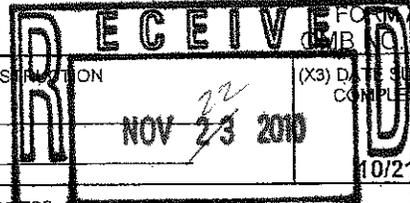


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
CIR 0938-0391



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 10/27/2010
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP 80 HOSPITAL BLVD 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 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two (2) of nine (9) sampled residents (residents #3 and #4) were free from physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Residents #3 and #4 were observed to utilize a lap buddy while out of bed in a wheelchair; however, there was no evidence the device was utilized to treat a medical symptom and no assessment had been conducted prior to the use of the lap buddy for these residents. In addition, there was no evidence the facility had informed the resident's responsible party (R/P) of the risks/benefits related to the use of the lap buddy for residents #3 and #4.</p> <p>The findings include:</p> <p>1. Record review revealed resident #3 was admitted to the facility on July 8, 2009, with the following diagnoses: Pernicious Anemia, Hypertension, Hyperlipidemia, Kyphosis, Impaired Circulation, Polio, and Dementia. Resident #3's</p>	F 221	See attached.	

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

TITLE

(X6) DATE

Ray Perry

CEO

11/22/10

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 221	<p>Continued From page 1</p> <p>Minimum Data Set (MDS) dated July 5, 2010, revealed both long and short-term memory problems and moderate independence with the ability to make daily decisions. The MDS also revealed the resident required assistance with transfers and mobility:</p> <p>Further record review revealed documentation that resident #3 slid out of the wheelchair on August 3, 2010, without injuries. The record revealed a physician's order was obtained on August 4, 2010, for a lap buddy to be used when resident #3 was up in a wheelchair. However, there was no evidence of a medical symptom to support the use of the lap buddy. There was no evidence the facility had conducted an assessment prior to the use of the lap buddy. In addition, there was no evidence the facility had informed the resident's R/P of the risks/benefits associated with using a restraint device.</p> <p>Observation of resident #3 on October 19, 2010, at 10:40 a.m., 11:20 a.m., 12:00 p.m., 1:20 p.m., 2:40 p.m., 3:00 p.m., and 5:15 p.m., revealed a lap buddy was present on the resident's wheelchair. Observation on October 20, 2010, at 8:30 a.m., 9:00 a.m., 9:30 a.m., 10:00 a.m., 10:30 a.m., 11:00 a.m., 12:00 p.m., and 1:30 p.m., revealed a lap buddy present on the resident's wheelchair.</p> <p>Interview with State Registered Nurse Aide (SRNA) #3 on October 21, 2010, at 2:55 p.m., revealed it was on the CNA care plan for the lap buddy to be utilized when resident #3 was up in the wheelchair and to remove it every two hours to take the resident to the bathroom. The CNA further revealed the resident could not remove the lap buddy and it was used for an activity board.</p>	F 221	<i>See attached</i>	

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F 221	<p>Continued From page 2</p> <p>Interview with SRNA #2 on October 21, 2010, at 3:05 p.m., revealed the lap buddy was to be used at all times when resident #3 was in the wheelchair. SRNA #2 stated the lap buddy was used as a table for the resident due to Kyphosis. The SRNA further stated being up in the wheelchair enabled the resident to be able to reach items more easily. The SRNA revealed the lap buddy is removed four to five times a day when the resident is taken to the bathroom.</p> <p>Interview with the Unit Manager (UM) on October 21, 2010, at 3:45 p.m., revealed the nurse on the floor should be responsible for ensuring the physician's orders were followed. The UM stated the staff nurse was also responsible to ensure the information was added to the nurse aide care plan. The UM stated he/she was responsible for the development of the comprehensive care plan, assessment, and obtaining the appropriate consent.</p> <p>A review of the facility's policy/procedure related to restraints (dated January 2007) revealed a physical restraint was defined as any mechanical device attached or adjacent to the resident's body that he/she could not remove and that restricted freedom of movement or normal access to one's body. The policy/procedure further noted the physician's order must specify the medical necessity for the restraint. In addition, the policy/procedure noted that the reason for the restraint, the resident's response, and a discussion with the resident's R/P would be documented in the medical record.</p> <p>Interview with the Unit Manager for the Long Term Care Unit and the Director of Nursing for</p>	F 221	See attached.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	<p>Continued From page 3</p> <p>the Hospital revealed no assessment had been conducted prior to application of the lap buddy for resident #3. The DON stated the resident's R/P had not been informed of the potential risks/benefits associated with restraint use. The DON stated the facility did not have a policy/procedure to address the use of a lap buddy and no protocol for assessment of the device prior to or following the application of a restraint device.</p> <p>2. A review of the medical record revealed resident #4 was admitted to the facility on March 15, 2010, with diagnoses of Alzheimer's Disease, Dementia, Osteoporosis, Degenerative Joint Disease, and Anxiety. A review of the significant change MDS assessment completed for resident #4 on July 7, 2010, revealed the resident was assessed to have a short/long-term memory deficit with minimally impaired decision-making skills, to require limited assistance of one for transfers, and to utilize side rails for bed mobility. In addition, the MDS assessment identified the resident to have sustained falls in the past 30 days. No other restraints were identified to be in use for resident #4.</p> <p>Resident #4 was observed on October 20, 2010, at 10:50 a.m. and 12:15 p.m., to be sitting in a wheelchair in the facility day room. A lap buddy was observed to be in place on the resident's wheelchair. The Activity Director (AD) was observed to be in the day room with the resident.</p> <p>Further record review revealed a skin tear was noted on resident #4's right lower leg on October 9, 2010, and physician's orders were obtained for treatment to the wound. In addition, a physician's order was obtained to apply a lap buddy for</p>	F 221	See attached.		

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F 221	<p>Continued From page 4</p> <p>safety. However, there was no evidence the facility had conducted an assessment prior to the use of the lap buddy and no evidence the facility had obtained a medical symptom for the use of the lap buddy prior to application of the device. In addition, there was no evidence the facility had informed the resident's R/P of the risks/benefits associated with using a restraint device.</p> <p>An interview conducted with the AD on October 20, 2010, at 10:55 a.m., revealed resident #4 required the use of the lap buddy due to the resident's attempts to climb out of the chair. The AD prompted the resident to remove the lap buddy; however, the resident did not respond to the command.</p> <p>An interview conducted with CNA #3 on October 20, 2010, at 2:00 p.m.; revealed the resident would make attempts to get out of the wheelchair, but was not sure why the resident needed the lap buddy. The CNA stated he/she had not received any training related to any specific care needs required for residents utilizing a lap buddy.</p> <p>A review of the facility's policy/procedure related to restraints (dated January 2007) revealed a physical restraint was defined as any mechanical device attached or adjacent to the resident's body that he/she could not remove and that restricted freedom of movement or normal access to one's body. The policy/procedure further noted the physician's order must specify the medical necessity for the restraint. In addition, the policy/procedure noted that the reason for the restraint, the resident's response, and a discussion with the resident's R/P would be documented in the medical record.</p>	F 221	See attached.		

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F 221	Continued From page 5 An interview conducted with the DON on October 21, 2010, at 11:05 a.m., revealed no assessment had been conducted prior to application of the lap buddy for resident #4. The DON stated the resident's R/P had not been informed of the potential risks/benefits associated with restraint use. The DON stated the facility did not have a policy/procedure to address the use of a lap buddy and no protocol for assessment of the device prior to or following the application of a restraint device.	F 221	See attached.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	See attached.	

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F 225	<p>Continued From page 6 investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct a thorough investigation into injuries of unknown source for two (2) of nine (9) sampled residents (residents #6 and # 7). In addition, the facility failed to report these injuries of unknown source to the appropriate state agencies.</p> <p>The findings include:</p> <p>1. A review of the risk/injury investigations for resident #6 revealed a skin tear was discovered by facility staff on the resident's left forearm on May 22, 2010, when the staff entered the resident's room. The cause of the injury was noted as old bruising to the affected area and the resident's skin was very thin and fragile. There was no evidence the facility had conducted a thorough investigation into the injury for resident #6 to attempt to determine the etiology of the wound. In addition, there was no documentation the facility had reported the injury of unknown source to the appropriate state agencies.</p> <p>Resident #6 was observed in bed on October 21,</p>	F 225	See attached.	

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F 225	<p>Continued From page 7</p> <p>2010, at 10:00 a.m. The resident was noted to have bilateral half side rails raised and mats on each side of the resident's bed. Resident #6 was not interviewable due to cognitive impairment.</p> <p>A review of the facility's policy/procedure related to abuse/neglect (revision date March 1, 2007) revealed that any suspicion of abuse involving mistreatment, neglect, or injuries of unknown source to any resident would be reported immediately to the Administrator, the Director of Nurses (DON), and Social Services. The policy/procedure further noted an internal investigation would be conducted into these allegations and reported to the appropriate state agencies.</p> <p>An interview conducted with the DON on October 21, 2010, at 4:10 p.m., revealed the DON was responsible for reviewing the risk/injury investigation reports to ensure a thorough investigation had been conducted and the appropriate agencies had been informed of the allegation. The DON stated he/she had not identified that a thorough investigation had not been conducted to determine the etiology of the injury sustained by resident #6. In addition, the DON stated he/she had not identified that the appropriate state agencies had not been informed.</p> <p>2. Record review for the risk/injury investigations of resident #7 revealed a skin tear on the left arm was discovered by the Certified Nurse Aide (CNA) on June 23, 2010. The cause of the injury was the resident's skin was noted to be "thin and fragile." There was no evidence the facility had conducted a thorough investigation into the injury for resident #7 to attempt to determine the</p>	F 225	<i>See attached.</i>	

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F 225	Continued From page 8 etiology of the wound. In addition, there was no documentation the facility had reported the injury of unknown source to the appropriate state agencies. An observation on October 21, 2010, at 9:45 a.m., revealed resident #7 was up in a chair in the Activity Room fully clothed with a tab alarm on. Further observation on this date at 1:15 p.m., 2:15 p.m., and 3:00 p.m., revealed the resident was in bed with half side rails, not padded as care planned with fall mats on both sides of the bed. A review of the facility's policy/procedure related to abuse/neglect (revision date March 1, 2007) revealed that any suspicion of abuse involving mistreatment, neglect, or injuries of unknown source to any resident wound be reported immediately to the Administrator, the Director of Nurses (DON), and Social Services. The policy/procedure further noted an internal investigation would be conducted into these allegations and reported to the appropriate state agencies. An interview conducted with the DON on October 21, 2010, at 4:10 p.m., revealed the DON was responsible for reviewing the risk/injury investigation reports to ensure a thorough investigation had been conducted and the appropriate agencies had been informed of the allegation. The DON stated he/she had not identified that a thorough investigation had not been conducted to determine the etiology of the injury sustained by resident #7. In addition, the DON stated he/she had not identified that the appropriate state agencies had not been informed.	F 225	<i>See attached.</i>	
F 272	483.20, 483.20(b) COMPREHENSIVE	F 272	<i>See attached.</i>	

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F 272 SS=E	Continued From page 9 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to comprehensively assess five (5) of nine (9) sampled residents (residents #1, #4, #5, #6, and #7) utilizing the	F 272	See attached.	

