

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

RECEIVED
DATE: 12/05/2011
FORM APPROVED
CMS NO. 0938-0391
DEC 13 2011
11/17/2011
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185420	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2011
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP+4 80 HOSPITAL DRIVE BARBOURVILLE, KY 40906	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served under sanitary conditions. Observations in the kitchen on 11/15/11, at the noon meal revealed dietary staff failed to wear a hair restraint for facial hair. In addition, a dietary employee's personal items were observed on the food service table.</p> <p>The findings include: A review of the Nutritional Services policy did not address employee facial hair restraints.</p> <p>Observation of the noon meal service on 11/15/11, at 11:45 AM, revealed the Dietary Manager was present in the kitchen without a hair restraint covering his facial hair. Further observation of the food service line table revealed</p>	F 371	See Attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Craig Morgan TITLE: CEO (X6) DATE: Dec 13, 2011

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

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F 371	Continued From page 1 the dietary line server's cell phone, keys, and tube of lotion were on the serving table during meal service. An interview with the Dietary Manager (DM) on 11/16/11, at 3:30 PM, revealed the DM was unaware of the need to restrain facial hair. The DM further stated the dietary employee who had personal items on the service table knew that was not allowed and had been counseled. The DM also stated he had been educated in "Safe Serve" practices prior to his employment. A second observation in the kitchen on 11/16/11, at 4:30 PM, revealed the DM continued to be present in the kitchen without a facial hair restraint. The DM stated he did not have any beard restraints and that he planned to order them.	F 371	See Attached		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT. SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	See Attached		

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F 441	<p>Continued From page 2</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 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 and interview the facility failed to ensure medication carts were clean and sanitary. Observation of the medication cart revealed dried sticky substances, debris, and soil inside the medication drawers.</p> <p>The findings include:</p> <p>The facility did not have a policy or schedule for medication cart cleaning.</p> <p>Observations on 11/16/11, at 8:45 AM, revealed the medication cart was soiled. Dried sticky substances were observed inside the medication</p>	F 441	<i>See Attached</i>	

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F 441	Continued From page 3 drawers as well as grit and pill debris. An interview with the Director of Nursing (DON) on 11/16/11, at 10:00 AM, revealed the facility did not have a policy or a cleaning schedule to ensure the medication cart was clean and sanitary. The DON stated the nurses clean it whenever they have time.	F 441	<i>See Attached.</i>		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure corridors were equipped with firmly secured handrails. Four handrails were observed to be loose from the walls of the hallway. The findings include: The Maintenance Supervisor denied having a policy related to handrail repair/maintenance. Observations conducted of the main hallway on 11/15/11, at 11:04 AM, revealed loose handrails located outside resident rooms 204, 205, and 216 and in the corridor located outside of the day room/dining room. Interview on 11/16/11, at 2:20 PM, with the Maintenance Supervisor revealed facility staff used the intranet to notify the Maintenance Department of any needed repairs or	F 468	<i>See Attached</i>		

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F 468	Continued From page 4 maintenance issues. Based on interview, the Maintenance Supervisor stated the Maintenance Department relied on facility staff to notify the Department of any issues. The Maintenance Supervisor stated she was unaware the handrails were loose. She also stated she looks at the handrails to make sure they are not broken or cracked but had not checked to see if any were loose.	F 468	<i>See Attached.</i>		
F-520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	<i>See Attached.</i>		

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F 520	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a Quality Assurance meeting was held on a quarterly basis to identify issues with respect to quality assessment and assurance activities. Interview and record review revealed one Quality Assurance meeting had been conducted within the previous twelve months. The findings include: A review of the facility's Quality Assurance (QA) policy revealed the QA Committee was to meet quarterly. An interview with the Director of Nursing (DON) on 11/17/11, at 10:00 AM, revealed the QA Committee had met one time in the previous twelve months. The DON stated, "I know we are supposed to meet quarterly, but I failed to schedule a meeting. I just forgot."	F 520	See Attached.	

F 371

It is the policy of this facility that all food will be prepared and served under sanitary conditions. To ensure compliance the following steps have been implemented:

1. The policy has been revised to include the requirement that Dietary staff with facial hair must wear beard restraints to prevent their hair from contacting exposed food. A new policy regarding proper placement of personal items in the Dietary Department was created.
2. All residents would have the potential to be affected by this practice.
3. Beard restraints will be made available to all Dietary staff with facial hair. All staff will be in serviced on the updated policy for hair restraints on December 12, 2011. All staff will be in serviced on the new policy for proper placement of personal items in the Dietary Department on December 12, 2011.
4. The Dietician and/or Infection Control Nurse will observe Dietary staff
 - a. Two (2) times a week for one (1) month
 - b. One (1) time a week for three (3) months
 - c. One (1) time a month for two (2) monthsto monitor compliance for proper use of hair restraints and proper placement of personal items.
5. Compliance will also be monitored through Hazardous Surveillance Rounds annually.

Completion Date: December 14, 2011

F 441

It is the policy of this facility that all medication carts will be kept clean and sanitary. To ensure compliance the following steps have been implemented:

1. The medication cart was cleaned and sanitized and a new policy was implemented for cleaning and sanitation of medication carts.
2. All residents would have the potential to be affected by this practice.
3. A new policy was implemented for cleaning and sanitation of the medication cart. This will also include a cleaning log to ensure that the medication cart is cleaned and sanitized. All nursing staff will be in serviced on the new policy and cleaning log on December 16, 2011 by the Director of Nursing.
4. The LTC DON will conduct random checks to ensure compliance. A new PI Monitor will be added: Medication Cart Cleaning and Sanitation: A) Medication cart is clean and sanitized. Threshold 100%. B) Medication cart cleaning schedule is completed and current. Threshold 100%.

