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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185427	(X2) MULTIPLE CONSTRUCTION OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2011
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NAME OF PROVIDER OR SUPPLIER NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was initiated and concluded on 11/22/11. A Life Safety Code survey was conducted on 11/22/11. Deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be imposed.</p>	F 000		
F 252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to maintain a clean environment. Two (2) of nine (9) resident room floors were discolored with multiple black marks and dull in color. Three (3) of nine (9) resident bathrooms had a build up of black discoloration along the outside seam of the shower where it meets the floor.</p> <p>The findings include:</p> <p>Record review of the facility policy on Frequency of Cleaning Schedule (Revised 07/08) revealed stripping and waxing floors were classified as project work and were cleaned on an as needed basis.</p>	F 252	<p>F252</p> <p>The floors in rooms 301, 302, 307, 310 and 312 have been stripped of all the old finish and were re-finished. The old caulking along outside seam of shower has been removed and replaced in rooms 304, 310, and 307. All remaining rooms in the Nursing Facility are scheduled for re-finishing to be completed by 1/1/2012.</p> <p>The Manager of Environmental Services will provide education to each housekeeper on the proper use and contact time for floor cleaner with the microfiber mop.</p> <p>Annual competency program has been revised to include the proper use and contact time for floor cleaner with the microfiber mop.</p> <p>Each room (floor) is set up on a routine polishing schedule which will be logged and documented each week on the rooms that were buffed. The floor tech will keep and maintain the log in the supervisor's office. (cont.)</p>	01/01/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
X Linda Brag
 TITLE
X VP/CNO
 (X8) DATE
X 12/22/11

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

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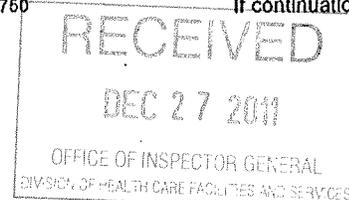
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F 252	<p>Continued From page 1</p> <p>Record review of the Patient Room-Occupied Cleaning Procedures revealed the floors of the resident rooms were to be mopped daily beginning in the far corner of the room. In addition, bathroom floors were also to be mopped daily.</p> <p>Observation, on 11/22/11 at 8:40 AM, in Room 302 revealed the floor in front of the bathroom having numerous long black marks. This discoloration was noted to go into the room the length of eight floor tiles. In Room 303 the floor was discolored with black marks in front of the bathroom and numerous tiles in the room were discolored in a half moon shape. At 11:40 AM it was observed that the floor outside of the showers in Room 304, 309, and 310 was missing caulking where the shower pan meets the tile floor and a brown/black discoloration was along the seam line.</p> <p>Interview, on 11/22/11 at 4:40 PM, with the Unit Manager revealed Rooms 302 and 303 were in need of buffing and cleaning. She stated the floors are cleaned twice a week and stripped and waxed twice a year. The condition of the floors had been reported to Environmental Services and Environmental Services had not been able to get to the floors. She stated the floors looked horrible.</p> <p>Interview, on 11/22/11 at 4:50 PM, with Registered Nurse (RN) #2 revealed the floors would look better if they were stripped, waxed and buffed. She noted there was a marked difference in how good the floors looked when they were not marked up.</p>	F 252	<p>F 252 (cont.)</p> <p>The Environmental Service Supervisor will inspect a different room, one room a day, and any floor that shows signs of wear or discoloration is to be reported and immediately scheduled for required maintenance in coordination with the Nursing Facility Manager, to be completed within two weeks time from reported date. Any caulking that is showing signs of discoloration or disrepair is to be reported to facilities management through the work order processing and is to be completed within thirty (30) days.</p> <p>In addition, housekeepers and floor care professionals will be held accountable for reporting any discoloration or unsightly conditions in the floor and the caulking around the showers and sinks through weekly quality inspections performed by their supervisors.</p> <p>In the absence of an identified need, all floors and caulking will re-finished according to the periodic cleaning policy, once every six (6) months for floors and annually for caulking.</p> <p>Environmental Services Manager will make weekly quality rounds with Supervisors through each of the inpatient units. Any immediate corrective action will be noted in the management log and appropriate maintenance will be completed within two week's time in coordination with the unit manager and room availability. A work order will be submitted for any issues related to caulking.</p>	
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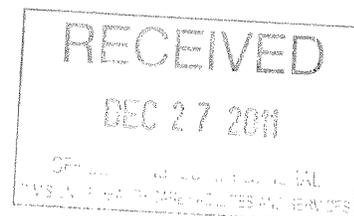
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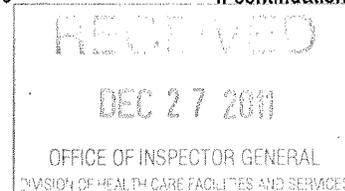
F 252	Continued From page 2 Interview, on 11/22/11 at 3:20 PM, with the Environmental Services Supervisor revealed the scratches and discoloration to the floors had been there and the floors were mopped daily. He stated he was aware of the look of the floors and the floors are not scheduled to be done until next month. The floor technicians were responsible to notify management of the condition of the floors and the cleaning schedule would have been moved up. However, previous interview with the unit manager revealed the status of the floors had been reported to Environmental Services without a response. He stated his observation of the floors revealed they needed to be redone, in reference to stripping and waxing.	F 252	F 252 - ADDENDUM (12/20/2011) The floor in room 303 was stripped of all the old finish and re-finished on Thursday, December 15, 2011. The old caulking along outside seam of shower was removed and replaced in room 309 on Thursday, December 15, 2011. The Administrator of the Nursing Facility will conduct a monthly walk-through of each room and do a visual inspection for cleanliness and disrepair of environment. Any issues of concern will be directed to the appropriate department manager for correction.	
F 371 SS=F	483.35(l) 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, record review and review of the facility's policy Food, Nutrition, and Dress Code and the Infection Control Policy, it was determined the facility failed to provide and maintain sanitary conditions in the kitchen area. There were food boxes sitting on the kitchen floor. The refrigerator had one (1) of the three	F 371	F 371 The food boxes identified sitting on the kitchen floor were emptied of the produce and stored in the appropriate storage area. Food and Nutrition Services Infection Control Policy 8030-0046 was reviewed and revised to state that when produce is delivered the time of delivery will be written on invoice and products will be stored promptly to refrigerator or shelving as appropriate. Ingredient Room staff will be educated regarding policy change by the Department Director at the December staff meeting. The Department Director will monitor compliance for process/policy change and document on compliance log for one month to ensure process in place. Periodic audits will be performed on an ongoing basis to ensure continued compliance.	12/31/2011