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F 272	<p>Continued From page 10</p> <p>Resident Assessment Protocol Summary (RAPS). The facility failed to assess the risk/causal factors and factors to be considered in developing an individualized plan of care to prevent falls/injury and for the use of physical restraint devices/side rails for residents #1, #4, #6, and #7. In addition, the facility failed to comprehensively assess residents #4 and #5 related to bladder incontinence. Residents #4 and #5 sustained a decline in bladder function; however, there was no evidence the facility had assessed the risk/causal factors and factors to be considered in developing an individualized plan of care related to bladder incontinence. (Refer to F279 and F315.)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Resident #4 was observed on October 19, 2010, at 10:55 a.m., to be lying on the bed with bilateral half (upper) side rails in use. Fall mats were observed on each side of resident #4's bed and an alarm was noted to be attached to the resident's clothing. No padding was noted to be on the half side rails. A bedside commode was observed to be sitting in the corner of the room. Resident #4 was not interviewable due to cognitive impairment. <p>A review of the admission comprehensive Minimum Data Set (MDS) assessment completed on March 20, 2010, revealed resident #4 was assessed to have a short/long-term memory deficit with minimally impaired decision-making skills and to require limited assistance of one for transfers, and to utilize side rails for bed mobility. Resident #4 was further assessed to be continent of bowel and bladder and to have sustained falls in the past 30 days and in 180 days. A significant</p>	F 272	See attached.	

