

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

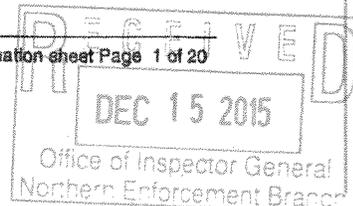
PRINTED: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/13/2015
NAME OF PROVIDER OR SUPPLIER NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701		
(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 225 SS=D	<p>A Recertification Survey was initiated on 11/12/15 and concluded on 11/13/15 with deficiencies cited at the highest scope and severity of an "F".</p> <p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the 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</p>	F 225	<p>F225 On Monday morning, 11/9/15, at the end of her shift, RN #1 reported to the Unit Manager about the previous evening with Resident #2, including her safety concerns, the subsequent room change, and the response of Resident #2. Because of this report, on 11/9/15, the Unit Manager visited Resident #2 to hear his/her feelings and perceptions of the activities the previous evening. The Unit Manager reports she discussed the nurse's safety concerns and provided emotional support to the resident. On 11/9/15, the Unit Manager also visited the roommate of Resident #2 in the original room to hear his/her feelings and perceptions of the activities the previous evening. The Unit Manager, as reported to the surveyor on 11/12/15, had not realized this could have been an allegation of abuse, nor had she documented any information gathered from her discussions with RN #1, Resident #2, or the roommate of Resident #2. On 11/12/15, the Unit Manager recorded the incident on Form M2087, "Suspected Abuse/Neglect, Dependency, or Exploitation Reporting Form". On 11/12/15, the report on Form M2087 was faxed to the Department of Protection and Permanency (DPP), Adult Protective Services. On 11/12/15, the Unit Manager reported the complaint of Resident #2 to the HMH Patient Advocate. On 11/13/15, the Patient Advocate visited Resident #2 and a visiting family member of Resident #2, to offer an opportunity to discuss feelings about the incident. The resident and family member denied any concerns at that time. The Patient (continue)</p>	12/24/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephen Toadvine TITLE: HMH NF Administrator (X6) DATE: 12/15/15

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

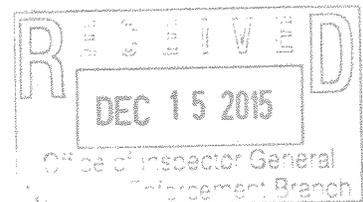
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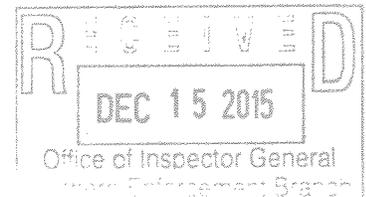
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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility's policy, it was determined the facility failed to investigate and report an allegation of abuse and failed to protect one (1) of five (5) sampled residents, (Resident #2). The Unit Manager received an allegation of abuse on 11/08/15 from Resident #2 that Registered Nurse (RN) #1 had grabbed his/her shoulder and "man-handled" the resident. However, there was no investigation and RN #1 did not report the allegation to the State Agencies. In addition, RN #1 was allowed to work and continued to care for other residents. The findings include: Review of the facility's Abuse Policy regarding Reporting Suspected Abuse/Neglect, reviewed March 2014, revealed the staff was to report suspected abuse or neglect to the Administrator/designee immediately. The Administrator/designee was to report the suspected abuse immediately to the State Agencies, Ombudsman Office, Facility Medical Director, the resident's physician, and Law Enforcement Officials. However, closer review of the Abuse Policy revealed the identification and reporting of suspected abuse referred to outside persons (child abuse and spousal abuse) and did	F 225	F225 (continued) Advocate sent a written response to Resident #2 on 12/3/15 addressing the original complaint. On 11/13/15, the Unit Manager received a response from the DPP Adult Protective Services stating there would not be any further investigation or actions resulting from the report. Based on this report, the Unit Manager and Director made the decision that no suspension of RN #1 would be required. No reports of mistreatment were received from the other residents. Nursing Facility Policy NF6050-0023 "Identification and Reporting of Suspected Abuse/Neglect & Exploitation Situations" was reviewed and revised by the Director of the Nursing Facility on 11/30/15. The policy revisions include the addition of: procedures for screening employees prior to employment and on an ongoing basis; requirements for training specifically for Nursing Facility staff; prevention strategies; processes for identification of abuse, neglect, or misappropriation of property; specific steps to take to investigate any allegations or suspected abuse, neglect or misappropriation of property sustained both prior to arrival or during residence in the Nursing Facility; process to remove the resident from potential harm, up to suspension of the employee during any investigation of alleged mistreatment or abuse; and procedures for reporting all alleged or suspected abuse, neglect or misappropriation of resident property, including those occurring before and/or during residence on the Nursing Facility. The policy was reviewed and approved by the Unit Manager on 12/1/15, the Director on 12/1/15, the Vice President/Chief Nursing Officer on 12/1/15, and the Vice President/Chief Medical Officer on 12/2/15. The policy was uploaded to the electronic policy manual on 12/2/15. All Nursing Facility staff is required to read the new policy and sign the roster attesting to understanding of the policy by 12/23/15. All (continue)	



