the nursing employees were educated on universal precautions specifically the need to remove soiled gloves and wash hands prior to donning clean gloves or touching any other object or thing. Every resident has the potential to be affected by the deficient practice. Systemic Changes: On both 09/22/14 and 09/23/14 by the Director of Nursing provided education and required every direct care nursing staff was required competency demonstrated in universal precautions and respiratory equipment storage. Director of Nursing in training</p>	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 23</p> <p>The findings include:</p> <p>1. Review of the facility policy for "Respiratory Care Services," last revised 06/12/14, revealed after each use, the tubing and nebulizer masks were to be placed into a plastic storage bag.</p> <p>Observations of Resident #1, on 08/19/14 at 10:11 AM, 2:56 PM and 3:30 PM and on 08/20/14 at 9:40 AM and 08/22/14 at 11:00 AM, revealed the portable O2 tank nasal cannula tubing and the nebulizer tubing were unbagged and there was no evidence of a bag nearby for the tubing.</p> <p>Interviews with Certified Nurse Aide (CNA) #8 and CNA #10 on 08/20/14 at 11:10 AM and 11:20 AM, revealed the O2 and nebulizer tubing should have been bagged. The CNA was unable to locate bags for the tubing and CNA #10 left the room to obtain the supplies.</p> <p>Interview with Registered Nurse (RN) #1, on 08/22/14 at 11:20 PM, revealed she would have expected the nurses and CNAs to ensure the tubing had been stored properly after use and was unaware this had not been done for this resident.</p> <p>2. Review of the facility policy titled, "Universal Precautions Policy", dated 06/22/09, revealed hands should be washed with soap and water after providing care, and if visibly soiled, after removing gloves and as needed.</p> <p>Record review revealed the facility admitted Resident #2 on 03/31/14 with diagnosis which included Pressure Ulcer to Lower Back, Hypertension, Urinary Tract Infection (UTI) and</p>	F 441	<p>on 09/08/14 presented education to all nursing staff regarding correct hand washing procedures including use of universal precautions (i.e gloves and proper storage of respiratory supplies. Additionally, direct care nursing employees will be required to demonstrate clinical competency as a final step in the orientation process and annually from their date of hire. Monitoring performance to ensure solutions are sustained will be performed by the Director of Nursing or RN designee through the performance of unannounced random monthly audits across all three shifts. These audits will include the demonstration of appropriate use of universal precautions, hand washing techniques, and the proper storage of oxygen equipment. The frequency of monthly audits may be changed upon direction of the Quality Assurance (QA) Committee after 100% Compliance is sustained for one year. The consultant respiratory therapist will conduct visual inspections during scheduled visits at least monthly and report noncompliance to the Director of Nursing as needed. Compliance reports will be presented by the Director of Nursing for review and discussion to the Internal Quality Assurance (QA) monthly.</p>	10/01/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 24 Urinary Device.</p> <p>Observation on 08/20/14 at 08:50 AM, revealed RN #1 entered Resident #2's room to provide wound care. RN #1 applied gloves and gathered her equipment and supplies. The RN removed the old dressing from the wound and then removed her contaminated gloves. The RN applied another pair of gloves without washing her hands prior to applying the clean gloves, and then completed the dressing change procedure.</p> <p>Interview with RN #1, on 08/20/14 at 2:00 PM, revealed she thought she washed her hands after removing her gloves. She stated she knew better and was aware of the importance of washing her hands.</p> <p>3. Observation of CNA #2 providing incontinent care for Resident #8, on 08/20/14 at 11:00 AM, revealed she completed the incontinent care without changing or removing her soiled gloves. She replaced the resident's brief, proceeded to put her hand in her pocket and remove a marker, redressed the resident all while continuing to wear the same contaminated gloves.</p> <p>Interview with CNA (#2), on 08/21/14 at 3:45 PM, revealed she knew the importance of cross contamination, and realized what she did after she left the room. She stated she had been trained to wash her hands and remove soiled gloves but just did not do it that day.</p> <p>Interview with Director of Nursing (DON), on 08/21/14 at 1:15 PM, revealed she expected staff to wash their hands between glove changes. She stated all of her employees had extensive training in handwashing.</p>	F 441		