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F 272	<p>Continued From page 11</p> <p>change MDS assessment completed for resident #4 on July 7, 2010, revealed the resident continued to utilize side rails for bed mobility, required extensive assistance of two staff persons for bed mobility, and was totally incontinent of bowel and bladder. In addition, the MDS assessment identified the resident to have sustained falls in the past 30 days.</p> <p>A Restraint RAP was not required to be conducted for resident #4 for the MDS assessments dated March 15, 2010 and July 7, 2010. A Fall Risk Assessment conducted for resident #4 on March 19, 2010, and on July 11, 2010, revealed the resident's score was 10 and the resident was at high risk for falls. In addition, the comprehensive care plan for resident #4 failed to include interventions for the use of side rails for the resident.</p> <p>A review of the Urinary Incontinence RAPS dated July 7, 2010, revealed resident #4 was incontinent of bowel and bladder and was required to be checked and changed every two hours and as needed. The RAP noted resident #4 utilized briefs when out of the bed. There was no evidence the facility assessed resident #4's decline in urinary incontinence to identify possible risk/causal factors for the decline in bladder function in an attempt to develop/implement individualized care plan interventions to restore bladder function, and to prevent the likelihood of further decline.</p> <p>A review of the facility's risk/injury investigations revealed resident #4 sustained a reddened area to the left leg on July 27, 2010. The investigation noted facility staff discovered resident #4 to be lying with the resident's legs off the side of the</p>	F 272	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
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F 272	<p>Continued From page 12</p> <p>bed with the resident's left leg "wedged" between the side rail and the bed. On October 5, 2010, resident #4's bed alarm sounded and staff found the resident on the mat next to the resident's bed with the resident's right arm between the mattress and the side rail. No injury was identified during the October 5, 2010 incident.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #3 on October 20, 2010, at 2:00 p.m., revealed resident #4 used half side rails to assist with turning/repositioning when in bed. CNA #3 stated the resident would put the resident's legs over the side rails and had made attempts to climb over the side rails. In addition, CNA #3 stated resident #4 was continent of bladder upon admission to the facility and used the bedside commode with assistance. The CNA stated approximately two months ago, resident #4 was noted to have increased incontinence episodes and was unable to verbalize the need to void. CNA #3 stated the resident was usually wet when checked during the routine incontinence rounds conducted every two hours.</p> <p>A review of the facility's policy/procedure (dated January 2002) related to safety devices for residents/side rails revealed the reason for the use of side rails would be "explained." However, there was no policy/procedure regarding assessment of side rails prior to use. The policy/procedure related to bladder training (dated January 2007) revealed an appropriate bladder training program would be implemented based on a bladder assessment conducted by the facility.</p> <p>An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed the MDS Nurse was familiar with the four criteria required</p>	F 272	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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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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F 272	<p>Continued From page 13</p> <p>to assess the RAPs. The MDS Nurse stated he/she believed the RAPs had been conducted appropriately. However, the MDS Nurse stated the side rails had not been assessed as a possible causal/contributing factor for falls for resident #4. In addition, the MDS Nurse stated a bladder assessment was completed upon admission and quarterly for each resident. The MDS Nurse stated he/she was aware of the decline in bladder function for resident #4. However, the causal factors for the decline had not been assessed and no interventions had been implemented to prevent further decline or restore the resident's bladder function.</p> <p>2. Resident #6 was observed on October 22, 2010, at 10:00 a.m., to be lying on the bed with bilateral half side rails in use. Mats were observed to be on the floor next to the resident's bed. Resident #6 was not interviewable due to cognitive impairment.</p> <p>A review of the medical record revealed resident #6 was admitted to the facility on September 10, 2008, with diagnoses of Degenerative Disk Disease, Dementia, Atrial Fibrillation, Osteoarthritis, and Parkinson's Disease. A review of the annual MDS assessment conducted on June 25, 2010, revealed the resident was assessed to have short and long-term memory impairment with modified decision-making skills. The resident was also assessed to require total assistance of two staff persons for bed mobility and transfers and to have sustained falls in the past 31 to 180 days. The assessment further noted resident #5 was transferred with a mechanical lift and side rails were used for bed mobility. Side rails were coded in the Restraint Section as being utilized daily for resident #6.</p>	F 272	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 272	<p>Continued From page 14</p> <p>However, the Restraint RAP was not triggered and was not required to be completed.</p> <p>A review of the ADL RAP dated June 25, 2010, revealed resident #6 required total care for ADLs, including turning/repositioning. The RAP noted the resident was transferred out of bed with a Hoyer lift. However, there was no evidence the facility had assessed the use of the side rails and how the resident used the side rails for bed mobility. In addition, there was no evidence the potential accident hazards associated with side rail use had been evaluated for resident #6.</p> <p>A review of the facility's policy/procedure (dated January 2002) related to safety devices for residents/side rails revealed the reason for the use of side rails would be "explained." However, there was no policy/procedure regarding assessment of side rails prior to use.</p> <p>An interview conducted with CNA #3 on October 21, 2010, at 10:00 a.m., revealed resident #6 was unable to use the side rails to assist with turning/repositioning. CNA #3 stated the resident required two staff persons for bed mobility. The CNA also stated resident #6 could move the resident's legs and would sometimes hang the legs over the side of the bed.</p> <p>An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed the MDS Nurse believed the RAPs had been conducted appropriately. However, the MDS Nurse stated the side rails had not been evaluated for possible causal factors related to falls and potential injury. The MDS Nurse further stated he/she was not familiar with the criteria to further assess the resident for causal factors related to changes in</p>	F 272	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 272	<p>Continued From page 15</p> <p>bladder function and to implement interventions to restore bladder function and to prevent further decline.</p> <p>3. Resident #5 was admitted to the facility on December 15, 2009, with diagnoses of Right Hip Fracture with ORIF, Osteoporosis, Dementia, Hypertension, and Hyperlipidemia. Further review of the medical record revealed resident #5 required repair of a vaginal/rectal fistula in September 2010.</p> <p>A review of the admission MDS assessment conducted on December 23, 2009, revealed resident #5 was assessed to have short and long-term memory deficit with modified decision-making skills. The resident was assessed to be continent of bowel and bladder with pads/briefs used, and to require total assistance of staff with toileting. A quarterly MDS assessment conducted on September 8, 2010, revealed resident #5 continued to be continent of bowel and bladder with pads and briefs used for continency control. No Urinary RAP was required to be completed.</p> <p>Further review of the medical record revealed the quarterly incontinency evaluation was completed on April 1, 2010, and resident #5 was noted to be incontinent of bowel and bladder. However, the facility failed to identify the decline in bladder function for resident #5 and failed to code the resident's bladder function correctly on the Quarterly assessment conducted on September 8, 2010. In addition, the facility failed to further assess the decline in bladder function for resident #5 and failed to develop interventions to prevent further decline in bladder elimination for resident #5.</p>	F 272	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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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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F 272	<p>Continued From page 16</p> <p>Resident #5 was observed on October 20, 2010, at 9:25 a.m., to be lying in bed positioned on the resident's back. A skin assessment conducted on October 20, 2010, at 1:50 p.m., revealed the resident's coccyx/buttocks were red and excoriated. The resident was observed to be wearing an incontinence brief which was heavily soiled with urine when removed by the staff nurse. Resident #5 stated he/she did not always recognize the urge to void, but was able to call staff after wetting the brief.</p> <p>A review of the policy/procedure related to bladder training (dated January 2007) revealed an appropriate bladder training program would be implemented based on a bladder assessment conducted by the facility.</p> <p>An interview conducted with CNA #3 on October 21, 2010, at 10:00 a.m., revealed resident #5 was able to call for staff assistance for toileting after being admitted to the facility. The CNA stated the resident no longer called for assistance prior to voiding, but would call staff when the resident was wet. The CNA stated resident #5 had been incontinent of bladder for "awhile."</p> <p>An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed bladder assessments were required to be conducted quarterly. The MDS Nurse stated he/she failed to identify the change in the resident's bladder function when the bladder evaluation was completed on April 1, 2010. The MDS Nurse stated he/she was not familiar with the criteria to further assess the resident for causal factors related to changes in elimination and to implement a toileting program to restore bladder</p>	F 272	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 272	<p>Continued From page 17 function and to prevent further decline.</p> <p>4. Review of resident #7's medical record revealed the resident was admitted to the facility on January 12, 2009, with diagnoses of Left Hip Fracture, Hypertension, History of Heart Disease and Seizures, Groin Hernia Repair, Dementia, Diabetes Mellitus, Anxiety, Depression, and History of Urinary Tract Infection. Review of an annual Minimum Data Set (MDS) dated January 17, 2009, revealed resident #7 was assessed to require assistance of two staff persons with bed mobility and transfers. The resident was further assessed to require a mechanical lift for transfers, to require side rails for bed mobility, and other side rails were coded to be used daily. Further review of the Quarterly MDS completed on September 8, 2010, revealed resident #7 continued to require total assistance with bed mobility and transfers, to require side rails for bed mobility, and other side rails to be used daily. However, the Restraint RAP was not triggered and was not required to be completed.</p> <p>A review of the ADL RAP dated June 25, 2010, revealed resident #7 was unable to turn/reposition self in the bed and required total assistance of staff for bed mobility. However, there was no evidence the facility had assessed the use of the side rails and how the resident used the side rails for bed mobility. In addition, there was no evidence the potential accident hazards associated with side rail use had been evaluated for resident #7.</p> <p>Observations on October 21, 2010, at 9:45 a.m., 1:15 p.m., 2:15 p.m., and 3:00 p.m., revealed resident #7's half side rails were in use and not padded.</p>	F 272	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 272	Continued From page 18 Interview with State Registered Nurse Aide (SRNA) #4 on October 21, 2010, at 8:45 a.m., revealed resident #7 required total assistance of two staff persons for bed mobility. The SRNA stated the resident was unable to utilize the side rails to assist with turning/repositioning. An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed the MDS Nurse believed the RAPs had been conducted appropriately. However, the MDS Nurse stated he/she was not aware the resident required side rails for bed mobility. The MDS Nurse stated the side rails had not been evaluated for possible causal factors related to falls and potential injury. 5. Review of resident #1's medical record revealed the resident was admitted to the facility on January 22, 2010, with the following diagnoses: Sacral Decubiti Ulcer, Status Post Debridement, Left Calcaneal Decubiti, Gastrointestinal Disease, Leukocytosis, Severe Dementia, Hypothyroidism, Hypertension, Degenerative Joint Disease, Anxiety, and History of Cerebral Vascular Disease. A review of the Minimum Data Set (MDS) dated January 26, 2010, revealed the resident was assessed to require assistance of two staff persons with bed mobility and transfers. The resident was further assessed to require a mechanical lift for transfers, to require side rails for bed mobility, and other side rails were coded to be used daily. Further review of the Quarterly MDS completed on October 10, 2010, revealed resident #1 continued to require total assistance with bed mobility and transfers, to require side rails for bed mobility, and other side rails to be used daily. However, the Restraint RAP was not triggered	F 272	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 272	Continued From page 19 and was not required to be completed. There was no evidence the facility had further assessed the use of the side rails and how resident #1 would benefit from the side rails. A review of the facility's policy/procedure (dated January 2002) related to safety devices for residents/side rails revealed the reason for the use of side rails would be "explained." However, there was no policy/procedure regarding assessment of side rails prior to use. Interview with SRNA #4 on October 21, 2010, at 8:45 a.m., revealed resident #1 was unable to turn/reposition self in bed and did not use the side rails for bed mobility. Interview with the MDS Coordinator on October 21, 2010, at 3:45 p.m., revealed that the resident should have been assessed and care planned for side rails. An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed the MDS Nurse stated he/she was not aware the resident required side rails for bed mobility. The MDS Nurse stated the side rails had not been evaluated to determine the risks/benefits for resident #1.	F 272	See attached.		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010	
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F 279	<p>Continued From page 20</p> <p>objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a Comprehensive Care Plan to address the use of half side rails for four (4) of nine (9) sampled residents (residents #1, #4, #6, and #7). In addition, residents #4 and #6 had falls, and interventions were noted to pad the residents' side rails; however, a Care Plan was not developed to include this intervention.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of resident #7's medical record revealed the resident was admitted to the facility on January 12, 2009, with diagnoses of Left Hip Fracture, Hypertension, History of Heart Disease and Seizures, Groin Hernia Repair, Dementia, Diabetes Mellitus, Anxiety, Depression, and History of Urinary Tract Infection. Review of an annual Minimum Data Set (MDS) dated January 17, 2009, revealed resident #7 was assessed to 	F 279	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 279	<p>Continued From page 21</p> <p>require assistance of two staff persons with bed mobility and transfers. The resident was further assessed to require a mechanical lift for transfers, to require side rails for bed mobility, and other side rails were coded to be used daily. Further review of the Quarterly MDS completed on September 8, 2010, revealed resident #7 continued to require total assistance with bed mobility and transfers, to require side rails for bed mobility, and other side rails to be used daily.</p> <p>A review of the comprehensive care plan dated March 22, 2010, revealed the facility identified an alteration in activities of daily living (ADL) function for resident #7 with interventions to turn/reposition the resident every two hours and as needed. However, there was no evidence the facility had developed a care plan to address the use of side rails to assist the resident with turning and repositioning.</p> <p>Observations on October 21, 2010, at 9:45 a.m., 1:15 p.m., 2:15 p.m., and 3:00 p.m., revealed resident #7's half side rails were in use and not padded.</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 on October 21, 2010, at 8:45 a.m., revealed resident #7 required total assistance of two staff persons for bed mobility. The SRNA stated the resident was unable to utilize the side rails to assist with turning/repositioning.</p> <p>Interview with LPN #2 on October 21, 2010, at 2:00 p.m., revealed resident #7 had always used side rails for safety.</p> <p>Interview with the MDS Coordinator on October 21, 2010, at 3:45 p.m., revealed that resident #7</p>	F 279	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
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F 279	<p>Continued From page 22</p> <p>should have been assessed and care planned for the use of side rails.</p> <p>2. Review of resident #1's medical record revealed the resident was admitted to the facility on January 22, 2010, with the following diagnoses: Sacral Decubiti Ulcer, Status Post Debridement, Left Calcaneal Decubiti, Gastrointestinal Disease, Leukocytosis, Severe Dementia, Hypothyroidism, Hypertension, Degenerative Joint Disease, Anxiety, and History of Cerebral Vascular Disease. A review of the Minimum Data Set (MDS) dated January 26, 2010, revealed the resident was assessed to require assistance of two staff persons with bed mobility and transfers. The resident was further assessed to require a mechanical lift for transfers, to require side rails for bed mobility, and other side rails were coded to be used daily. Further review of the Quarterly MDS completed on October 10, 2010, revealed resident #1 continued to require total assistance with bed mobility and transfers, to require side rails for bed mobility, and other side rails to be used daily.</p> <p>A review of the comprehensive care plan dated July 5, 2010, revealed the facility identified an alteration in ADL function for resident #1 with interventions to turn/reposition the resident every two hours and as needed. However, there was no evidence the facility had developed a care plan to address the use of side rails to assist the resident with turning and repositioning.</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 on October 21, 2010, at 8:45 a.m., revealed resident #1 required total assistance of two staff persons for bed mobility. The SRNA stated the resident was unable to utilize the side</p>	F 279	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 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 279	<p>Continued From page 23</p> <p>rails to assist with turning/repositioning. SRNA #4 stated the nurse aide had not been trained on the risk versus the benefit use and safety use of side rails.</p> <p>An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed a care plan should have been developed to address the use of side rails for resident #1.</p> <p>3. Resident #4 was observed on October 19, 2010, at 10:55 a.m., to be lying on the bed with bilateral half (upper) side rails in use. Fall mats were observed on each side of resident #4's bed and an alarm was noted to be attached to the resident's clothing. No padding was noted to be on the half side rails. Resident #4 was not interviewable due to cognitive impairment.</p> <p>A review of the admission comprehensive Minimum Data Set (MDS) assessment completed on March 20, 2010, revealed resident #4 was assessed to require limited assistance of one for transfers and to utilize side rails for bed mobility. Resident #4 was further assessed to have sustained falls in the past 30 days and in the last 180 days. A significant change MDS assessment completed for resident #4 on July 7, 2010, revealed the resident continued to utilize side rails for bed mobility and to have sustained falls in the past 30 days.</p> <p>A review of the fall investigation reports for resident #4 revealed the resident was found by staff on July 27, 2010, to be lying with the resident's legs off the side of the bed with the resident's left leg "wedged" between the side rail and the bed. Interventions implemented to prevent further falls/incidents included: to pad the</p>	F 279	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
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F 279	<p>Continued From page 24</p> <p>side rails and to check the safety alarm frequently.</p> <p>A review of the comprehensive care plan dated July 7, 2010, revealed the facility identified an alteration in ADL function for resident #4 with interventions to turn/reposition the resident every two hours and as needed. However, there was no evidence the facility had developed a care plan to address the use of side rails to assist the resident with turning and repositioning. In addition, the comprehensive care plan identified the resident's fall risks, but the care plan failed to include interventions to pad the resident's side rails.</p> <p>An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed a care plan should have been developed to address the use of side rails for resident #4. The MDS Nurse stated he/she was responsible to ensure fall interventions were implemented and care planned for the residents. However, the MDS Nurse stated the intervention to pad the resident's side rails had not been implemented or care planned for resident #4.</p> <p>4. Resident #6 was observed on October 22, 2010, at 10:00 a.m., to be lying on the bed with bilateral half side rails in use. No padding was observed to be on the side rails. Mats were observed to be on the floor next to the resident's bed. Resident #6 was not interviewable due to cognitive impairment.</p> <p>A review of the annual MDS assessment conducted on June 25, 2010, revealed the resident was assessed to require total assistance of two staff persons for bed mobility and transfers</p>	F 279	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 279	Continued From page 25 and to have sustained falls in the past 31 to 180 days. The assessment further noted resident #6 was transferred with a mechanical lift and side rails were used for bed mobility. A review of the risk/injury investigation report dated October 27, 2009, revealed resident #6 was assessed to have sustained a skin tear of the right arm as a result of the resident's arm brushing against the side rail when the resident was being turned/repositioned. Interventions to prevent reoccurrence included to lower the side rail during turning/repositioning and to pad the side rails. A review of the comprehensive care plan for resident #6 dated August 3, 2009, revealed the facility addressed the resident's self-care deficit with interventions to turn and reposition the resident every two hours and as needed. The facility also identified the resident's risks for falls/injury with intervention for fall mats on each side of the resident's bed. However, there was no evidence the facility had developed a care plan to address the use of the side rails for resident #6 and no evidence the care plan included an intervention to pad the resident's side rails. An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed the MDS Nurse revealed a care plan should have been developed to address the use of side rails for resident #6. The MDS Nurse stated he/she was responsible to ensure fall interventions were implemented and care planned for the residents. However, the MDS Nurse stated the intervention to pad the resident's side rails had not been implemented or care planned for resident #6.	F 279	See attached.		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 80 HOSPITAL DRIVE BARBOURVILLE, KY 40906		
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F 281 SS=D	Continued From page 26 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, the facility failed to provide services to meet professional standards of quality for one (1) of nine (9) sampled residents (resident #4). Resident #4 had a physician's order for Ensure to be provided with each meal; however, Ensure was not provided for resident #4 during the lunch and evening meals on October 19, 2010. The findings include: A review of the nutritional progress notes dated May 17, 2010, revealed the Registered Dietitian (RD) noted the resident's weight was 85 pounds and was stable. The RD noted the resident's average meal consumption was 43.5 percent and "may need an appetite stimulant." Further review of the nurse's notes dated May 17, 2010, revealed a physician's order was obtained for Ensure one can to be provided with each meal. Resident #4 was observed during the lunch meal on October 19, 2010, at 12:15 p.m. The resident was observed to be spoon-fed by facility staff. The resident's meal consisted of pureed meat, corn, carrots, dessert, Coke, and coffee. During the evening meal on October 19, 2010, at 5:15 p.m., resident #4 was served a puree tray with juice, milk, and coffee. There was no evidence that Ensure was offered to resident #4 during either the lunch or dinner meal.	F 281	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 80 HOSPITAL DRIVE BARBOURVILLE, KY 40906	
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F 281	Continued From page 27 A review of the lunch tray card revealed resident #4 was to receive a puree diet with whole milk, coffee, and Coke. The tray card did not identify Ensure was to be added to the tray. An interview conducted with CNA #3 on October 21, 2010, at 2:00 p.m., revealed Ensure was not provided on resident #4's tray. An interview conducted with the Dietary Manager (DM) on October 21, 2010, at 3:40 p.m., revealed the nurses were responsible to enter the new diet orders into the computer system and to transmit the orders to the Dietary Department. The DM stated he/she had not received an order for Ensure to be added to resident #4's tray. However, a review of the facility's computer "view order details" report revealed an order for one can of Ensure with each meal was entered on May 17, 2010.	F 281	See attached.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care was provided in accordance with the written plan of care for one (1) of nine (9) sampled residents (resident #7). A care plan intervention had been added to pad the side rails on resident #7's bed;	F 282	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 80 HOSPITAL DRIVE BARBOURVILLE, KY 40906	
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F 282	<p>Continued From page 28</p> <p>however, the facility failed to implement this intervention.</p> <p>The findings include:</p> <p>Review of resident #7's medical record revealed the resident was admitted to the facility on January 12, 2009, with the diagnoses of Left Hip Fracture, Hypertension, History of Heart Disease and Seizures, Groin Hernia Repair, Dementia, Diabetes Mellitus, Anxiety, Depression, and History of Urinary Tract Infection. Review of an annual Minimum Data Set (MDS) dated January 17, 2009, revealed resident #7 was assessed to require assistance of two staff persons with bed mobility and transfers. The resident was further assessed to require a mechanical lift for transfers, to require side rails for bed mobility, and other side rails were coded to be used daily. Further review of the Quarterly MDS completed on September 8, 2010, revealed resident #7 continued to require total assistance with bed mobility and transfers, to require side rails for bed mobility, and other side rails to be used daily.</p> <p>A review of the risk/injury investigation report dated June 23, 2010, revealed facility staff identified a skin tear to resident #7's left arm. The cause of the injury was noted to be due to the resident's skin being thin and fragile. Intervention to prevent reoccurrence was to pad the resident's side rails and to use a draw sheet when turning/repositioning the resident.</p> <p>Observations on October 21, 2010, at 9:09 a.m., 1:15 p.m., 2:15 p.m., and 3:00 p.m., revealed resident #7's side rails were in use, but no padding was observed.</p>	F 282	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 80 HOSPITAL DRIVE BARBOURVILLE, KY 40906		
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F 282	<p>Continued From page 29</p> <p>A review of the comprehensive care plan for resident #7 dated March 22, 2010, and updated on June 10, 2010, revealed the facility identified the resident's potential for injury and interventions included to pad the side rails. However, there was no evidence the facility had implemented this intervention.</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 on October 21, 2010, at 8:45 a.m., revealed resident #7's side rails had never been padded.</p> <p>Interview with LPN #2 on October 21, 2010, at 2:00 p.m. revealed resident #7 had never had padded side rails.</p> <p>Interview with the Unit Manager (UM) on October 21, 2010, at 3:45 p.m., revealed the UM was responsible to put the padding on the side rails after the resident was care planned for the interventions. The UM further indicated this had not been done.</p>	F 282	<i>See attached.</i>	
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 315	<i>See attached.</i>	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 80 HOSPITAL DRIVE BARBOURVILLE, KY 40906		
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F 315	<p>Continued From page 30</p> <p>by: Based on observation, interview, and record review, the facility failed to ensure that two (2) of nine (9) sampled residents (residents #4 and #5) received the appropriate treatment and services to maintain as much bladder function as possible. Residents #4 and #5 were assessed to have a decline in bladder function; however, the facility failed to appropriately assess residents #4 and #5 for causal factors related to the change in bladder function and to determine if the resident could benefit from a bladder retraining program. (Refer to F272.)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Resident #4 was observed on October 19, 2010, at 10:55 a.m., to be lying on the bed. A bedside commode was observed to be sitting in a corner of the resident's room. <p>A review of the admission comprehensive Minimum Data Set (MDS) assessment completed on March 20, 2010, revealed resident #4 was assessed to have a short/long-term memory deficit with minimally impaired decision-making skills and to require limited assistance of one for transfers. Resident #4 was further assessed to be continent of bowel and bladder. A significant change MDS assessment completed for resident #4 on July 7, 2010, revealed the resident continued to require extensive assistance of two staff persons for bed mobility, and was totally incontinent of bowel and bladder.</p> <p>A review of the Urinary Incontinence RAP dated July 11, 2010, revealed resident #4 was incontinent of bowel and bladder and required total care for incontinence care every two hours</p>	F 315	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010	
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 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 315	<p>Continued From page 31 and as needed. The RAP noted the resident utilized briefs when out of bed. However, there was no evidence the facility had further assessed resident #4 to attempt to determine possible contributing factors for the decline.</p> <p>A review of the comprehensive care plan for resident #4 revealed the facility identified bowel/bladder incontinence for resident #4 with interventions to check and change the resident every two hours and as needed, to apply briefs, depends, or pantliners when out of bed, and to keep the call light within reach. However, there was no evidence the facility had evaluated/implemented interventions to restore the resident's bladder function or to prevent further decline.</p> <p>An interview conducted with CNA #3 on October 20, 2010, at 2:00 p.m., revealed resident #4 was continent of bladder upon admission to the facility and used the bedside commode with assistance. The CNA stated approximately two months ago resident #4 was noted to have increased incontinence episodes and was unable to verbalize the need to void. CNA #3 stated the resident was usually wet when checked during the routine incontinence rounds conducted every two hours.</p> <p>A review of the facility's policy/procedure related to bladder training (dated January 2007) revealed an appropriate bladder training program would be implemented based on a bladder assessment conducted by the facility.</p> <p>An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed the MDS Nurse was responsible to complete a bladder</p>	F 315	<i>See attached.</i>	