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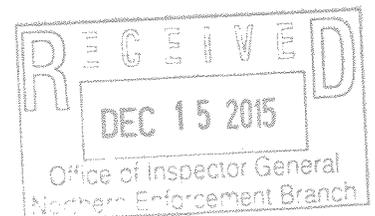
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F 225	<p>Continued From page 2</p> <p>not include staff to resident abuse. The policy did not include protection of the resident during the investigation. Refer to F226.</p> <p>Interview with Resident #2 during the initial tour, on 11/12/15 at 8:15 AM, revealed the resident voiced a concern regarding a room change. However, as the resident detailed the story, he/she stated a nurse grabbed him/her by the shoulder and moved the resident to another room. The resident voiced they were upset. The resident told the surveyor he/she had informed the Unit Manager of the incident. The resident remained upset regarding what had happened to him/her.</p> <p>Review of Resident #2's clinical record revealed the facility admitted the resident to the Skilled Nursing Facility (SNF) on 10/31/15 with diagnoses of Myocardial Infarction, Degenerated Joint Disease, Osteoarthritis, and History of Cerebrovascular Accident (stroke). The facility performed a Brief Interview for Mental Status where the resident scored a thirteen (13) out of possible fifteen (15), which meant the resident's cognition was intact and could be interviewed.</p> <p>Interview with the Unit Manager revealed the Charge Nurse (RN#1) reported to her that on Sunday (11/08/15) Resident #2 had asked to go to the bathroom. RN #1 was administering medications to the roommate and told the resident if he/she could wait, she would assist. RN#1 told the UM the resident became angry-cursing and yelling. She spoke with the resident on Monday and the resident told her when he/she came out of the bathroom, the RN grabbed his/her shoulder and walked him/her to</p>	F 225	<p>F225 (continued) staff is also required to attend a mandatory staff meeting before 12/23/15 to receive verbal education from the Unit Manager about reporting all allegations of mistreatment, abuse, neglect, and/or misappropriation of property according to the revised Nursing Facility Policy NF6050-0023. The Director of the Nursing Facility contacted the Lincoln Trail Area District Ombudsman on 11/13/15. Mandatory training for all staff of the Nursing Facility with the ombudsman is scheduled for the earliest available date of 1/13/16 and 1/14/16. All new residents are assessed for indications of abuse, neglect, or exploitation upon admission to the facility. The Unit Manager rounds on all new residents at least once after admission, or more often depending on length of stay, providing residents opportunities to voice concerns and ask questions. She writes her name and contact number on the white board for each resident to be able to contact her for any concerns that arise. Each resident also receives an Information Guide from nursing staff upon admission, which includes information on how to report an incident without fear of reprisal.</p> <p>F225 ADDENDUM (12/15/15) The follow up report on the allegation of abuse for resident #2 was completed on 11/12/15. The report was faxed to the Cabinet for Health and Family Services Office of Inspector General by the Unit Manager on 12/11/15. The Unit Manager has completed purposeful rounding on all residents, asking each about the care they are receiving and if they have any concerns. No concerns or allegations of mistreatment or abuse were reported; therefore no other residents were affected. The Unit Manager will report all reportable events to the Nursing Facility Quality Committee (continue)</p>		