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F 371	Continued From page 3 (3) plastic storage bags undated. A scoop was stored in one (1) container of dried navy beans. Three (3) of four (4) ovens had grease build up. Four (4) male kitchen staff with beards were not wearing beard covers. The findings include: Record Review of the facility's policy Infection Control, #3. Storage: food is stored sufficiently above floor level and away from walls and perishable foods with no expiration dates and at time of purchase are dated with a sticker or label indicating date received: #5 Serving/Holding: A. Food is served with clean tongs, scoops, forks, spoons, spatulas or suitable implements so as to avoid direct hand contact with foods and, I. Equipment: ranges and grills are cleaned daily. Record review of the facility's policy Food and Nutrition Dress Code, dated 8/10, Section A. Personal Hygiene: #3. Male employees must be clean shaven or wear a beard no more than one half (1/2) inch long. B. Hair Restraints: #2. Men must be clean shaven or facial hair must be kept to one half (1/2) inch in length and well groomed. If longer than one half (1/2) inch a face/beard net will be worn. The Infection Control Policy, dated 6/10, revealed males were allowed to have beards up to one-half (1/2) inch. Observation, on 11/22/11 at 8:35 AM, revealed boxed produce of oranges, lettuce, baked potatoes wrapped in aluminum foil sitting directly on the tiled kitchen floor. Interview, on 11/22/11 at 8:35 AM, with the Dietary Director verified the policy was not to	F 371	F 371 (cont) Department specific policy will be reviewed during initial orientation for all new employees. (SEE – ADDENDUM - Behind Page 11) Undated plastic storage bags were removed from inventory. Food and Nutrition Services Infection Control Policy 8030-0046 was reviewed and found to include procedures for storing opened/leftover foods. Proper storage includes marking of expiration date. Re-education of Food and Nutrition staff regarding policy requirements will be provided during the December staff meeting by Director of FANS. Director of FANS will monitor for compliance with dating of items and document on compliance log for one month following education. Periodic audits will be performed on an ongoing basis to ensure continued compliance. Department specific policies will be reviewed during initial orientation for all new employees. (SEE – ADDENDUM - Behind Page 11) The scoop identified in the container of dried navy beans was removed. FANS Infection Control Policy 8030-0046 was reviewed and revised to include "scoops will not be stored in food bins".	