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

PRINTED: 11/19/2010
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OMB NO. 0938-0391

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F 315	<p>Continued From page 32</p> <p>assessment for each resident upon admission and quarterly. The MDS Nurse stated he/she was aware of the decline in bladder function for resident #4, but the causal factors had not been evaluated. The MDS Nurse further stated no interventions had been implemented to prevent further decline or to restore the resident's bladder function.</p> <p>2. Resident #5 was observed on October 20, 2010, at 9:25 a.m., to be lying in bed positioned on the resident's back. A skin assessment conducted on October 20, 2010, at 1:50 p.m., revealed the resident's coccyx/buttocks were red and excoriated. The resident was observed to be wearing an incontinence brief which was heavily soiled with urine when removed by the staff nurse. Resident #5 stated he/she did not always recognize the urge to void, but was able to call staff after wetting the brief.</p> <p>A review of the admission MDS assessment for resident #5 conducted on December 23, 2009, revealed the resident was assessed to be continent of bowel and bladder with pads/briefs used, and to require total assistance of staff with toileting. A quarterly MDS assessment conducted on September 8, 2010, revealed resident #5 continued to be continent of bowel and bladder with pads and briefs used for continency control. No Urinary RAP was required to be completed.</p> <p>Further review of the medical record revealed a quarterly incontinency evaluation completed on April 1, 2010, revealed resident #5 was incontinent of bowel and bladder. However, the facility failed to identify the decline in bladder function for resident #5 and failed to code the resident's bladder function correctly on the</p>	F 315	See attached.		

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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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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F 315	<p>Continued From page 33</p> <p>Quarterly assessment conducted on September 8, 2010. In addition, the facility failed to further assess the decline in bladder function for resident #5 and failed to develop interventions to prevent further decline in bladder elimination for resident #5.</p> <p>A review of the policy/procedure related to bladder training (dated January 2007) revealed an appropriate bladder training program would be implemented based on a bladder assessment conducted by the facility.</p> <p>An interview conducted with CNA #3 on October 21, 2010, at 10:00 a.m., revealed resident #5 was able to call for staff assistance for toileting after being admitted to the facility. The CNA stated the resident no longer called for assistance prior to voiding, but would call staff when the resident was wet.</p> <p>An interview conducted with the MDS Nurse on October 21, 2010, at 4:10 p.m., revealed bladder assessments were required to be conducted quarterly. The MDS Nurse stated he/she was not familiar with the criteria to further assess the resident for causal factors related to changes in elimination and to implement a toileting program to restore bladder function and to prevent further decline. The MDS Nurse stated no toileting program had been implemented for resident #5.</p>	F 315	<i>See attached.</i>	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p>	F 323	<i>See attached.</i>	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that one (1) of nine (9) sampled residents (resident #4) remained free of accident hazards as is possible. Resident #4 was assessed to be at high risk for falls and to utilize half side rails to assist with bed mobility. However, the facility failed to identify and evaluate the potential hazards associated with side rail use and to implement interventions to reduce hazards/risks for resident #4. (Refer to F272.) The findings include: A review of the admission comprehensive Minimum Data Set (MDS) assessment completed on March 20, 2010, revealed resident #4 was assessed to have a short/long-term memory deficit with minimally impaired decision-making skills and to require limited assistance of one for transfers and to utilize side rails for bed mobility. Resident #4 was further assessed to have sustained falls in the past 30 days and in 80 days. A significant change MDS assessment completed for resident #4 on July 7, 2010, revealed the resident continued to utilize side rails for bed mobility and to have sustained falls in the past 30 days. A review of the facility's risk/injury investigations dated July 27, 2010, revealed facility staff discovered resident #4 to be lying with the resident's legs off the side of the bed with the	F 323	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 80 HOSPITAL DRIVE BARBOURVILLE, KY 40906	
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F 323	<p>Continued From page 35</p> <p>resident's left leg "wedged" between the side rail and the bed. The resident was assessed to have a reddened area to the left leg. The cause of the incident was determined to be confusion and weakness. Interventions to prevent reoccurrence included to check the safety alarm frequently, pad the side rails, assess for scheduled toileting needs, and to review the resident's medication list. Further review of the risk/injury investigations revealed resident #4 again attempted to get out of bed unassisted on October 5, 2010, and was found on the fall mat beside the resident's bed. The resident was noted to be sitting in an upright position with the resident's back against the bed with the resident's right arm between the mattress and the side rail. No injury was noted and no new interventions were implemented.</p> <p>Resident #4 was observed on October 19, 2010, at 10:55 a.m., to be lying on the bed with bilateral half (upper) side rails in use. Fall mats were observed on each side of resident #4's bed and an alarm was noted to be attached to the resident's clothing. No padding was noted to be on the half side rails.</p> <p>An interview conducted with CNA #3 on October 20, 2010, at 2:00 p.m., revealed resident #4 used half side rails to assist with turning/repositioning when in bed. CNA #3 stated the resident would put the resident's legs over the side rails and had made attempts to climb over the side rails.</p> <p>A review of the facility's policy/procedure (dated January 2002) related to safety devices for residents/side rails revealed the reason for the use of side rails would be "explained." However, there was no policy/procedure regarding assessment of side rails prior to use.</p>	F 323	See attached.

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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 10/21/2010
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F 323	Continued From page 36	F 323	<i>See attached.</i>	
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 329	<i>See attached.</i>	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 37 by: Based on interview and record review, the facility failed to ensure that the drug regimen for one (1) of nine (9) sampled residents was free of unnecessary drugs. Resident #5 received Plavix daily without adequate indications for its use. The findings include: A review of the medical record for resident #5 revealed the resident was admitted to the facility on December 15, 2009, with diagnoses to include Right Hip Fracture with ORIF, Osteoporosis, Hyperlipidemia, Hypertension, and Dementia. A review of the current physician's orders dated October 2010 revealed resident #5 had an order for Plavix 75 milligrams to be administered daily. According to the physician's order, the medication was originally ordered on March 16, 2010. However, there was no diagnosis documented for the use of Plavix. An interview conducted with LPN #2 on October 20, 2010, at 4:00 p.m., revealed the LPN was aware the resident received the Plavix daily; however, LPN #2 stated he/she did not know why the medication was administered to the resident. An interview conducted with the DON on October 20, 2010, at 4:30 p.m., revealed the staff nurse was responsible to obtain a diagnosis for a medication when a new order was obtained from the resident's physician. The DON stated he/she did not know why the resident was receiving Plavix.	F 329	See attached.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 334	<p>Continued From page 38</p> <p>that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse</p>	F 334	See attached.	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 334	<p>Continued From page 39 immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the pneumococcal vaccine was provided for one (1) of nine (9) sampled residents (resident #5).</p> <p>The findings include: A review of the medical record for resident #5 revealed the resident was admitted to the facility on December 15, 2009. A review of the pneumococcal consent/declination form revealed the risks/benefits of the influenza vaccine were reviewed by resident #5 on December 16, 2009.</p>	F 334	See attached.	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 334	<p>Continued From page 40</p> <p>Documentation on the consent form indicated the pneumococcal vaccine was due to be administered in January 2010. However, a review of the immunization administration record revealed no evidence the pneumococcal vaccine had been administered to resident #5 after the resident was admitted to the facility.</p> <p>A review of the facility's policy/procedure related to pneumococcal/influenza immunizations (dated January 2002) revealed the pneumococcal vaccine would be administered based on the resident's physician's decision.</p> <p>A review of the physician's orders for October 2010 revealed the pneumococcal vaccine was ordered to be administered per the facility's policy.</p> <p>An interview conducted with LPN #2 on October 20, 2010, at 4:00 p.m., revealed there was no documentation to indicate resident #5 had received the pneumococcal vaccine as ordered after being admitted to the facility.</p>	F 334	<i>See attached.</i>	
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the</p>	F 431	<i>See attached.</i>	