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F 225	Continued From page 3 another room. She stated the resident had been moved to another room that day and was unhappy about the move. She then stated the resident had told her the nurse had man-handled him/her. The Unit Manager stated she had not asked the resident what he/she meant by those statements and did not investigate further to determine if it was an allegation of abuse. She stated she had not reported because she had not realized it could have been an allegation of abuse. The Unit Manager could not provide any written documentation that she investigated the incident. A telephone interview with RN #1, on 11/12/15 at 11:41 AM, revealed there was an incident on Sunday (11/08/15) where Resident #2 was upset about being moved to another room. She stated she was worried about the resident falling so she asked the resident to go to another room (Room 302) to be closer to the bathroom. The resident became very angry and called the nurse a "bitch". When the nurse attempted to put a gait belt around the resident's waist, he/she demanded the belt be remove. She told me to call the "law". She stated she walked the resident to Room 302 and tried to hold the resident's hand but he/she refused. The nurse stated the only time she touched the resident was when she applied the gait belt. She denied touching the resident's shoulder. The resident told the nurse she was going to go to prison for what she did. Interview with RN #2, on 11/12/15 at 3:55 PM, revealed she had worked the following Monday after the incident. She stated RN #1 requested to change teams so Resident #2 would not be assigned to her. RN #1 informed her of the	F 225	F225 (ADDENDUM Continued) quarterly to monitor and identify any trend for mistreatment, abuse, neglect, or misappropriation of property. The Quality Committee will monitor that these events are reported to the all required entities within the required time frames. All Nursing Facility policies will be reviewed by the Quality Committee every two years or more often when indicated by process changes or regulatory statutes.	



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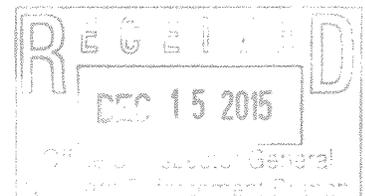
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F 225	<p>Continued From page 4</p> <p>incident and she stated that was out of character for the resident. During the morning medication pass, Resident #2 told RN #2 she didn't like being moved and should not have been treated like that. The resident explained the story as the resident had to go to the bathroom very quickly. When she left the bathroom, the nurse (RN #1) had whisked the resident off to another room because he/she got up without asking for assistance. The resident felt he/she was being punished. The resident told the nurse he/she had been mistreated.</p> <p>Interview with the Director of Medical Inpatient Services (Director of Nursing for the SNF), on 11/13/15 at 11:30 AM, revealed she was unaware of the incident. She stated the Unit Manager had not investigated the incident as an allegation of abuse. There were no documentation of the incident except what was documented in the clinical record. She stated she now realized the facility's Abuse Policy was the same used for the acute hospital and did not have the components required in Long Term Care setting. She stated the incident was not investigated nor reported. She validated RN #1 was allowed to work after the resident allegation.</p> <p>In addition, review of the abuse training provided to the facility's staff revealed the staff were educated with other hospital staff using the same online modules. The training included the information in the facility's Abuse Policy regarding outside sources of abuse and not staff to resident abuse.</p>	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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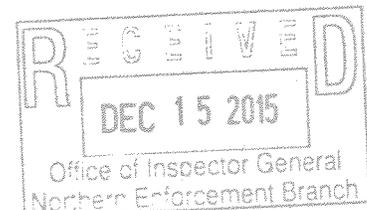
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F 226	Continued From page 5 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interviews and review of the facility's policy, it was determined the facility failed to develop and implement procedures to prevent abuse/neglect of residents. The facility's Abuse Policy was integrated with the acute hospital's policies and did not include procedures on how to investigate an allegation of abuse, and the protection of the resident. In addition, the facility failed to develop policy and procedures for identification of abuse that involved staff to resident. The facility's Abuse Policy only addressed outside sources of abuse such as Child and Spouse Abuse. The facility received an allegation of abuse on 11/08/15; however, failed to investigate or report to the State Agencies. In addition, the facility failed to protect the resident and allowed the nurse to continue to work with other residents after the allegation. Refer to F225 The findings include: Review of the facility's Abuse Policy regarding Reporting Suspected Abuse/Neglect, reviewed March 2014, revealed the staff was to report suspected abuse or neglect to the Administrator/designee immediately. The Administrator/designee reported the suspected abuse immediately to the State Agencies,	F 226	F226 On Monday morning, 11/9/15, at the end of her shift, RN #1 reported to the Unit Manager about the previous evening with Resident #2, including her safety concerns, the subsequent room change, and the response of Resident #2. Because of this report, on 11/9/15, the Unit Manager visited Resident #2 to hear his/her feelings and perceptions of the activities the previous evening. The Unit Manager reports she discussed the nurse's safety concerns and provided emotional support to the resident. On 11/9/15, the Unit Manager also visited the roommate of Resident #2 in the original room to hear his/her feelings and perceptions of the activities the previous evening. The Unit Manager, as reported to the surveyor on 11/12/15, had not realized this could have been an allegation of abuse, nor had she documented any information gathered from her discussions with RN #1, Resident #2, or the roommate of Resident #2. On 11/12/15, the Unit Manager recorded the incident on Form M2087, "Suspected Abuse/Neglect, Dependency, or Exploitation Reporting Form". On 11/12/15, the report on Form M2087 was faxed to the Department of Protection and Permanency (DPP), Adult Protective Services. On 11/12/15, the Unit Manager reported the complaint of Resident #2 to the HMH Patient Advocate. On 11/13/15, the Patient Advocate visited Resident #2 and a visiting family member of Resident #2, to offer an opportunity to discuss feelings about the incident. The resident and family member denied any concerns at that time. The Patient Advocate sent a written response to Resident #2 on 12/3/15 addressing the original complaint. On 11/13/15, the Unit Manager received a response from the DPP Adult Protective Services stating there would not be any further (continue)	12/24/15	