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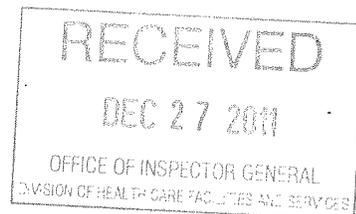
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F 371	<p>Continued From page 4</p> <p>store food on the floor. The produce vendor placed items of boxed produce on the floor as the facility staff reviewed items were correctly received then facility staff sign for the delivery of produce.</p> <p>Interview, on 11/22/11 at 12:15 PM, with the Dietary Supervisor revealed when produce was delivered to the facility it was placed on the floor until facility staff was able to put the produce away.</p> <p>Interview, on 11/22/11 at 4:06 PM, with the Dietary Director reported that stored food on the kitchen floor would be a risk for contamination, pest and rodents and a counter would provide a clean environment for delivered produce. She was not able to determine the time in which the food was stored on the kitchen floor.</p> <p>Observation, on 11/22/11 at 8:35 AM, revealed one (1) of three (3) plastic storage bags which contained fresh broccoli was not dated and one (1) of two (2) large plastic bags with elbow macaroni opened and not dated by facility staff.</p> <p>Interview, on 11/22/11 at 8:55 AM, with the Dietary Director revealed all food items when opened was to be dated the same day. She further stated all the employees received orientation which included the policy and procedures for the food and nutrition department.</p> <p>Observation, on 11/22/11 at 8:35 AM, revealed a large scoop was stored in a large plastic lidded storage container of dried northern beans.</p> <p>Interview, on 11/22/11 at 9:00 AM, with the</p>	F 371	<p>F 371 (cont)</p> <p>Department Director will provide education regarding policy change during the December staff meeting.</p> <p>Department Director will monitor for compliance policy/process change and document on compliance log for one month following education. Periodic audits will be performed on an ongoing basis to ensure continued compliance.</p> <p>Department specific policy will be reviewed during initial orientation for all new employees. (SEE – ADDENDUM - Behind Page 11)</p> <p>The ovens identified with grease build-up have been cleaned thoroughly.</p> <p>FANS Infection Control Policy 8030-0046 was reviewed and found to include the requirement for cleaning and maintaining ovens on a rotational basis. Cleaning of ovens are to be done daily and as needed so that each oven is cleaned at a minimum of every four (4) days and more often as required. A documentation log is to be kept to track cleaning of each oven.</p> <p>Re-education of Food and Nutrition staff regarding policy requirements will be provided during the December staff meeting by Director of FANS.</p>	
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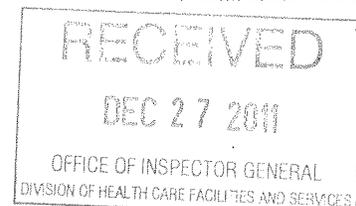
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F 371	<p>Continued From page 5</p> <p>Dietary Director revealed all scoops should have been stored outside the container.</p> <p>Observation, on 11/22/11 at 9:10 AM, with Dietary Director revealed three (3) of the four (4) facility ovens had a greasy, hard, black/brown substance in and outside.</p> <p>Record Review of the facility's compliance form for oven breakdown and the cleaning log for September, October, and November 2011 revealed that oven #1 was not cleaned, oven #2 was cleaned twice, oven #3 was cleaned twice and oven #4 was cleaned once in the three month period.</p> <p>Interview, on 11/22/11 at 9:10 AM, with kitchen staff #9, revealed the facility ovens were dirty and were not being cleaned according to the facility policy.</p> <p>Interview, on 11/22/11 at 4:06 PM, with the Dietary Director revealed monthly in-services were provided to all employees on the care of the facility kitchen environment.</p> <p>Observation, on 11/22/11 at 9:05 AM, one male kitchen staff had facial hair without a facial covering.</p> <p>Observation, on 11/22/11 at 11:15 AM, of the Dietary Supervisor revealed had with facial hair without a facial cover and prepared food trays for the residents.</p> <p>Interview, on 11/22/11 at 3:25 PM, with the Dietary Supervisor revealed he acknowledged he and three (3) other male kitchen staff had facial</p>	F 371	<p>F 371 (cont)</p> <p>The Director of the department will monitor for cleaning of ovens and documentation of cleaning on an ongoing basis to ensure compliance of policy.</p> <p>Department specific policy will be reviewed during initial orientation for all new employees. (SEE – ADDENDUM - Behind Page 11)</p> <p>Policy/process allowing staff with facial hair to not wear beard cover has been changed.</p> <p>FANS Infection Control Policy 8030-0046 was reviewed and revised to include requirements for hair restraints as outlined in the FDA 2005 Food Code Chapter 2 Section 402.11. "All food employees shall wear hair restraint such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair". Dress code policy 8030-0009 that provide for staff to wear beards/facial hair without beard restraints has been deleted.</p> <p>Department Director will provide education regarding policy changes during the December staff meeting.</p> <p>Beard covers have been purchased and received.</p> <p>Department Director will monitor for compliance policy/process change and document on compliance log for one month following education.</p>	