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

PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 41</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit 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 and interview, the facility failed to label all drugs and biologicals used in the facility in accordance with currently accepted professional principles including the expiration date when applicable. One (1) multi-dose vial of Tuberculin Purified Protein for tuberculin skin testing was opened, but not dated to indicate when the medication had been opened.</p> <p>The findings include:</p> <p>Observation of the Medication Storage Room on October 21, 2010, at 3:00 p.m., revealed one multi-dose vial of Tuberculin Purified Protein utilized for tuberculin skin testing was opened and</p>	F 431	See attached.	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 431	Continued From page 42 stored in the medication refrigerator. However, there was no date to indicate the date the medication vial was initially opened. A review of the facility's policy related to multiple-dose vials (not dated) revealed the facility was responsible to date the vial when the medication was initially opened and to discard the medication 30 days after opening. An interview conducted with LPN #2 on October 21 2010, at 3:10 p.m., revealed the nurses were responsible to date all multi-dose vials when opened. LPN #2 stated the medication was to be discarded 30 days after being opened.	F 431	<i>See attached.</i>		

F 221

It is the policy of this facility that all residents will be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. To ensure compliance the following steps have been implemented:

1. The restraint policy was updated to include an assessment to be completed prior to any resident being placed in restraint. Residents #3 and #4 were assessed to determine the need for restraint. Based on the assessment, the restraint was discontinued for both residents.
2. There are no other residents with restraint devices.
3. The restraint policy was updated to include an assessment to be completed prior to any resident being placed in restraint, notification of responsible party of the risks, benefits, and alternatives of use, informed consent, and ongoing assessment. All nursing staff will be in-serviced on the updated policy on November 16, 2010 by the Director of Nursing.
4. The Director of Nursing or Charge nurse will complete the Restraint Use Assessment form and consult with the physician and resident or the resident's legal representative prior to the restraint being applied, except in emergency situations.
5. All residents placed in a restraint device will be monitored by the Director of Nursing weekly for two weeks, then monthly for 6 months and the findings reported through PI. The following monitor will be used: Restraint Use: A) Type of restraint used. B) Medical symptom(s) warranting the use of restraint is documented. Threshold: 100%. C) Assessment completed prior to restraint use. Threshold: 100%. D) Resident / responsible party notified of risks, benefits and alternatives to restraint use and how restraint will be used to treat the resident's medical symptom. Threshold: 100%. E) Informed consent given by resident / responsible party. Threshold: 100%. F) Physician order for restraint includes medical symptom(s) warranting use of restraint. Threshold: 100%. G) Reassessment for continued use, reduction, or elimination completed quarterly. Threshold: 100%.

Completion Date: November 19, 2010

F 225

It is the policy of this facility that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are thoroughly investigated and the results are reported to the administrator or his designated representative and to other officials in accordance with State law (including the State survey and certification agency) within 5 working days of the incident. To ensure compliance, the following steps have been implemented:

1. The injuries identified in the risk injury investigation forms for residents #6 and #7 were investigated and the findings reported to the CEO, state Social Services and the State survey and certification agency.
2. All residents have been assessed for bruises and skin tears. All bruises and skin tears noted have been investigated and the State survey and certification agency and State social services have been notified of all injuries of unknown source.
3. The Risk Injury Investigation Form has been updated to prompt documentation of the investigation performed, injuries of unknown source, and notification of the State survey and certification agency and State Social Services.
4. All staff members will be re-in serviced on the abuse policy and in-serviced on the updated Risk Injury Investigation Form on November 15, 2010 by the Director of Nursing.

5. The C.N.O. will review all Risk Injury Investigation forms to ensure that all injuries are thoroughly investigated and will report all injuries of unknown source immediately to the facility Administrator and appropriate agencies according to state law. The final report of the investigation will be reported to the facility Administrator and other appropriate agencies within 5 working days of the injury.
6. All Risk Injury Investigation forms will be reviewed by the Director of Nursing and reported through PI monthly for 6 months. The following monitor will be added: Risk Injury Investigation Form: A) Documentation of a thorough investigation of the injury. Threshold 100%. B) Documentation of notification of State Social Services and State survey and certification agencies within 5 working days of the injury for injuries of unknown source. Threshold: 100%.

Completion Date: November 19, 2010

F 272

It is the policy of this facility to conduct initial and periodic comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity. To ensure compliance, the following steps have been implemented.

1. Resident #4 and #5 have been assessed to determine risk/causal factors related to bladder incontinence and their potential for bladder retraining and their plan of care has been updated appropriately based on their assessment.
2. A new policy regarding use of side rails has been developed which includes an assessment to be completed on each resident to determine need for side rails. Residents #1, #4, #6, and #7 have been assessed to determine need to continue, reduce, or eliminate side rail use. Updates have been made to each resident's plan of care, as appropriate to their individual assessment. All staff will be in-serviced on this new policy on November 16, 2010 by the Director of Nursing.
3. All residents have been assessed to determine need to continue, reduce or eliminate side rails and their plan of care has been updated based on their assessed need.
4. If it is determined that side rails are not indicated for a resident, the side rails will be removed from the resident's bed or secured to ensure they are not used.
5. A new Director of nursing will start on November 22, 2010. The new Director of Nursing has prior MDS experience and attended education on the MDS 3.0 in August, 2010.
6. All residents noted by the S.R.N.A or nurse to have a decline in bladder function will be reviewed by the DON/MDS Coordinator. All new residents will be assessed by the MDS Coordinator for the need for side rails use. All residents who currently use side rails will be assessed by the MDS Coordinator quarterly for continued need.
7. The Director of Nursing will audit two Comprehensive assessments monthly for twelve months and report the findings to the PI Committee.

Completion Date: November 19, 2010

F 279

It is the policy of this facility that the results of the resident assessment will be used to develop, review and revise the resident's comprehensive plan of care. To ensure compliance, the following steps have been implemented:

1. A new policy regarding use of side rails has been developed which includes an assessment to be completed on each resident to determine need for side rails. Residents #1, #4, #6, and #7 have been assessed for side rail use and residents #4 and #6 have been assessed for the need of padded side rails. Updates have been made to each resident's plan of care, as appropriate to their individual assessment. All staff will be in-serviced on this new policy on November 16, 2010 by the Director of Nursing.
2. All residents have been assessed for side rail use. Updates were made to each resident's plan of care, as appropriate to their individual assessment.
3. Residents care plans will be updated, as appropriate, by the D.O.N. or Charge nurse following each reassessment.
4. The D.O.N. or Charge Nurse will assess all new residents for side rail use and update their plan of care as appropriate to their assessed need.
5. The Director of Nursing will in-service all nursing staff on the need to use assessment data to develop, review and revise the resident's comprehensive plan of care on November 16, 2010.
6. The D.O.N. will review two charts monthly for 12 months to ensure the resident's plan of care has been updated based on the results of their assessment. The results of the audit will be reported monthly to the PI Committee.

Completion Date: November 19, 2010

F 281

It is the policy of this facility that services being provided or arranged by the facility will meet professional standards of quality. To ensure compliance, the following steps have been implemented:

1. Diet and dietary supplement orders for Resident #4 were called to Dietary and an order placed in the computer system.
2. All diet and dietary supplement orders for all residents were delivered to Dietary and compared with current orders to ensure all residents were receiving appropriate diets / supplements.
3. All diet and dietary supplement orders will be placed on the C.N.A. treatment records to ensure the resident receives the appropriate diet / dietary supplement each shift. The D.O.N. or Charge nurse will update the C.N.A. treatment record as new diet / dietary supplement orders are received. All staff will be in-serviced on this new process on November 16, 2010 by the Director of Nursing.
4. The Dietary Manager or designee will provide a copy of diet and dietary supplement orders to the D.O.N. or designee each week for review to ensure all diet orders and dietary supplement orders have been received.
5. The Dietary Manager or designee will ensure the trays are correct prior to the trays being delivered to the LTC unit.
6. The Director of Nursing will audit 5 trays per week for 4 weeks then 5 trays per month for 5 months and report the finding to the PI Committee.

Completion Date: November 19, 2010

F 282

It is the policy of this facility that services being provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. To ensure compliance, the following steps have been implemented:

1. The written plan of care for resident #7 was reviewed by the D.O.N. to ensure all planned interventions were in place for the resident.
2. The written plan of care for all residents has been reviewed by the D.O.N. to ensure all planned interventions are being provided to each resident.
3. The Risk Injury Investigation policy has been updated to include a signature, date & time lines to document the update to the plan of care and initiation of the planned intervention. All nursing staff will be in-serviced on this updated policy on November 16, 2010 by the Director of Nursing.
4. The Director of Nursing will review all Risk Injury Investigation forms and the corresponding resident care plans for 3 months to sure all planned interventions are being placed on the written plan of care and the results of the audit will be reported to the PI Committee.

Completion Date: November 19, 2010

F 315

It is the policy of this facility that a resident who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. To ensure compliance, the following steps have been implemented:

1. Resident #4 and #5 have been assessed to determine risk/causal factors related to bladder incontinence and their potential for bladder retraining and each resident's plan of care has been updated as appropriate based on their individual assessment.
2. All resident assessments were reviewed to identify residents who have a documented decline in bladder or bowel function in the past 4 quarters to ensure appropriate assessments and interventions have been implemented.
3. All staff will be in-serviced on the Bladder Training policy on November 16, 2010 by the Director of Nursing.
4. All residents noted by the S.R.N.A or nurse to have a decline in bladder function will be reported to the MDS nurse for assessment. The results of each assessment will be reported to the PI Committee for the next 6 months.

Completion Date: November 19, 2010

F 323

It is the policy of this facility that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

1. A bed rail use policy was developed to include an assessment to be completed prior to any resident using side rails. Resident #4 was assessed to determine the need for bed rail use and based on the assessment; the bed rails have been discontinued.
2. All residents have been assessed to determine need for side rail use and their plan of care has been updated based on their assessed need. All staff will be in-serviced on this new policy on November 16, 2010 by the Director of Nursing.

3. All new admissions will be assessed to determine need for side rails and all residents will receive a quarterly assessment to determine the need to continue, reduce or eliminate side rail use. If it is determined that side rails are not indicated for a resident, the side rails will be removed or secured to ensure they are not used.
4. All residents using side rails will be reviewed by the Director of Nursing weekly for four weeks then monthly for two months and the results of the audit will be reported to the PI Committee monthly.

Completion Date: November 19, 2010

F 329

It is the policy of this facility that the resident's drug regimen will be free from unnecessary drugs. To ensure compliance, the following steps have been implemented:

1. The indication for Plavix use with Resident #5 was discussed with the physician and the resident's medical record has been updated to reflect the indication.
2. All resident's medications have been reviewed for the indication for use. All medications lacking an indication have been reviewed with the resident's physician and an appropriate indication for use or an order to discontinue the medication has been documented in the resident's medical record.
3. The indication for use will be written as part of the order for new medications. All nursing staff and admitting physicians will be in-serviced on this process on November 16, 2010 by the Director of Nursing.
4. During monthly order review, the nurse will ensure that all medications have an appropriate indication listed. If no indication is listed, the nurse will contact the physician to discuss the indication and need for continued use of the medication. A clarification order will be obtained indicating the appropriate indication for the medication or discontinuing the medication. All nursing staff will be trained on this new process.
5. The Director of Nursing will audit 16 charts per month for 3 months and the results of the audit will be reported to the PI Committee monthly.