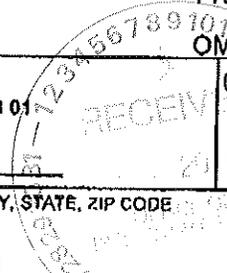
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 21 smoke detectors and 21 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/20/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of fifty five (55) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>The facility corrective action was to immediately, on 08/20/14, educate all facility staff on duty at the time which included administrative staff, nursing staff, dietary staff, housekeeping/laundry staff and maintenance staff of the following information relative to the north hall fire doors. This impromptu education was provided by the, Maintenance Supervisor. Education was in regard to the possibility of the North Hall fire doors not closing properly and if the fire alert system is alarming employees are to physically inspect all fire doors in the facility to ensure they are closing properly. Additional education occurred on 09/04/14 when Housekeeping/Laundry and Maintenance staff were educated by the Housekeeping/Laundry Supervisor and the Maintenance Supervisor. Instruction in the form of documented communication was given to administrative staff and licensed nurses by the Director of Nursing in training on 09/12/14. This same education was provided to all nursing staff on both 09/22/14 and 09/23/14 by the Director of Nursing in training. Other residents that are admitted to the affected area, employees and visitors may have the potential to be affected by the deficient practice. Measures to ensure the practice will not</p>	09/30/14
-------	--	-------	---	----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *James H. Council* TITLE *Administrator* (X6) DATE *10/08/14*

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: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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)	(X6) COMPLETION DATE
K 000 K 027 SS=D	<p>Continued From page 1</p> <p>A deficiency was cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with National Fire Protection Agency (NFPA) standards. The deficient practice has the potential to affect two (2) of four (4) smoke compartments, thirty (30) residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-five (55).</p> <p>The findings include:</p> <p>Observation, on 08/20/14 at 2:06 PM with the Maintenance Supervisor, revealed the cross-corridor doors located in the North Hall</p>	K 000 K 027	<p>recur: On 09/26/14, the new coordinating device was installed on the cross-corridor doors located in the North Hall. The facility will monitor its performance to ensure that solutions are sustained by increasing frequency of inspections from quarterly to monthly. The inspections are conducted by the Maintenance Supervisors. The inspections are to ensure that all cross-corridor doors located in a smoke barrier are properly functioning and completely closing when tested and in accordance with the NFPA standards. The Administrative Assistant will review the Maintenance checklist monthly for compliance and provide a monthly report to the Internal Quality Assurance (QA) Committee for review and discussion.</p>	09/30/14

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 027	<p>Continued From page 2</p> <p>would not close completely when tested. This was due to the doors not having a coordinating device installed to ensure the door without the t-astragal would close first after the initial close.</p> <p>Interview, on 08/20/14 at 2:07 PM with the Maintenance Supervisor, revealed he was not aware of the requirement.</p> <p>The census of fifty-five (55) was verified by the Administrator on 08/20/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/20/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.</p> <p>Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition)</p> <p>2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting</p>	K 027		
-------	--	-------	--	--

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 027	Continued From page 3 latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		
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 for Protection of Hazards, in accordance with the National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, four (4) residents, staff and visitors. The facility has the capacity for sixty (60) beds and the census was fifty-five (55) on the day of the survey.	K 029	The facility corrective action: a self-closing device was installed on the door to the kitchen on 09/08/2014. Other residents that are admitted to the effective area, employees and visitors may have the potential to be affected by the deficient practice. Measures to ensure the practice will not recur: The facility has installed a self-closing device on the door to the kitchen. The facility plans to monitor its performance to ensure that solutions are sustained by increasing the frequency of inspection from quarterly to monthly. The inspections are conducted by the Maintenance Supervisors. The inspections are to ensure that all self closing doors and magnetic locks are releasing properly. The Administrative Assistant will review the Maintenance checklist monthly for compliance and provide a monthly report to the Internal Quality Assurance (QA) Committee.	09/30/14