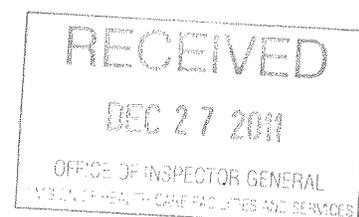
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F 371	Continued From page 6 hair and did not use facial covers while in the facility kitchen, as the facility policy allowed male staff with facial hair to go without covers. Interview, on 11/22/11 at 4:06 PM, with the Dietary Director confirmed the facility policy allowed male staff with facial hair, up to one half (1/2) inch, to go without covers.	F 371	F 371 (cont) Periodic audits will be performed on an ongoing basis to ensure continued compliance. Department specific policy will be reviewed during initial orientation for all new employees. (SEE - ADDENDUM - Behind Page 11)	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	F 431 Removed identified ophthalmic solution, and topical medications from oral medication drawers and stored them in a separate locked cart with resident name, in individual compartments, away from oral medications. Inventoried all resident medication drawers to ensure other residents were not impacted by deficiency. No other findings were noted. Reviewed Storage of Medication Policy 0203-0042 and found policy to be compliant in that "external preparations were to be stored separately from internal medications". Manager of Nursing Facility will provide re-education of applicable staff through one-on-one education and at December staff meeting regarding policy requirements. (cont)	12/31/2011



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F 431	<p>Continued From page 7</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to store all drugs and biologicals in accordance with currently accepted professional principles on two (2) of two (2) medication carts.</p> <p>The findings include:</p> <p>Record review of the facility policy Storage of Medications (Reviewed 11/11) revealed external preparations were to be stored separately from internal medications.</p> <p>Observation, on 11/22/11 at 11:00 AM, of the two (2) medication carts positioned at the nurses station, revealed in the medication drawer for Resident #3 Tobramycin Ophthalmic Solution, oral medication and a topical medication stored together. The medication drawer for Unsampled Resident "A" was found to contain topical Bacitracin ointment, oral Lanoxin pills and an inhaler. The medication drawer for Unsampled Resident "B" contained Bacitracin topical ointment and oral Bisacodyl. In addition, a topical medication for Unsampled Resident "A" was found in the medication drawer of Resident #3.</p> <p>Interview, on 11/22/11 at 11:15 AM, with</p>	F 431	<p>F 431 (cont)</p> <p>Manager of Nursing Facility will perform daily audits to monitor for compliance and document on audit form for one month.</p> <p>Random audits will be done on an ongoing basis to ensure continued compliance.</p> <p>Review of department specific policy will be incorporated into initial orientation program for all new employees.</p> <p>F 431 - ADDENDUM (12/20/2011)</p> <p>The Manager of the Nursing Facility will perform daily (Monday-Friday) audits of 100% of the resident's medication drawers to monitor for compliance with separation of oral and topical medications for one month. Any non-compliant issues identified will be corrected immediately, by separating oral and topical medications. Nursing staff responsible for medication draw will receive education / remediation as indicated from the Manager of the Nursing Facility. The percentage compliance rate will be calculated by dividing the number of medication drawers that are compliant (oral and topical medications separated appropriately) by the total number of drawers observed x 100. The compliance rate will be documented on an audit form.</p> <p>After one month of daily auditing, described above, the manager of the Nursing Facility will evaluate the compliance rate and if there is a 100% compliance rate the audit (cont)</p>	