Completion Date: November 19, 2010

F 334

It is the policy of this facility to provide the influenza immunization (October 1 through March 31 annually) and pneumococcal immunization to each resident unless the resident/legal representative refuses, there is a medical contraindication or the resident has already received the immunization. To ensure compliance, the following steps have been implemented:

1. Education has been provided to the responsible party of resident #5, consent obtained, and the immunization administered.
2. An immunization calendar has been developed to track resident immunization dates. All resident immunizations that were due or past due have been administered, unless contraindicated or refused.
3. A Pneumococcal and Influenza Vaccination policy has been developed along with a vaccine log to be placed on each residents chart to document vaccination dates.
4. Each month the vaccinations that are due to be given, will be placed on the nurses MAR by the nurse reviewing the monthly orders. The D.O.N. will then compare

the monthly orders to the vaccine calendar to ensure all vaccines have been placed on the MAR to be administered per policy.

5. The D.O.N. or Charge nurse will place the vaccine schedule for all new residents on the vaccine calendar. The nurse providing the initial vaccines will place the vaccine log on the residents chart.
6. All nursing staff will be in-serviced on this new policy and process on November 16, 2010 by the Director of Nursing.
7. The Director of Nursing will audit 16 charts monthly for 3 months to ensure all scheduled immunizations are being placed on the calendar. The D.O.N. will review the chart of all residents with scheduled immunizations each month for three months to ensure that education is being provided to the resident/responsible party and that immunizations are being administered. The results of this audit will be reported to the PI Committee monthly.

Completion Date: November 19, 2010

F431

It is the policy of this facility that all drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principles including the expiration date when applicable. To ensure compliance, the following steps have been implemented.

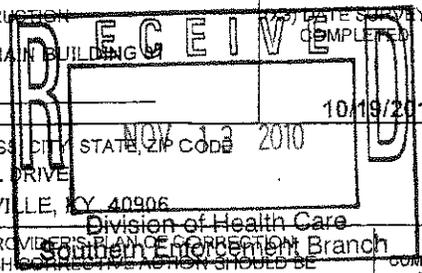
1. All multi-dose vials in the refrigerator that were open and not labeled with the expiration date have been discarded.
2. All multi-dose vials in the LTC medication stock that have been opened, have been checked to ensure they are labeled with the expiration date when opened and are not expired.
3. All nursing staff will be in-serviced on the policy related to labeling of multi-dose vials on November 16, 2010 by the Director of Nursing.
4. The Director of Nursing will review all open multi-dose vials weekly for 12 weeks to ensure they are labeled with the expiration date. The results of this audit will be reported to the PI Committee monthly.

Completion Date: November 19, 2010

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185420	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2010
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY HOSPITAL			STREET ADDRESS CITY STATE ZIP CODE 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
K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on October 19, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain fire/smoke dampers that penetrated the fire/smoke barrier walls above the fire doors. This deficient practice affected two (2) of two (2) smoke compartments, staff, and sixteen (16) residents. The facility has the capacity for 16 beds with a census of 16 on the day of the survey. This deficient practice also affected numerous smoke compartments, staff, and occupants located throughout the hospital.	K 025	See attached.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Craig Morgan TITLE: CEO (X6) DATE: 11/12/10

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 025	Continued From page 1 The findings include: During the Life Safety Code survey on October 19, 2010, at 11:15 a.m., a record review with the Director of Maintenance (DOM) revealed documentation by an outside contractor dated May 12, 2010, that numerous fire/smoke dampers located throughout the facility were inoperable. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years. An interview with the DOM on October 19, 2010, at 11:15 a.m., revealed the dampers were approved to be repaired in September 2010 but no action by the facility had been taken to ensure the repairs were completed. Reference: NFPA 90a (1999 Edition). 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the emergency battery-operated lighting located in the generator room was maintained according to NFPA standards. The findings include:	K 025		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the emergency battery-operated lighting located in the generator room was maintained according to NFPA standards. The findings include:	K 046	See attached.	

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K 046	Continued From page 2 During the Life Safety Code survey on October 19, 2010, at 10:20 a.m., an interview with the Director of Maintenance (DOM) at the outside generator set enclosure revealed the emergency battery-operated lighting located in the generator room was not tested 30 seconds monthly and one and one-half hours annually as required. The DOM was not aware testing was required. Reference: NFPA 101 (2000 Edition). 7.9.3 Periodic Testing of Emergency Lighting Equipment A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 050	See attached.	

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K 050	<p>Continued From page 3</p> <p>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 record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. 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 October 19, 2010, at 11:10 a.m., with the Director of Maintenance (DOM) a record review revealed the facility had not been performing fire drills at unexpected times and varying conditions on the third shift. From November 26, 2009 to September 30, 2010, fire drills were conducted between 5:00 a.m. and 6:00 a.m. An interview with the DOM on October 19, 2010, at 11:10 a.m., revealed the DOM was not aware of this requirement. A review of prior statements of deficiencies issued to the facility revealed the facility had been cited for this same deficient practice on December 12, 2007 and September 8, 2008.</p>	K 050		
K 054 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>All required smoke detectors, including those activating door hold-open devices, are approved,</p>	K 054	See attached.	

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K 054	<p>Continued From page 4</p> <p>maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the fire alarm system by NFPA standards. This deficient practice affected two (2) of two (2) smoke compartments, staff, and sixteen (16) residents. The facility has the capacity for 16 beds with a census of 16 on the day of the survey. This deficient practice also affected all the smoke compartments, staff, and occupants throughout the hospital.</p> <p>The findings include:</p> <p>During the Life Safety Code tour conducted on October 19, 2010, at 10:50 a.m., with the Director of Maintenance (DOM) a record review revealed there were no reports made available regarding the sensitivity testing of the smoke/heat detectors. A sensitivity report entails the testing of components associated with the fire alarm system, e.g., smoke detectors and heat detectors. An interview on October 19, 2010, at 10:50 a.m., revealed the DOM was aware of this required testing but could not locate the reports. A review of previous statements of deficiencies revealed the facility was cited for this same deficient practice on September 5, 2008.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration</p>	K 054		

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K 054	Continued From page 5 test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an	K 054		

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K 054	Continued From page 6 unmeasured concentration of smoke or other aerosol into the detector. 7-3.2.2 Test frequency of interfaced equipment shall be the same as specified by the applicable NFPA standards for the equipment being supervised. 7-3.2.3 For restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested.	K 054			

K 025

Smoke barriers are constructed to provide at least a one half hour fire resistance rating.

1. A proposal from Life Safety Services was accepted / signed for the total damper repair which included thirty actuators and three for just damper repair on November 11, 2010.
2. Life Safety Services scheduled a repair start date of November 29, 2010.
3. The MEOC / Safety Manager will report the progress and completion of this repair through the MEOC Committee and the PI Committee.

Completion Date: December 2, 2010

K 046

Emergency lighting of at least one and one half hour duration is provided.

1. A one and one half hour test of the emergency lighting equipment was completed on November 12, 2010.
2. The maintenance log was updated to allow documentation of the periodic testing of the emergency lighting equipment: Thirty second test to be administered monthly and a one and one half hour test to be done annually.
3. The Conducting Monthly Tests of Emergency Diesel Generators policy was updated to reflect the thirty second test monthly and the one and one half hour test annually.
4. A PI Monitor will be added as follows: Emergency Lighting: A) Thirty second test completed monthly. Threshold: 100%. B) One and one half hour test completed annually. Threshold: 100%.

Completion Date: November 12, 2010

K 050

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.

1. An unexpected fire drill was performed at twelve am on November 13, 2010.
2. The Drills Policy and Fire Drill Summary Log were updated to reflect all drills to be done at varying times on each shift.
3. The Fire Drill Summary Log will note the times of the previous quarterly drills and will be utilized to ensure drill times are varied on each shift. each quarter.
4. The MEOC / Safety Manager will review the log quarterly to ensure all drills are being completed @ varying times on each shift.

Completion Date: November 19, 2010

K 054

All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications.

1. A proposal from Allied Communications was accepted / signed for the quarterly testing of alarm initiating devices on ~~November 11, 2010.~~
2. Allied has scheduled the inspection for this quarter to occur in December 2010.
3. The MEOC / Safety Manager will report the completion of the quarterly testing to the MEOC Committee and PI Committee quarterly.

Completion Date: December 31, 2010

FIRE/SMOKE DAMPER REPAIR / REPLACEMENT PROPOSAL

Tammy Patterson
KNOX COUNTY HOSPITAL
80 Hospital Dr.
Barbourville, KY 40906
(606) 546-4175 x 5526

Proposal Number: 05-10-021js

ACTUATOR REPLACEMENT AND DAMPER REPAIR OR REPLACEMENT PROPOSAL

Life Safety Services, LLC ("Life Safety Services") is pleased to submit the following proposal ("Proposal") to **KNOX COUNTY HOSPITAL** ("Customer") for the Replacement of the Customer's Fire/Smoke Actuators ("Actuators") and/or Repair or Replacement of Customer's Fire and/or Smoke Dampers ("Dampers").

ACTUATOR REPLACEMENT SERVICES AND DAMPER REPAIR/REPLACEMENT SERVICES TO BE PROVIDED. Based on Customer's drawings and other information provided to Life Safety Services, Life Safety Services agrees to provide the following replacement and repair services with respect to Customer's Dampers (collectively, "Repair Services")

- a. Use its commercially reasonable efforts Life Safety Services' technician(s) will determine the appropriate Actuator to replace the old defective actuator. The replacement Actuator will be UL555 listed.
- b. The following items will be verified for the replacement actuator
 - i. **Temperature:** The replacement actuator shall operate at the rating of the original actuator.
 - ii. **Torque:** The replacement actuator shall have equal or greater torque than the failed actuator.
 - iii. **Time:** The replacement actuator shall drive open and spring closed at the same or faster speed than the original.
 - iv. **Voltage:** The Replacement actuator shall have the same voltage as the original.
 - v. **Amperage:** The replacement actuator(s) shall not draw more amperage than the original(s) and cause the total amperage to rise above that which the electrical circuit breaker is designed to carry.
- c. With the assistance and guidance of Customer in locating the applicable source, disconnect power to the old actuator.
- d. The old actuator will be removed and the damper will be cleaned.
- e. Open and close the blades of the Damper that is having the actuator replaced to ensure they are operational.
- f. Close the Damper and place Actuator on shaft in sprung closed direction.
- g. Mark holes and install anti-rotation strap; set anti-rotation strap with one screw and rotate out of way of U-slot in actuator. Close tight, and then insert anti-rotation stud and second screw.
- h. Test functions after installation of new actuator:
 - i. Power Actuator to open the damper, take digital photograph of open damper.
 - ii. Cut power to actuator to close damper; take digital photograph of closed damper providing proof of operational actuator.
 - iii. Power Actuator to reopen damper; take digital photograph of open damper to provide proof of operational actuator.
- i. Additional Dampers not in need of Actuator Replacement Services, but in need of repair will also be repaired by Life Safety Services' technicians; as deemed within the scope of services offered by Life Safety Services on-site Project Manager. The list of dampers in need of repair will be provided to Life Safety Services by the Customer.
 - i. Dampers in need of complete replacement will be replaced with Dampers listed by Underwriters Laboratory as UL555 (Fire Dampers), UL555S (Smoke Dampers), UL555C (Ceiling Dampers).
 1. The proper rating (e.g. 1 1/2, 3 hours and Dynamic Rated or Static Rated) will be determined for replacement damper.
 2. Standard Damper Installation issues will be considered prior to installation:
 - a. Damper Size
 - b. Where should damper be located
 - c. Expansion Clearance
 - d. Retaining Angle(s)
 - e. Sleeve requirements
 - f. Duct to Sleeve Connections
 - ii. The Dampers in need of repair that Life Safety Services' Project Manager deems is outside of Life Safety Services' scope of work will be provided to the Customer.