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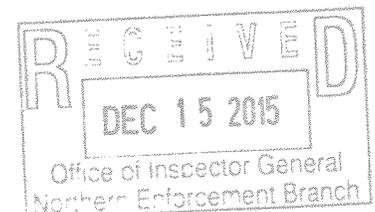
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F 226	<p>Continued From page 6</p> <p>Ombudsman Office, Facility Medical Director, the resident's physician, and Law Enforcement Officials. However, closer review of the Abuse Policy revealed the identification and reporting of suspected abuse referred to outside persons (child abuse and spousal abuse) and did not include staff to resident abuse. The policy did not include protection of the resident during the investigation.</p> <p>Interview with Resident #2 during the initial tour, on 11/12/15 at 8:15 AM, revealed the resident voiced a concern regarding a room change. However, as the resident detailed the story, he/she stated a nurse grabbed him/her by the shoulder and moved the resident to another room. The resident voiced they were upset. The resident told the surveyor he/she had informed the Unit Manager of the incident. The resident remained upset regarding what had happened to him/her.</p> <p>Review of Resident #2's clinical record revealed the facility admitted the resident to the Skilled Nursing Facility (SNF) on 10/31/15 with diagnoses of Myocardial Infarction, Degenerated Joint Disease, Osteoarthritis, and History of Cerebrovascular Accident (stroke). The facility performed a Brief Interview for Mental Status where the resident scored a thirteen (13) out of possible fifteen (15), which meant the resident's cognition was intact and could be interviewed.</p> <p>Interview with the Unit Manager revealed the Charge Nurse (RN#1) reported to her that on Sunday (11/08/15) Resident #2 had asked to go to the bathroom. The nurse was administering medications to the roommate and told the resident if he/she could wait, she would assist.</p>	F 226	<p>F226 (continued)</p> <p>investigation or actions resulting from the report. Based on this report, the Unit Manager and Director made the decision that no suspension of RN #1 would be required. No reports of mistreatment were received from the other residents. Nursing Facility Policy NF6050-0023 "Identification and Reporting of Suspected Abuse/Neglect & Exploitation Situations" was reviewed and revised by the Director of the Nursing Facility on 11/30/15. The policy revisions include the addition of: procedures for screening employees prior to employment and on an ongoing basis; requirements for training specifically for Nursing Facility staff; prevention strategies; processes for identification of abuse, neglect, or misappropriation of property; specific steps to take to investigate any allegations or suspected abuse, neglect or misappropriation of property sustained both prior to arrival or during residence in the Nursing Facility; process to remove the resident from potential harm, up to suspension of the employee during any investigation of alleged mistreatment or abuse; and procedures for reporting all alleged or suspected abuse, neglect or misappropriation of resident property, including those occurring before and/or during residence on the Nursing Facility. The policy was reviewed and approved by the Unit Manager on 12/1/15, the Director on 12/1/15, the Vice President/Chief Nursing Officer on 12/1/15, and the Vice President/Chief Medical Officer on 12/2/15. The policy was uploaded to the electronic policy manual on 12/2/15. All Nursing Facility staff is required to read the new policy and sign the roster attesting to understanding of the policy by 12/23/15. All staff is also required to attend a mandatory staff meeting before 12/23/15 to receive verbal education from the Unit Manager about reporting all allegations of mistreatment, abuse, neglect, (continue)</p>		