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NAME OF PROVIDER OR SUPPLIER NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701
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F 431 Continued From page 8
Registered Nurse (RN) #2 revealed resident medication was to be stored under lock and key. Each resident had an individual drawer for their medications. She revealed oral medications, topical medications and ophthalmic medications were to be stored separately. She stated there was a locked cart in the storage room for the topicals and ophthalmic to be stored.

Interview, on 11/22/11 at 11:20 AM, with RN #3 revealed oral medications were to be stored in the drawer on the medication cart and the topical medications and ophthalmic medication was to be stored in a separate room. She revealed during the medication pass the practice had been to store all the medications together until the medication pass was completed.

Interview, on 11/22/11 at 11:20 AM, with the Unit Manager revealed topical, oral and ophthalmic medications were to be stored separately. She stated the nurses were responsible to ensure proper storage of medications.

F 465
SS=F 483.70(h)
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's Utilities Management Program and the water temperature log, it was determined the facility failed to maintain a safe, functional and

F 431 **ADDENDUM (cont)**
frequency will be decreased to one time per month using same methodology as described in the daily audit. If the compliance rate is less than 100% then the daily audits will continue until 100% compliance is maintained for at least one month and then audits be reduced to monthly.

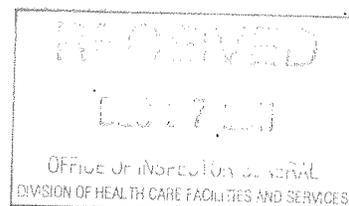
Compliance rate data will be reported to the Quality Assurance (QA) Committee on a quarterly basis. The QA Committee (that include Nursing Facility Administrator) will review data and make recommendations / take actions as applicable.

F 465
F 465
Water temperatures in excess of 110 degrees.

A manual adjustment to the hot water control valve was completed and water temperatures monitored to bring hot water temperature below maximum range of 110 degrees.

System will be reviewed for control issues and appropriate action taken to improve tolerance of temperature to stay within range.

1/1/2012



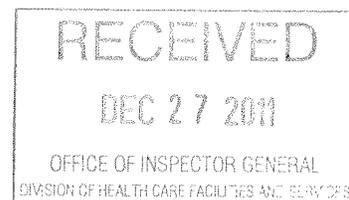
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F 465	<p>Continued From page 9</p> <p>comfortable environment for the residents. Eight (8) of eight (8) resident rooms had temperatures in excess of one-hundred ten (110) degrees when checked.</p> <p>The findings include:</p> <p>Review of the facility's policy on the Utilities Management Program (Revised 06/07) revealed the facility shall maintain a program designed to assure operational reliability, assess risks and respond to failures of the domestic hot water. However, the system did not flag the hot water temperatures in the resident rooms as too hot on 11/22/11 during the survey.</p> <p>Record review of the facility temperature log, which is produced every morning listing the temperatures of the previous day, revealed the water temperatures were within acceptable range prior to 6:00 AM on 11/22/11, the date of the survey.</p> <p>Observation, on 11/22/11 at 3:25 PM, revealed the following hot water temperatures: Room 302 at 114.9 degrees, Room 303 at 115.1 degrees, Room 304 at 115.0 degrees, Room 305 at 114.5 degrees, Room 307 at 112.2 degrees, Room 308 at 116 degrees, Room 309 at 117 degrees, and Room 310 at 114.5 degrees. These temperatures were obtained with the Plant Engineering Supervisor utilizing a calibrated thermometer.</p> <p>Observations of rooms 301 and 310 temperatures, on 11/22/11 at 5:00 PM, revealed they were under 110 degrees.</p>	F 465	<p>F 465 (cont)</p> <p>Plant engineering staff will manually check temperature of patient or department room hot water temperature with a calibrated thermometer at least once per shift and document on rounding log.</p> <p>Hot water temperature check will be added to current rounding log. The supervisor of plant engineering will review rounding logs weekly to ensure high temperature range remains below 110 degrees.</p> <p>F 465 - ADDENDUM (12/22/2011)</p> <p>The Director of Facilities and Supervisor of Plant Engineering completed a review of the hot water distribution system. The analysis consisted of an evaluation of the steam control valve, piping distribution system and consultation with the manufacturers of the hot water heater. All components were found to be functioning as designed.</p> <p>The water temperatures will be manually monitored in one room, one time per shift, (three alternating rooms in a twenty-four hour period) using a digital thermometer on an ongoing basis. If the range is not within the 101-110 degree range, Plant Engineering personnel will manually adjust the water heater controls to bring temperature within range. (cont)</p>	