2. **Report.** On conclusion of the performance of the Repair Services, Life Safety Services will provide Customer with a report ("Report"), which is intended to provide Customer evidence of repair replacement for submission to applicable agencies, such as the Customer's local fire protection agencies, and to the Customer's Risk Management Department or Insurance Company. The Report shall include:

- a. *A field report listing each Damper that had a replacement actuator installed or damper repaired or replaced, the damper's location, and damper's identifier number.*
- b. *The name and signature of the Life Safety Services' Service Technician that performed the Repair Service, as well as the date of the service.*
- c. *A check list completed by the Service Technician that all post-installation Test Functions (See item h.) were completed.*
 - i. *The original of the field report will be left with the Customer.*
- d. *A final report will be prepared that will list every damper that had a replacement actuator installed or damper repaired or replaced, a digital photograph of every damper with a replacement actuator or repaired damper "open", "closed", and "reopen" demonstrating the operability of the new actuator or repaired damper. The pictures will be accompanied by a detailed summary report listing the location of the damper(s) with replacement actuator(s), replacement damper(s), the date(s) of installation, the model of actuator(s) installed, and the identification number of the damper.*



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3. PRICE AND TERMS

3.1 Base Bid. The Base Bid for Repair Services is as follows (does not include the cost of access door installation) and final price will be based on actual number of actuators installed, number of dampers repair and dampers replaced and an adjustment will be made at the applicable price per actuator, repair, damper respectively: NOTE: Prices below include the labor and material for the Repair Services as well as labor to re-inspect the "failed damper" as required in NFPA 80 and 105.

ITEM	SIZE	Quantity	PROVIDE AND INSTALL	Extended Price
Fire Damper				
Smoke Damper				
Combo Fire/Smoke Damper				
Actuator	30		\$585.00	\$17,550.00
Damper Repair	3		\$225.00	\$675.00
Total Damper Repair(s)				\$18,225.00

NOTE:

****DOES NOT INCLUDE THE COST OF ACCESS DOOR INSTALLATION.**

- 1) Access Doors may need to be installed to facilitate installation of replacement actuator.
- 2) Prices above for replacement does INCLUDE the price to re-inspect the damper after repair.
- 3) If a damper failed due to "no-air" or "no-power" and the air or the power has been restored the damper will be re-inspected. The re-inspection price will be \$40.00/damper.

4.2 Access Door Installation. The cost of access door installation will be:

- | | |
|---|----------------|
| a. Cam-Lock Door (8" x 8"): | \$59.00 / each |
| b. Cam-Lock Door (12" x 12"): | \$65.00/ each |
| c. Cam-Lock Door (14" x 14") | \$69.00 / each |
| d. Cam-Lock Door (Larger than 14" x 14") | \$79.00 / each |
| e. Sheet Metal Door (8" x 8") | \$25.00 / each |
| f. Sheet Metal Door (12" x 12") | \$29.00 / each |
| g. Sheet Metal Door (18" x 18") | \$36.00 / each |
| h. Round Sandwich Door (8") | \$82.00 / each |
| i. Round Sandwich Door (12") | \$92.00 / each |
| j. Round Sandwich Door (Larger than 12"): | \$99.00 / each |

Above access door prices and damper inspection prices are for 2010 only. Such prices will be subject to a 4% per year increase in price.



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3.3 Payment Terms. Customer will pay all invoices net 30 days from date thereof.

3.4 Additional Charges. Any additional work requested by Customer or any additional work needed to be performed due to extenuating circumstances will be made on a time and material basis, as mutually agreed between Customer and Life Safety Services prior to the performance of such additional work. For example, access panels need to be installed in hard ceilings, fire-rated walls need to be altered, or additional trips are required due to circumstances outside of Life Safety Services control then Additional Charges will apply.

3.6 Additional Report(s). The Base Bid Price incorporates the price for one (1) copy of the final project Report. All requests for additional reports will be at a charge of \$150.00 per report.

4. MISCELLANEOUS

4.1 Certain Inaccessible Actuators and Dampers. Customer acknowledges that Life Safety Services agrees to use its commercially reasonable efforts to find and replace as well as repair all of Customer's Actuators and Dampers. Nonetheless, certain Actuators and Dampers may be inaccessible due to construction restraints (for example, those located in concrete shafts) and may not be serviceable by Life Safety Services. The location of such inaccessible Actuators and Dampers shall be included in the Report.

4.2 Permits. If a permit is required for any Repair Services it is the sole responsibility of the Customer to secure the permit. Customer agrees to hold Life Safety Services harmless from and against any loss or damages (including attorney's fees) ("Damages") incurred by Life Safety Services as a result of Customer's failure to obtain any such permits.

4.3 Codes and Regulations. The Customer must make Life Safety Services aware of any codes or regulations in place by the Customer's Authority Having Jurisdiction ("AHJ") that could impact the Repair Services. Customer agrees to hold Life Safety Services harmless from and against any Damages incurred by Life Safety Services as a result of any variances from the AHJ's requirements if not informed of such requirements by the Customer.

4.3 Scope of Services. Customer acknowledges that the scope of the Repair Services to be performed by Life Safety Services is limited to those described in Sections 1 and 2 of this Proposal. The purpose of the Final Report to be delivered by Life Safety Services is to describe the location and operability of the new actuators as of the date of such Final Report or the date of the repair or replacement of the damper(s) as of the date of such Final Report, and is not intended to constitute and warrant as to the continued operation of any actuator or Damper on the part of Life Safety Services. Belimo® provides a five (5) year warranty on the actuators that will be installed. Terms and Conditions of Belimo's® Warranty can be obtained from Belimo's® Product Guide and Price List, which can be accessed on their website www.belimo.us. Other Actuator Manufactures and/or Damper Manufactures may also provide its own warranty, which will be assigned to the Customer. Life Safety Services sole warranty (whether express or implied) is that each Actuator and/or Damper will be operable as of the date of its installation or repair. In the event it is determined that any Actuator and or Damper fails to conform to such warranty, then Life Safety Services shall, at Customer's option, correct the deficiencies with respect to such Actuator and or Damper, or refund the purchase price thereof. The foregoing constitutes Customer's sole remedy and Life Safety Services' sole liability in the event of a breach of Life Safety Services' warranty. In no event shall Life Safety Services be liable for any incidental or consequential damages of any nature whatsoever.

4.4 Complete Agreement. This Proposal constitutes the complete agreement between Customer and Life Safety Services and supersedes and prior or contemporaneous negotiations or agreements with respect to the subject matter hereof, and may not be otherwise deemed modified or amended except in a writing signed by the parties hereto. Without limiting the generality of the foregoing, no provisions contained in Customer's purchase order or other forms shall be construed to amend or otherwise modify the terms of this Proposal, or otherwise accepted by Life Safety Services, unless agreed to in writing by Life Safety Services.



YOU'RE SAFE WITH USSM

LIFE SAFETY SERVICES

4720 Pinewood Rd. • Louisville, Ky 40218

Phone: 1-888-675-4519

Fax: 502-964-1337

Email: info@lifesafetyservices.com

www.lifesafetyservices.com

If this Proposal is acceptable to Customer, then please execute it where indicated below, in which event this Proposal shall constitute the binding agreement between Customer and Life Safety Services.

This Proposal shall expire on May 27, 2011 if not accepted by Customer on or before such date.

Thank you for allowing Life Safety Services the opportunity to submit this Proposal, and we look forward to having the opportunity to work with the staff of the Customer.

Very truly yours,

Life Safety Services, LLC

By: _____

Judy Shission

Accepted by:

Customer:

Knox County Hospital
[Signature] _____ July 07, 2010
Date

By: Craig Morgan _____ CEO
Title

P.O.# 26059

Maintenance of fire/smoke dampers will start 11/29/2010 and will take 1-2 days to complete.

Ther
Kett
uEOL

Please advise if a separate Purchase Order number is required if the Base Bid is exceeded.

OR

Credit Card Type (Please Circle One): Visa, MasterCard, American Express

Credit Card Number: _____

Expiration Date: _____

Name as it appears on the card: _____

1. Life Safety Services, LLC and the Purchaser are contemplating a possible transaction (the "Transaction") with respect to a Fire and Smoke Damper Inspection. In connection with the Transaction (the "Permitted Purpose"), the Purchaser has requested certain confidential information regarding a Fire and Smoke Damper Inspection.
2. This Proposal is considered Confidential Information of Life Safety Services, LLC. The Confidential Information will remain the exclusive property of Life Safety Services, LLC, and will only be used by the Purchaser for the Permitted Purpose. The Purchaser will not use the Confidential Information for any purpose which might be directly or indirectly detrimental to Life Safety Services, LLC or any of its affiliates or subsidiaries.
3. The obligations to ensure and protect the confidentiality of the Confidential Information imposed on the Purchaser in this Proposal will survive the expiration or termination, as the case may be, of this Proposal.



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KNOX COUNTY HOSPITAL

SUBJECT: CONDUCTING MONTHLY TESTS OF EMERGENCY DIESEL GENERATORS	REFERENCE #7012
DEPARTMENT: MAINTENANCE	PAGE: 1 OF: 2
APPROVED BY:	EFFECTIVE: 2008 REVISED: 11/11/2010

Deleted: 2/18/2010

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POLICY:

- This policy is to ensure operations reliability developed to promulgate the procedures, which will be carried out in conducting tests of the emergency generators.
- The following procedures are established for conducting the tests. The responsible personnel assigned to conducting these tests in accordance with the Monthly Test and Inspection Sheet shall be familiar with the procedures outlined below:
 - The emergency diesel generators will be tested under dynamic load of the facility for 30 minutes each month.

Note: Some states' regulations may require weekly testing. Check your state regulations.
 - The proper log entries will be made.
- In the event a holiday or extenuating circumstances preclude the conducting of the test as outlined above, the responsible party will coordinate with Nursing Manager on the revised time and date the test will be conducted. The offices concerned will also be notified.
- Prior to conducting dynamic load tests of the units, the following offices and/or personnel associated with the offices, will be notified that the test is to be conducted. This notification shall be 30 minutes prior to the start of the test.
 - Surgery
 - Urgent Care Areas
 - Nursing Supervisor
 - Operator
- Should there be a requirement to delay the test by an individual office, the office concerned will be called again immediately after their requested time delay.
- During the generator testing the emergency battery – operated lighting located in the generator building needs to be tested 30 seconds monthly and one and one half hours annually.