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
---	--

(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	<p>Continued From page 4</p> <p>The findings include:</p> <p>Observation, on 08/20/14 at 2:12 PM, with the Maintenance Supervisor revealed the door to the Kitchen was not equipped with a self-closing device.</p> <p>Interview, on 08/20/14 at 2:12 PM, with the Maintenance Supervisor revealed he was not aware the room would have to meet the requirements of protection from hazards.</p> <p>The census of fifty-five (55) was verified by the Administrator on 08/20/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/20/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 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</p>	K 029		
-------	---	-------	--	--

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
--	--

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 029	<p>Continued From page 5</p> <p>(2) Central/bulk laundries larger than 100 ft² (9.3 m²)</p> <p>(3) Paint shops</p> <p>(4) Repair shops</p> <p>(5) Soiled linen rooms</p> <p>(6) Trash collection rooms</p> <p>(7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</p> <p>(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.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing.</p>	K 029		
-------	---	-------	--	--

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 6 (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-five (55). The findings include:	K 047	The facility corrective action: an exit sign has been installed above the door to the kitchen making the path of egress clearly recognizable on 09/15/14. Employees and visitors may have the potential to be affected by the deficient practice. Measures to ensure the practice will not recur: The facility has installed a exit sign above the kitchen door making the path of egress clearly recognizable. The facility plans to monitor its performance to ensure that solutions are sustained by increasing the frequency from quarterly to monthly and conducted by the Maintenance Supervisors. The inspections are to ensure that all exit doors have the proper exit signage making the path of egress clearly recognizable. The Administrative	09/30/14

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105147	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 047	<p>Continued From page 7</p> <p>Observation, on 08/20/14 at 2:12 PM with the Maintenance Supervisor, revealed the Kitchen have a manual hood suppression pull located next to an exit door. However, the exit door did not have proper exit signage making the path of egress clearly recognizable.</p> <p>Interview, on 08/20/14 at 2:13 PM with the Maintenance Supervisor, revealed he was unaware of the requirements for egress.</p> <p>The census of fifty-five (55) was verified by the Administrator on 08/20/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/20/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.</p> <p>7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits.</p>	K 047	Assistant will review the Maintenance checklist for compliance and provide a monthly report to the Internal Quality Assurance (QA) Committee.		

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 047	Continued From page 8 Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. 7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more	K 047			

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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 047	Continued From page 9 than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame. 7.10.1.6* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. 7.10.1.7* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted. 7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.3* Sign Legend. Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters.	K 047		

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 047	Continued From page 10 7.10.4* Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception*: illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.6 Externally Illuminated Signs. 7.10.6.1* Size of Signs. Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum	K 047		1	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 047	<p>Continued From page 11</p> <p>established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height.</p> <p>Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high.</p> <p>Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5.</p> <p>7.10.6.2* Size and Location of Directional Indicator.</p> <p>The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated.</p> <p>Exception: This requirement shall not apply to approved existing signs.</p> <p>Figure 7.10.6.2 Chevron-type indicator.</p> <p>7.10.6.3* Level of Illumination.</p> <p>Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5.</p> <p>7.10.7 Internally Illuminated Signs.</p> <p>7.10.7.1 Listing.</p> <p>Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment.</p>	K 047		

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 047	Continued From page 12 Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5. Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 047			
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	The facility corrective action: On 09/03/14, R. Carr and Associates inspected and tested the charger, discharger and a load voltage on the fire alarm batteries. All current and future residents, employees and visitors may have the potential to be affected by the same deficient practice. Measures to ensure that the deficient practice will not recur: A schedule will be maintained to ensure that all required inspections and testings are performed in a timely manner. The Administrative Assistant	09/30/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 052	Continued From page 13 This STANDARD is not met as evidenced by: Based on fire alarm inspections and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-five (55). The findings include: Fire alarm inspection review, on 08/20/14 at 2:30 PM with the Maintenance Supervisor, revealed the charger test was not documented on the fire alarm inspection paperwork. Interview, on 08/20/14 at 2:31 PM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a charger test on the fire alarm batteries on an annual basis. Fire alarm inspection review, on 08/20/14 at 2:32 PM with the Maintenance Supervisor, revealed the discharge test was not documented on the fire alarm inspection paperwork. Interview, on 08/20/14 at 2:33 PM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a discharge test on the fire alarm batteries on an annual basis.	K 052	and Maintenance Supervisor will audit the schedule and performance logs to ensure load voltage test has been performed semi-annually and the charger and discharger testing has been performed annually. The audits will be reported monthly to the Internal Quality Assurance (QA) Committee.		