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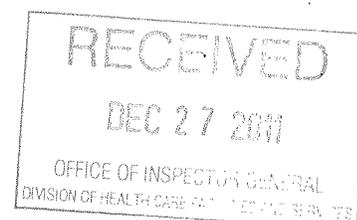
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F 465 Continued From page 10
Interview, on 11/22/11 at 3:55 PM, with the Plant Engineering Supervisor revealed the water temperatures are checked hourly and he received a print out each morning of the water temperatures from the previous day. There was an instantaneous hot water heater control valve. The hot water temperatures are adjusted a little at a time. The sensor, to detect the water temperature rising, was either out of calibration or out of place, he stated. Continued interview with the Plant Engineering Supervisor revealed he had knowledge of the consequences to the residents' skin when the water temperatures are too hot.

F 465 **F 465 - ADDENDUM (cont)**

The Plant Engineering personnel will document the room number and temperature on an audit log which is kept in the Nursing Facility.

The audit log will be reviewed at the quarterly NF Quality Assurance Committee. The QA Committee (that include Nursing Facility Administrator) will review data and make recommendation / take action as applicable.



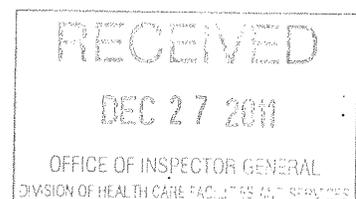
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F 371		F 371	<p>F 371 – ADDENDUM (12/20/2011)</p> <p>Timeliness of Food Storage:</p> <p>The Director of Food and Nutrition Services (FNS) will audit the timeliness of storage of produce by comparing time of receipt of produce to storage of produce. Compliance is defined as less than 30 minutes from receipt to storage completed. The time of receipt and time of storage will be documented on the invoice. 100% of deliveries will be audited for one month and compliance rate calculated by dividing deliveries that were stored in less than thirty (30) minutes by total number of deliveries received x 100. Director of FNS will conduct ongoing audits, one (1) time per month to ensure processes are hardwired using methodology described above and perform walk-through of departments at usual delivery times for visual confirmation of storage. Compliance rate will be documented on an audit log.</p> <p>Expiration dates on opened foods/leftovers:</p> <p>The Director of FNS will audit dating of opened food/leftover items placed in storage by performing a walkthrough of storage area (one time per month) and conducting visual observation for dates on opened/leftover food items. Any items without dates will be removed from inventory. Compliance will be documented by dividing number of walkthrough when no undated items were found by total number of walkthroughs x 100.</p>	