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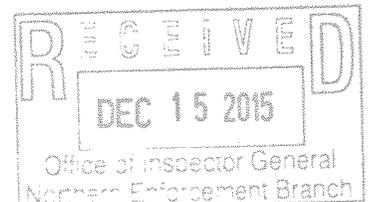
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F 226	Continued From page 7 The nurse told her the resident became angry-cursing and yelling. She spoke with the resident on Monday (11/09/15) and the resident told her when he/she came out of the bathroom, the nurse grabbed his/her shoulder and walked him/her to another room. She then stated the resident had told her the nurse had man-handled him/her. The Unit Manager stated she had not asked the resident what he/she meant by those statements and did not investigate further to determine if it was an allegation of abuse. She stated she had not reported because she had not realized it could have been an allegation of abuse. A telephone interview with RN #1, on 11/12/15 at 11:41 AM, revealed there was an incident on Sunday (11/08/15) where Resident #2 was upset about being moved to another room. She stated she was worried about the resident falling so she asked the resident to go to another room (Room 302) to be closer to the bathroom. The resident became very angry and called the nurse a "bitch". When the nurse attempted to put a gait belt around the resident's waist, he/she demanded the belt be removed. The resident told RN #1 to call the "law". The RN stated she walked the resident to Room 302 and tried to hold the resident's hand, but he/she refused. The nurse stated the only time she touched the resident was when she applied the gait belt. She denied touching the resident's shoulder. The resident told the nurse she was going to go to prison for what she did. She stated the Unit Manager had told her the resident alleged she had touched his/her shoulder. Interview with RN #2, on 11/12/15 at 3:55 PM, revealed she had worked the following Monday	F 226	F226 (continued) and/or misappropriation of property according to the revised Nursing Facility Policy NF6050-0023. All new residents are assessed for indications of abuse, neglect, or exploitation upon admission to the facility. The Unit Manager rounds on all new residents at least once after admission, or more often depending on length of stay, providing residents opportunities to voice concerns and ask questions. She writes her name and contact number on the white board for each resident to be able to contact her for any concerns that arise. Each resident also receives an Information Guide from nursing staff upon admission, which includes information on how to report an incident without fear of reprisal. F226 ADDENDUM (12/15/15) The Unit Manager will report all reportable events to the Nursing Facility Quality Committee quarterly to monitor and identify any trend for mistreatment, abuse, neglect, or misappropriation of property. The Quality Committee will monitor that these events are reported to the all required entities within the required time frames. All Nursing Facility policies will be reviewed by the Quality Committee every two years or more often when indicated by process changes or regulatory statutes.		



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F 226	Continued From page 8 after the incident. During the morning medication pass, Resident #2 told this nurse she didn't like being moved and should not have been treated like that. The resident stated he/she had to go to the bathroom in a hurry, when she left the bathroom, the nurse whisked him/her off to another room because the resident had gotten up without assistance. The resident stated he/she felt they were being punished. The resident told the nurse he/she had been mistreated. Interview with the Director of Medical Inpatient Services (Director of Nursing for the SNF), on 11/13/15 at 11:30 AM, revealed she was unaware of the incident. She stated the Unit Manager had not investigated the incident as an allegation of abuse. There was no documentation of the incident except what was documented in the clinical record. She stated she now realized the facility's Abuse Policy was the same used for the acute hospital and did not have the components required in Long Term Care setting. She stated the incident was not investigated nor reported. She validated RN #1 was allowed to work after the resident's allegation. She stated she was new in this position and did not realize the SNF needed a different Abuse Policy from the hospital.	F 226			
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review	F 247	F247 On Monday morning, 11/9/15, at the end of her shift, RN #1 reported to the Unit Manager about the previous evening with Resident #2, including her safety concerns, the subsequent room change, and the response of Resident #2. Because of this report, on 11/9/15, the Unit Manager visited Resident #2 to hear his/her feelings and perceptions of the activities the previous evening. The Unit Manager reports she discussed the nurse's safety concerns and (continue)	12/24/15	