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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)	(X6) COMPLETION DATE	
K 052	Continued From page 14 Fire alarm inspection review, on 08/20/14 at 2:34 PM with the Maintenance Supervisor, revealed the load voltage test was not documented on the fire alarm inspection paperwork. Interview, on 08/20/14 at 2:35 PM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a load voltage test on the fire alarm batteries on a semi-annual basis. The census of fifty-five (55) was verified by the Administrator on 08/20/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/20/14. Actual NFPA Standard: Reference: NFPA 101 (2000 ed.), 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052			
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056	The facility corrective action: All sprinkler heads have been unobstructed by relocating the light fixtures. Other residents that are admitted to the affected area, employees and visitors may have the potential to be affected by the same deficient practice. Measures to ensure the deficient practice will not recur: the Maintenance Supervisors will complete an inspection to ensure that all	09/30/14	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041	
(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)	(X6) COMPLETION DATE
K 056	<p>Continued From page 15</p> <p>switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the sprinklers were installed, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, four (4) residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-five (55). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems.</p> <p>The findings include:</p> <p>Observation, on 08/20/14 at 2:10 PM with the Maintenance Supervisor, revealed two (2) sprinkler heads were blocked from developing a full spray pattern by light fixtures being installed within twelve (12) inches of the sprinkler head and extending down below the sprinkler diffuser.</p> <p>Interview, on 08/20/14 at 2:11 PM with the Maintenance Supervisor, revealed he was not aware of the requirement.</p> <p>Observation, on 08/20/14 at 2:19 PM with the Maintenance Supervisor, revealed one (1) sprinkler head was blocked from developing a full spray pattern by a light fixture being installed within twelve (12) inches of the sprinkler head and extending down below the sprinkler diffuser.</p>	K 056	<p>sprinkler heads are free from any type of obstruction. The facility plans to monitor its performance to ensure that solutions are sustained by increasing the frequency of sprinkler head inspections from quarterly to monthly. The inspections are conducted by the Maintenance Supervisors. The inspections are to ensure that all sprinkler heads are free from any type of obstruction. The Administrative Assistant will review the Maintenance checklist for compliance and provide a monthly report to the Internal Quality Assurance (QA) Committee.</p>	

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014																		
NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041																			
(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 056	<p>Continued From page 16</p> <p>Interview, on 08/20/14 at 2:20 PM with the Maintenance Supervisor, revealed he was not aware of the requirement.</p> <p>The census of fifty-five (55) was verified by the Administrator on 08/20/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/20/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.6.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)</th> <th>Maximum Allowable Distance of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> </tbody> </table>	Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Maximum Allowable Distance of Deflector Obstruction (in.)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	K 056		
Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Maximum Allowable Distance of Deflector Obstruction (in.)																					
Less than 1 ft	0																					
1 ft to less than 1 ft 6 in.	2 1/2																					
1 ft 6 in. to less than 2 ft	3 1/2																					
2 ft to less than 2 ft 6 in.	5 1/2																					
2 ft 6 in. to less than 3 ft	7 1/2																					
3 ft to less than 3 ft 6 in.	9 1/2																					
3 ft 6 in. to less than 4 ft	12																					
4 ft to less than 4 ft 6 in.	14																					

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

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041		
(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 056	Continued From page 17 4 ft 6 in. to less than 5 ft 161/2 6 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls, Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056			