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KNOX COUNTY HOSPITAL

SUBJECT: CONDUCTING MONTHLY TESTS OF EMERGENCY DIESEL GENERATORS	REFERENCE #7012
	PAGE: 2 OF: 2
DEPARTMENT: MAINTENANCE	EFFECTIVE: 2008
APPROVED BY:	REVISED: 11/11/2010

Deleted: 2/18/2010

PROCEDURE FOR TESTING OR STARTING EMERGENCY GENERATORS:

- Check the oil level before starting the engine, add oil, if necessary, to bring it to the proper level of the dipstick.
- Check the coolant level. Maintain it near the top of heat exchanger tank or radiator upper tank.
- Check the generator main bearing oil reservoir to the proper level on the sight gauge.
- Check the battery, the top should be clean and dry the terminals tight and the electrolyte must be at the proper level. No corrosion should be visible.
- Check all electrical connections; make certain they are correct and tight.
- Make sure the power generator unit has been cleared of all tools or other objects, which might interfere with its operation.
- Make sure the selector switch is on auto position.

PROCEDURE FOR CHECKING FUEL LEVELS OF DIESEL TANKS:

- Fuel levels will be checked monthly.
- By using the graduated stick determine how many gallons of diesel fuel oil is inside the tanks.
- Record number of inches of diesel fuel indicated on the dipstick.
- Use the conversion chart located in **MAINTENANCE** to convert inches to gallons. Record number of gallons. Under a full load the generator uses approx. 12 gallons per hour.
- Notify **G & M OIL COMPANY** when reading approaches 500 gallons.

Note: JCAHO requires generator testing intervals 12 times per year at intervals not less than 20 days or more than 40 days. Please check your state standards and comply with the most stringent standard.

GENERATOR MAINTENANCE SCHEDULE



W - WEEKLY

M - MONTHLY

Q - QUARTERLY

PERFORMED BY

DATE

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COMPONENT

FREQUENCY

1. FUEL

A) MAIN SUPPLY TANK LEVEL	MONTHLY								
B) WATER IS SYSTEM	WEEKLY								
C) FLEXIBLE HOSE AND CONNECTORS	WEEKLY								

2. LUBRICATION SYSTEM

A) OIL LEVEL	WEEKLY								
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2. COOLING SYSTEM

A) LEVEL	WEEKLY								
B) FAN AND ALTERNATOR BELT	MONTHLY								
C) WATER PUMPS	WEEKLY								
D) CONDITION OF FLEXIBLE HOSES AND CONNECTION	WEEKLY								
E) JACKET WATER HEATER	WEEKLY								

4. EXHAUSTED SYSTEMS

A) LEAKAGE	WEEKLY								
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5. BATTERY SYSTEM

A) ELECTROLYTE LEVEL	WEEKLY								
B) TERMINALS CLEAN AND TIGHT	QUARTERLY								
C) REMOVE CORROSION, CASE EXTERIOR CLEAN AND DRY	MONTHLY								
D) SPECIFIC GRAVITY OR STATE OF CHARGE									
BATTERY # 1	MONTHLY								
BATTERY # 2	MONTHLY								
E) CHARGER AND CHARGE RATE	MONTHLY								

6. ELECTRIC SYSTEM

A) GENERAL INSPECTION	WEEKLY								
A) GENERAL INSPECTION	WEEKLY								
B) WIRE CHAFING WHERE SUBJECT TO MOVEMENT	QUARTERLY								
C) CIRCUIT BREAKERS, FUSES	MONTHLY								
D) AMPS DURING LOAD	MONTHLY								

NOTE: DO NOT BREAK MANUFACTURERS SEALS OR PERFORM INTERNAL INSPECTION ON THESE DEVICES

7. PRIME MOVER

A) GENERAL INSPECTION	WEEKLY								
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8. RUNNING

A) START HOURS	WEEKLY								
B) FINISH HOURS	WEEKLY								
TEST UNDER LOAD	MONTHLY								
TEST NO LOAD	WEEKLY								

9. TRANSFER SWITCHES									
A) TRANSFER SWITCH #1	TRANSFERRED AND RE-TRANSFERRED PROPERLY	MONTHLY							
B) TRANSFER SWITCH #2	TRANSFERRED AND RE-TRANSFERRED PROPERLY	MONTHLY							
C) TRANSFER SWITCH #3	TRANSFERRED AND RE-TRANSFERRED PROPERLY	MONTHLY							
10. EMERGENCY LIGHTING									
A) 30 SECOND FUNCTIONAL TEST		MONTHLY							

K

GENERATOR MAINTENANCE SCHEDULE

S - SEMIANNUALLY A - ANNUALLY NOS - INDICATE HOURS



PERFORMED BY									
DATE									

COMPONENT FREQUENCY

1. FUEL

A) TANK VENTS AND OVERFLOW PIPING OBSTRUCTED	ANNUALLY								
B) PIPING	ANNUALLY								

2. LUBRICATION SYSTEM

A) OIL CHANGE	50 OR ANNUALLY								
B) OIL FILTERS	50 OR ANNUALLY								

2. COOLING SYSTEM

A) ANTIFREEZE PROTECTION LEVEL	SEMI-ANNUALLY								
B) ANTIFREEZE	ANNUALLY								
C) CLEAN EXTERIOR OF RADIATOR	ANNUALLY								
D) CLEAN LOUVERS	ANNUALLY								
E) LOUVER MOTOR AND CONTROLS	ANNUALLY								

4. EXHAUSTED SYSTEMS

A) EXHAUST SYSTEM HANGERS AND SUPPORTS	ANNUALLY								
B) FLEXIBLE EXHAUST SECTION	SEMI-ANNUALLY								

6. ELECTRIC SYSTEM

A) TIGHTEN CONTROL AND POWER WIRING CONNECTIONS	ANNUALLY								
B) OPERATION OF SAFETIES AND ALARMS	SEMI-ANNUALLY								
C) TRANSFER SWITCH MAIN CONTACTS	ANNUALLY								
D) WIRE INSULATION BREAKDOWN	ANNUALLY								

NOTE: DO NOT BREAK MANUFACTURERS SEALS OR PERFORM INTERNAL INSPECTION ON THESE DEVICES

7. PRIME MOVER

A) GOVERNOR OIL	ANNUALLY								
B) INJECTOR PUMP AND INJECTORS FOR FLOW RATE PRESSURE, AND/OR SPRAY PATTERN	ANNUALLY								
C) INJECTOR PUMP AND INJECTORS FOR FLOW RATE PRESSURE, AND/OR SPRAY PATTERN	ANNUALLY								

9. Emergency Lighting

A) 1 1/2 HOUR FUNCTIONAL TESTING	ANNUALLY								
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K



708 Werne Drive
Lexington, KY 40504-1009

**** Proposal ****
Project Number: 3952FA

11/9/2010

v: 859-255-3058 f: 859-231-7535
www.alliedlex.com systems@alliedlex.com

Project: Sensitivity Testing

**** Proposal ** to:**

Knox County Hospital
One Hospital Way, P.O. Box 160 Barbourville, K
Barbourville, KY 40906-0160

Fax: 606-545-6547

Project Site:

Mfr-Part No.	Qty	Description	Extended
		<p>Thank you for the opportunity to develop this proposal for Sensitivity Testing of smoke detectors for entire hospital.</p> <p>Cost of smoke detector sensitivity testing will be \$16.50 per head. Price does not include replacement of any defective smoke detectors found during inspection. A separate quote will be given to replace defective units. A daily trip charge of \$50.00 will also be charged.</p> <p>Sensitivity report will be completed after each inspection and given to hospital personal.</p>	
	353	Smoke Detectors	5,824.50
		NOTE: Above price is based on our records. Any additional smoke detectors will be charged accordingly.	

Need Quarterly Quote, would these test start in Dec

Sensitivity will be administered Quarterly until complete Starting Dec 2010

TRP

This ** Proposal ** is Valid for 90 Days.

Signature:

Date: 11/11/2010

Shipping & Handling:	\$	-
Tax:	\$	-
Project Total:	\$	5,824.50

KNOX COUNTY HOSPITAL

SUBJECT: DRILLS POLICY	REFERENCE #5015
DEPARTMENT: HOSPITAL WIDE	PAGE: 1
	OF: 2
APPROVED BY: MEOC	EFFECTIVE: 12-2008
	REVISED: 11-2010

Deleted: 12-2008

POLICY:

All personnel are required to participate in fire drills and emergency management drills. Drills will be conducted periodically to assure patient and employee safety, and also as required by the Joint Commission on Accreditation of Healthcare Organizations.

PROCEDURE:

- At least 50% of the drills will be unannounced. Each shift of personnel will have a drill at least quarterly. One fire drill will be conducted between the hours of 7 AM and 3PM (1st shift). One fire drill will be conducted between the hours of 3PM and 11PM (2nd shift). One fire drill will be conducted between the hours of 11PM and 7AM (3rd shift) With all drills being done at varied times each shift by utilizing the summary of fire drills form. All fire drills will be critiqued to the extent necessary to ensure that the facility's fire plan aspects have been met. If activities are required outside of the smoke compartment where the fire originated, those will be included in the evaluation of the fire drill as well.
- A random sample of personnel shall be verbally quizzed following each drill. Their knowledge of the following will be assessed:
 - Fire alarm systems
 - Transmission of alarms
 - Containment of smoke and fire
 - Transfer to areas of refuge
 - Fire extinguishment
 - Assignment of specific duties
 - Preparation for building evacuation
- Fire drills shall be designed to test staff knowledge of general organization fire protocols and all aspects of response that may be unique to an employee's specific work area including but not limited to:
 - How to identify the location of the fire and what their response would include

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KNOX COUNTY HOSPITAL

SUBJECT: DRILLS POLICY	REFERENCE #5015
DEPARTMENT: HOSPITAL WIDE	PAGE: 2
	OF: 2
APPROVED BY: MEOC	EFFECTIVE: 12-2008
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- The use and functioning of fire alarm systems
- The transmission of alarms
- How to contain smoke and fire
- How to transfer patients, visitors and staff to safe area
- How to extinguish a fire
- What are their specific fire response duties
- How to prepare for building evacuation
- Organizations that are business occupancies perform fire drills in areas used for business purposes and evacuate employees, visitors and simulated patients. It is not required to evacuate actual patients. A minimum of one staff member will continue through the exit from the building ensuring that exits are well lit and unobstructed. Staff members in free-standing buildings which are classified as business occupancies by the Life Safety Code need to participate in only one fire drill per shift annually.
- Fire drills performed in areas of the building used for healthcare delivery will have employees, visitors and patients escorted to areas of refuge within the building.
- All fire drills will be evaluated and critiqued for the purpose of identifying deficiencies and opportunities for improvement.
- A written report documenting the evaluation of each drill and the corrective actions recommended or taken for any deficiencies found will be completed by a member of the Safety Committee and filed with the Safety Officer.
- All personnel will be trained in fire response pursuant to the fire safety component of the Life Safety Management Program. The effectiveness of personnel training will be evaluated on an annual basis, through an assessment of the fire drill evaluations and any corresponding improvement activities conducted.
- The Fire Safety Manual will be kept current and available in every department. Personnel are expected to read this manual, and the effective performance of responsibilities under the plan is a condition of employment.

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KNOX COUNTY HOSPITAL SUMMARY OF FIRE DRILLS

Record Date, Time (varied), Location and Results of Fire Drill. Include Fire Drill Report and any additional documentation with this summary.

Results: PI = Problems Identified CA = Corrective Action Taken SP = Good Staff Participation

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
AM Shift (7AM – 3PM)	Date: _____ Time: _____ Location: _____ Results: PI CA SP			
PM Shift (3PM – 11PM)	Date: _____ Time: _____ Location: _____ Results: PI CA SP			
Third Shift (11PM – 7AM)	Date: _____ Time: _____ Location: _____ Results: PI CA SP			

All fire drill times throughout the year should vary so all employees have the same training.