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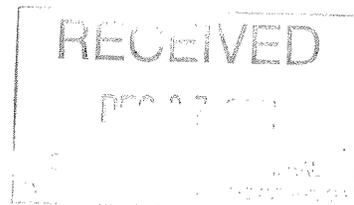
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F 371		F 371	<p>F 371 - ADDENDUM (cont)</p> <p>Compliance rate will be document on an audit log. Audits will be performed on an ongoing monthly basis. Department supervisors will perform daily walkthrough within their department and monitor for opened/leftover food items without dates and if found remove item and provide education/remediation to staff as applicable.</p> <p>Scoop found in food bin:</p> <p>The Director of FNS will audit for proper storage of food utensils by performing a walkthrough of storage area (one time per month) and conducting visual observation for scoops or other items improperly stored in food bins. Any item found stored in a food bin will be removed immediately. Compliance will be documented by dividing number of walkthroughs with no improper storage of items found by total number of walkthroughs x 100. Compliance rate will be documented on an audit log. Department supervisors will perform daily walkthrough within their department and monitor for improver storage of food utensils and if found remove item and provide education/remediation to staff as applicable.</p> <p>Compliance with beard policy:</p> <p>Monitoring of compliance with covering of facial hair will be documented monthly. Supervisor of FNS will provide ongoing, daily, supervision and monitoring (cont)</p>	
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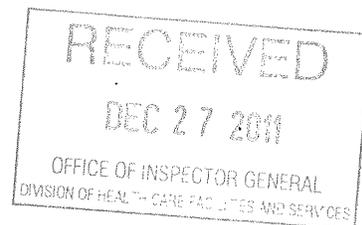
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F 371		F 371	<p>F 371 – ADDENDUM (cont)</p> <p>for compliance with covering of facial hair and will provide education and/or remediation to any employee found not in compliance with policy. Director of FNS will conduct a walkthrough at a minimum of one time per month to audit for compliance with policy. Compliance rate will be calculated by dividing number of staff wearing facial covering divided by the total number of staff where the facial covering was indicated x 100. Compliance rate will be documented on an audit log.</p> <p>Cleaning of oven The Director of FNS will: 1) Conduct a monthly walkthrough and do a visual inspection of 100% of the ovens to monitor for cleanliness/buildup. Compliance with cleaning will be calculated by dividing number of items that are clean/without any grease buildup divided by total number of ovens x 100. 2) Review documentation of cleaning logs to ensure process for cleaning is followed. Compliance with documentation of cleaning will be calculated dividing number of times documentation of cleaning occurred by total number of time documentation should have occurred.</p> <p>Administrator Role in Monitoring: Audit data, for all items related to F 371, will be forwarded to the Nursing Facility Quality Assurance Committee for review. The QA Committee (that include Nursing Facility Administrator) will review data and make recommendations / take action as applicable.</p>	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1954, 1967, 1979, 1983, 1989, 1993, 2005</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Six stories, Type I protected</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system</p> <p>GENERATOR: Type I generator installed in 2005. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/22/11. The Nursing Facility of Hardin Memorial Hospital was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for fifteen (15) beds with a census of ten (10) 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</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X Funda Bracy* TITLE: *X VP/CNO* (X6) DATE: *X 12/22/11*

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.

DEC 27 2011
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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K 000	Continued From page 1 Fire).	K 000		
K 050 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is licensed for fifteen (15) beds with a census of ten (10) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Drill review, on 11/22/11 at 11:51 AM, with the Director of Facilities Management revealed the fire drills were not being conducted at unexpected times under varied conditions. The second shift fire drills have been performed predictably around 8:15 PM each quarter. Third</p>	K 050	<p>K 050</p> <p>The Director of Facilities Management worked in collaboration with the security shift leader to establish that the timing of fire drills will be at unexpected times under varied conditions as required by NFPA 101 Life Safety Code Standard.</p> <p>Reviewed and revised Administrative Policy 0070-0028, Fire Drills, to include "timing of fire drills will be at unexpected times under varied conditions".</p> <p>The drills will be staggered so as to not occur within at least one hour of previous drill. All drills will be recorded on a log and will be reviewed by the Security Manager/Life Safety Committee Chairperson to ensure that compliance with the unexpected times is maintained.</p> <p>Compliance information will be reported to the Environment of Care Safety Committee.</p>	1/6/2012

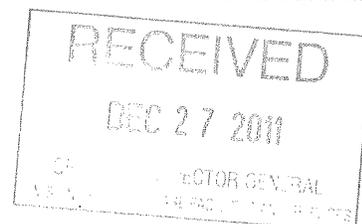
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K 050	<p>Continued From page 2</p> <p>shift fire drills have been performed predictably around 5:00 to 5:15 AM.</p> <p>Interview, on 11/22/11 at 11:51 AM, with the Director of Facilities Management revealed he was not aware the fire drills were not being conducted as required.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p>	K 050		