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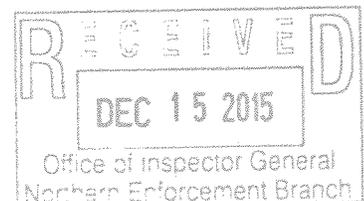
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F 247	<p>Continued From page 9</p> <p>of the facility's policy, it was determined the facility failed to provide notice before a room change for two (2) of five (5) sampled residents. Residents #2 and 4. Registered Nurse (RN) #1 moved Resident #2 against the resident's will and without notice to the resident or responsible party. The facility also moved Resident #4 without notice for isolation purposes.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Notification of Changes, reviewed June 2013, revealed the facility would notify the resident, family and/or legal representative when there was a room change.</p> <p>1. During the initial tour of the facility, on 11/12/15 at 8:15 AM, Resident #2 stated he/she had recently been moved to the present room without notice and the resident was upset about the move. The resident stated a nurse was giving medication to the resident's roommate when Resident #2 had requested assistance to the bathroom. The resident stated the nurse assisted the resident to the bathroom and when they came out of the bathroom, the nurse put her hands on the resident's shoulders and told the resident he/she was being moved to another room. Resident #2 stated he/she was very upset and started fussing with the nurse. The resident told the nurse he/she did not want to move. However, the resident stated the nurse did not listen to him/her and moved the resident anyway. The resident stated he/she had informed the Unit Manager on Monday, 11/10/15, of the incident</p>	F 247	<p>F247 (continued)</p> <p>provided emotional support to the resident. On 11/12/15, the Unit Manager reported the complaint of Resident #2 to the HMH Patient Advocate. On 11/13/15, the Patient Advocate visited Resident #2 and a visiting family member of Resident #2, to offer an opportunity to discuss feelings about the incident. The resident and family member denied any concerns at that time. The Patient Advocate sent a written response to Resident #2 on 12/3/15 addressing the original complaint. On 11/13/15, the Unit Manager visited Resident #4 to discuss his/her feelings and perceptions of the room change that previously occurred. The Unit Manager reports she discussed the purposes of isolation for his/her safety and the safety of other residents, and provided emotional support to the resident. On 11/24/15, a new policy was drafted by the Director of the Nursing Facility, to provide more specific guidance to Nursing Facility staff for notifying residents and/or resident's family of room or roommate changes. The policy outlines requirements for the notification, including the communication of change, reasons for change, documentation of notification, and the resident's right to refuse change. The policy was reviewed and approved by the Unit Manager on 11/30/15, the Director on 12/1/15, the Vice President/Chief Nursing Officer on 11/30/15, and the Vice President/Chief Medical Officer on 11/30/15. The policy was uploaded to the electronic policy manual on 11/30/15. On 12/4/15, the IT Clinical Informatics Manager built a documentation screen into Meditech, added to the Nursing Facility Standard of Care (SOC), which provides a consistent location for staff to document all communication with residents about room and roommate changes. The screen requires documentation of the type of change, the reason for change, who was notified, and the response (continue)</p>		

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F 247	<p>Continued From page 10</p> <p>and was told the Unit Manager would get back with him/her. However, the resident had not been told anything about the Unit Manager's findings and the resident still wanted to move back to the former room.</p> <p>Review of the electronic clinical record for Resident #2 revealed an Activity of Daily Living (ADL) assessment note for 11/08/15 that stated the resident had been moved to Room 302 so the resident could be closer to the bathroom. The writer documented the resident was angry and would rather have the police called to give him/her a ride home. Another note (no date or time) revealed the House Supervisor was notified of the resident's unhappiness with being moved for safety and the resident told the writer he/she should be able to go wherever and whenever they wished without a babysitter.</p> <p>Continued review of the clinical record revealed the facility admitted the resident to the Skilled Nursing Facility (SNF) on 10/31/15 to Room 305. The resident was receiving rehabilitation (rehab) services to improve mobility. The facility performed a Brief Interview for Mental Status where the resident scored a thirteen (13) out of possible fifteen (15), which meant the resident's cognition was intact and could be interviewed.</p> <p>Interview with the Unit Manager, on 11/12/15 at 11:29 AM, revealed the Charge Nurse (Registered Nurse #1) reported to her that on Sunday (11/08/15) Resident #2 had asked to go to the bathroom. The nurse was administering medications to the resident's roommate and she told the resident if he/she waited she would assist. The nurse told the Unit Manager Resident #2 became angry-cursing and yelling. She spoke</p>	F 247	<p>F247 (continued)</p> <p>of the resident or family representative. The screen includes fields to document a room or roommate change requested by the resident as well. All Nursing Facility staff is required to read the new policy and sign the roster attesting to understanding of the policy by 12/23/15. All staff is also required to attend a mandatory staff meeting before 12/23/15 to receive verbal education from the Unit Manager. Education will include providing advanced notification to the resident prior to all room and/or roommate changes, with reasons, and documenting in the medical record, in addition to the resident's right to refuse room changes. Before 12/11/15, the Unit Manager will add the review of Nursing Facility Policy NF6050-0041 "Resident Notification of Room or Roommate Change on the Nursing Facility" to the Job-specific Orientation Checklist for all new hires on the Nursing Facility. To ensure residents are notified of room changes on an ongoing basis, the IT Clinical Informatics Manager is building a report in Meditech that will list all room to room transfers. Another report will list all documentation on the "Room/Roommate Change Notification" screen. The Unit Manager will pull both reports at least quarterly to determine a compliance rate of documenting notification of room changes. The data will be reported to the Nursing Facility Quality Committee quarterly to monitor, analyze, and develop corrective action when indicated for sustained compliance.</p>	