Completion Date: December 16, 2011

F 468

It is the policy of this facility that all corridors will be equipped with firmly secured handrails. To ensure compliance the following steps have been implemented:

1. Four loose handrails were secured and all other handrails were checked. A policy has been implemented by housekeeping in conjunction with maintenance on daily

monitoring and reporting loose handrails to the maintenance department. A daily cleaning schedule has been implemented to include inspection of handrails.

2. All residents would have the potential to be affected by this practice.
3. All housekeeping and maintenance staff will be in serviced on the policy and the daily cleaning schedule by December 16, 2011 by the Housekeeping and Maintenance Supervisors. During daily cleaning, housekeeping will inspect handrails and will report any loose handrails to the maintenance department for repair.
4. The housekeeping staff will check handrails daily while cleaning and report any loose handrails to the maintenance department.
5. The Maintenance Supervisor will make rounds monthly to monitor compliance to ensure that solution is sustained.

Completion Date: December 16, 2011

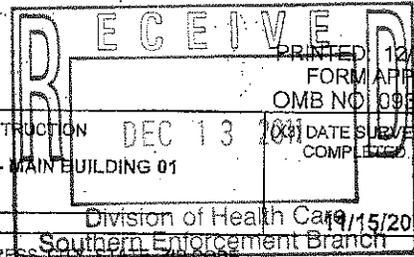
F 520

It is the policy of this facility to maintain a Quality Assessment and Assurance committee to identify issues with respect to which quality assessment and assurance activities are necessary and to develop and implement appropriate plans of action to correct identified quality deficiencies. To ensure compliance the following steps have been implemented:

1. The policy has been revised to reflect Quality Assessment and Assurance committee requirements as directed by the LTC Regulation 483.75. A Quality Assessment and Assurance Committee meeting is scheduled for December 29, 2011 for the fourth quarter.
2. All residents would have the potential to be affected by this practice.
3. The Quality Assessment and Assurance Committee members will be in serviced on the revised policy by December 31, 2011 by the LTC DON. Quality Assessment and Assurance Committee meetings will be scheduled quarterly to follow the LTC Care Plan Meeting.
4. The LTC DON will schedule the Quality Assessment and Assurance Committee meetings quarterly. The LTC DON will keep a calendar of these scheduled meetings and notify the members prior to each scheduled meeting. Minutes of meetings will be maintained by the LTC DON.

Completion Date: December 31, 2011

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 80 HOSPITAL DRIVE BARBOURVILLE, KY 40906
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1992 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type II (000) SMOKE COMPARTMENTS: Two COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type I diesel generator A life safety code survey was initiated and concluded on 11/15/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
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	K 052	See attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Craig Morgan TITLE: CEO (X8) DATE: Dec 13, 2011

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

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K 052	<p>Continued From page 1 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</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the fire alarm system was maintained according to NFPA standards. This deficient practice affected two of two smoke compartments, staff, and all the residents. The facility has the capacity for 16 beds with a census of 16 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/15/11, at 1:45 PM, with the Director of Maintenance (DOM), a record review of the facility's fire alarm system revealed the last two inspections were performed on 09/10/10 and 09/20/11, by a fire alarm contractor. No documentation was provided that components associated with the fire alarm system had been inspected or maintained between those dates as required.</p> <p>An interview with the DOM revealed the facility</p>	K 052	See Attached	

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K 052	Continued From page 2 failed to maintain the fire alarm system as required due to financial issues. Reference: NFPA 72 (1999 Edition). 7-1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this code, shall conform to the equipment manufacturer's recommendations, and shall verify correct operation of the fire alarm system.	K 052	See Attached	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the sprinkler system was maintained according to NFPA standards. This deficient practice affected two of two smoke compartments, staff, and all the residents. The facility has the capacity for 16 beds with a census of 16 on the day of the survey. The findings include: During the Life Safety Code survey on 09/15/11, at 1:45 PM, with the Director of Maintenance (DOM), a record review of the facility's sprinkler system revealed the last two sprinkler inspections were performed on 11/18/10 and 09/29/11, by a sprinkler contractor. No documentation was	K 062	See Attached	

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K 062	<p>Continued From page 3</p> <p>provided that components associated with the sprinkler system had been inspected or maintained between those dates as required.</p> <p>An interview with the DOM revealed the facility failed to maintain the sprinkler system as required due to financial issues.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>1-4.2* The responsibility for properly maintaining a water-based fire protection system shall be that of the owner(s) of the property. By means of periodic inspections, tests, and maintenance, the equipment shall be shown to be in good operating condition, or any defects or impairments shall be revealed. Inspection, testing, and maintenance shall be implemented in accordance with procedures meeting or exceeding those established in this document and in accordance with the manufacturer's instructions. These tasks shall be performed by personnel who have developed competence through training and experience.</p> <p>1-9.1 System components shall be inspected at intervals specified in the appropriate chapters.</p>	K 062	<i>See Attached</i>		

K 052

The fire alarm system is maintained according to NFPA 101 Life Safety Code Standard.

1. A proposal from Allied Communications was accepted for quarterly inspections of the fire alarm system.
2. The fourth quarter inspection is scheduled for December 14, 2011. (will forward report of inspection on December 14, 2011)
3. The MEOC/Safety Manager will report the completion of the quarterly testing to the MEOC Committee and PI Committee quarterly.

Completion Date: December 14, 2011

K 062

The sprinkler system is inspected and maintained according to NFPA 101 Life Safety Code Standard.

1. Agreement with Simplex Grinnell is in place for inspection of the sprinkler system. (Attachment)
2. The fourth quarter inspection was done on December 8, 2011. (Attachment)
3. The MEOC/Safety Manager will report the completion of the quarterly testing to the MEOC Committee and PI Committee quarterly.

Completion Date: December 8, 2011