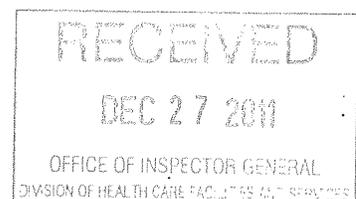
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F 371		F 371	<p>F 371 – ADDENDUM (12/20/2011)</p> <p>Timeliness of Food Storage:</p> <p>The Director of Food and Nutrition Services (FNS) will audit the timeliness of storage of produce by comparing time of receipt of produce to storage of produce. Compliance is defined as less than 30 minutes from receipt to storage completed. The time of receipt and time of storage will be documented on the invoice. 100% of deliveries will be audited for one month and compliance rate calculated by dividing deliveries that were stored in less than thirty (30) minutes by total number of deliveries received x 100. Director of FNS will conduct ongoing audits, one (1) time per month to ensure processes are hardwired using methodology described above and perform walk-through of departments at usual delivery times for visual confirmation of storage. Compliance rate will be documented on an audit log.</p> <p>Expiration dates on opened foods/leftovers:</p> <p>The Director of FNS will audit dating of opened food/leftover items placed in storage by performing a walkthrough of storage area (one time per month) and conducting visual observation for dates on opened/leftover food items. Any items without dates will be removed from inventory. Compliance will be documented by dividing number of walkthrough when no undated items were found by total number of walkthroughs x 100.</p>	



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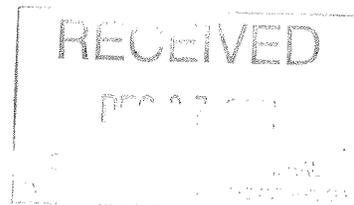
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F 371		F 371	<p>F 371 - ADDENDUM (cont)</p> <p>Compliance rate will be document on an audit log. Audits will be performed on an ongoing monthly basis. Department supervisors will perform daily walkthrough within their department and monitor for opened/leftover food items without dates and if found remove item and provide education/remediation to staff as applicable.</p> <p>Scoop found in food bin:</p> <p>The Director of FNS will audit for proper storage of food utensils by performing a walkthrough of storage area (one time per month) and conducting visual observation for scoops or other items improperly stored in food bins. Any item found stored in a food bin will be removed immediately. Compliance will be documented by dividing number of walkthroughs with no improper storage of items found by total number of walkthroughs x 100. Compliance rate will be documented on an audit log. Department supervisors will perform daily walkthrough within their department and monitor for improver storage of food utensils and if found remove item and provide education/remediation to staff as applicable.</p> <p>Compliance with beard policy:</p> <p>Monitoring of compliance with covering of facial hair will be documented monthly. Supervisor of FNS will provide ongoing, daily, supervision and monitoring (cont)</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2011
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NAME OF PROVIDER OR SUPPLIER NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 371		F 371	<p>F 371 – ADDENDUM (cont)</p> <p>for compliance with covering of facial hair and will provide education and/or remediation to any employee found not in compliance with policy. Director of FNS will conduct a walkthrough at a minimum of one time per month to audit for compliance with policy. Compliance rate will be calculated by dividing number of staff wearing facial covering divided by the total number of staff where the facial covering was indicated x 100. Compliance rate will be documented on an audit log.</p> <p>Cleaning of oven The Director of FNS will: 1) Conduct a monthly walkthrough and do a visual inspection of 100% of the ovens to monitor for cleanliness/buildup. Compliance with cleaning will be calculated by dividing number of items that are clean/without any grease buildup divided by total number of ovens x 100. 2) Review documentation of cleaning logs to ensure process for cleaning is followed. Compliance with documentation of cleaning will be calculated dividing number of times documentation of cleaning occurred by total number of time documentation should have occurred.</p> <p>Administrator Role in Monitoring: Audit data, for all items related to F 371, will be forwarded to the Nursing Facility Quality Assurance Committee for review. The QA Committee (that include Nursing Facility Administrator) will review data and make recommendations / take action as applicable.</p>	
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