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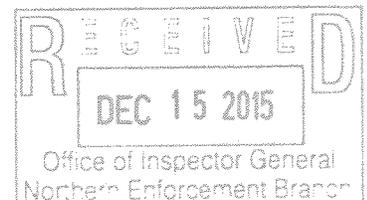
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F 247	<p>Continued From page 11</p> <p>with the resident on Monday and the resident was still upset. The resident told her when the resident came out the bathroom, the nurse grabbed his/her shoulder and walked him/her to another room. She stated the resident had moved before because of a roommate problem. The Unit Manager had not asked the nurse if she had given notice to the resident before the move. She validated the resident was moved that day and the resident was unhappy about the move. The Unit Manager stated the resident did not want to move; however, the nurse had moved the resident because of safety reasons.</p> <p>A telephone interview with Registered Nurse (RN #1), on 11/12/15 at 11:41 AM, revealed she was the Charge Nurse for the unit on Sunday (11/08/15) and was Resident #2's nurse for that day. She stated normally the resident's roommate would put on the call light whenever Resident #2 was attempting to get up without assistance. When she went into Room 305 that day, Resident #2 was observed walking half-way across the room, going to the bathroom, unassisted. The safety alarm had not activated because the resident had removed the box and placed it in the top drawer of the night stand. This was around 10-10:30 AM. The nurse stated she was worried about the resident so I asked him/her to go to Room 302 with me, so he/she would be closer to the bathroom. She stated the resident became very angry and called the nurse a stupid "bitch". When she attempted to put a gait belt around the resident's waist, the resident demanded the device be removed and it was. The resident told the nurse to call the "law". RN #1 stated she walked the resident to Room 302. She stated the resident's daughter was out of town and she attempted to call the contact</p>	F 247			

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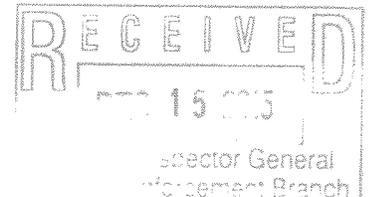
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F 247	<p>Continued From page 12</p> <p>person. She stated the resident was very upset about the move and had become upset as soon as she talked to the resident about the room change.</p> <p>She stated the resident had gone to the bathroom two times that morning and the resident's roommate voiced frustration. The nurse stated she had asked the roommate if he/she wanted to move and the roommate told her he/he should not have to move, the roommate preferred to have Resident #2 moved and that was what the nurse did. RN #1 stated she called the Unit Manager and reported the incident. She had not asked Resident #2 if he/she wanted to move to another room, she just thought it would be safer for the resident.</p> <p>Interview with RN #2, on 11/12/15 at 3:55 PM, revealed when she returned to work on Monday, 11/09/15, she received report from RN #1 and was informed about the resident being upset. She stated RN #1 had requested a change of teams so she would not have to take care of Resident #2. During the medication pass that morning, the resident told this nurse he/she had been moved to another room and didn't like it. The resident told the nurse he/she should not have been treated like that. The resident told RN #2 he/she had to go to the bathroom very quickly. When the resident left the bathroom, RN #1 whisked the resident to another room because the resident had gotten up without asking for assistance. The resident told RN #2, he/she felt like they were being punished. The resident told the nurse he/she had been mistreated, and that was the resident's perception.</p> <p>2. Interview with Resident #4, on 11/13/15 at</p>	F 247			



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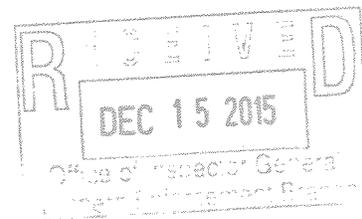
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F 247	Continued From page 13 11:45 AM, revealed he/she had been moved to another room in the middle of the night without notice. The resident stated it was because of his/her cancer. The resident stated nobody had asked him/her if they wanted to move. Record review revealed the facility admitted the resident on 11/05/15 with diagnosis of Lung Cancer. Interview with the RN #3, on 11/13/15 at 10:40 AM, revealed the resident was moved because they needed to place the resident in isolation. Interview with the Infection Preventionist, on 11/13/15 at 10:48 AM. revealed infection control practices are hospital wide including the SNF. She stated it was the hospital's policy to look back up to a year for any patient that had a history of infectious disease and isolate them. This included the SNF.	F 247			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	F371 On 11/12/15, all food items that were stored opened, with no date label, were discarded. On 12/1/15, the Clinical Nutrition Manager created an HMH FANS Handbook for all Food and Nutrition Services (FANS) staff. The Handbook describes the requirement and process for labeling all opened and stored foods in any freezer, refrigerator, bin, or storage area. For consistency, labeling procedures are now standardized to use only the date dots stickers, or ziplock bags with dates written on the bag. Date labels will contain open and/or expiration date, depending on recommended storage times from USDA guidelines. The FANS (continue)	12/24/15	



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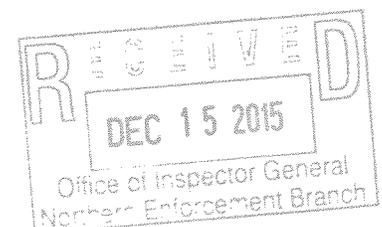
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F 371	<p>Continued From page 14</p> <p>by: Based on observation, interview and policy review, it was determined the facility failed to store food in a sanitary manner with opened food items not dated in the freezer (four (4) bags), raw meat opened and not labeled, dessert trays in the refrigerator with no date, sugar and flour bins-tops dirty and not dated when food product was placed in the bins.</p> <p>The findings include:</p> <p>Review of the Infection Control Policy (as it related to the dating system of food items), revised February 2012, revealed left overs would be disposed of within seven (7) days. The staff may write date prepared on aluminum foil or use special stickers that say "Made Tues, Use by Mon" (date of use to be written in).</p> <p>1. Observation of the Early Cook Freezer door, on 11/12/15 at 8:30 AM, revealed there was a sign on the outside of the door that asked are all opened foods covered and dated?</p> <p>Observations made during the Kitchen Tour, on 11/12/15 at 8:30 AM, revealed the Early Cook Freezer had two (2) bags of corn opened, not dated, one (1) bag of peas open and not dated, one (1) bag of mixed vegetables opened and not dated.</p> <p>2. Observation of the self rising flour bin, sugar bin and plain flour bin, on 11/12/15 at 8:32 AM,</p>	F 371	<p>F371 (continued) Supervisor placed a USDA Guideline Booklet in the FANS Department on 12/1/15 in three convenient areas for staff reference. The HMH FANS Handbook also describes a new process for accountability of proper food storage. Specific staff is responsible for proper storage in their own areas, and for daily monitoring of a different area. For example, the staff member assigned to salads is responsible for properly storing and labeling all foods in the salad food area, and for checking the dessert staff areas each day for properly stored and labeled food items. Daily monitoring completion is documented on a daily checklist with staff initials. The daily checklist also includes cleaning of the lid, rim, and outside surface of all dry storage bins daily. Dry food bins are fully sanitized each time it is emptied of food product. On 12/1/15, the Clinical Nutrition Manager reviewed the FANS Policy 8060-0004 "Leftover Foods", and FANS Policy 8030-0046 "Infection Control", to be updated with the labeling of stored foods using only date dot stickers or ziplock bags. The HMH FANS Handbook was distributed to each FANS staff by the Clinical Nutrition Manager beginning on 12/2/15. Additionally, all FANS staff is required to attend a mandatory staff meeting with the Clinical Nutrition Manager and FANS Supervisor for re-education before 12/23/15. Education will enforce the contents of the HMH FANS Handbook and daily checklists. By 12/11/15, the Clinical Nutrition Manager and FANS Supervisor will add the review of the HMH FANS Handbook to each FANS Job-specific Orientation checklist for all new hires. On 11/23/15, the Assistant Vice President of Operations, made the decision to require all Cooks and Food Specialists to obtain Person in Charge (PIC) training and certification rather than only select individuals. (continue)</p>		



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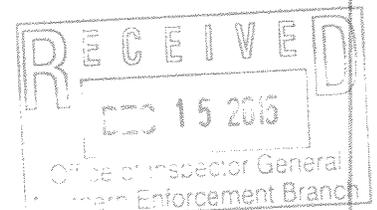
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F 371	<p>Continued From page 15</p> <p>revealed all three (3) bins had a yellow and white film on the lid and rim of the bin. There was no date or label for how long the product had been in the bin.</p> <p>3. Observation of the dessert and salad refrigerator, on 11/12/15 at 8:35 AM, revealed a large cart, ten (10) shelves long, with different desserts and salads covered with no label or date.</p> <p>4. Observation of the walk in refrigerator, on 11/12/15 at 8:40 AM, revealed raw (bloody) pork tenderloin opened with no label or date. No food was under the meat.</p> <p>5. Observation of the Dry Storage Area, on 11/12/15 at 8:44 AM, revealed six (6) bins holding items such as northern beans, pinto beans, macaroni noodles, and other types of noodles, rice and brown rice, not labeled or dated to show how long the product had been in the bins.</p> <p>Interview with the Food Specialist, on 11/13/15 at 12:41 PM, revealed food was to be dated when opened. She stated the food items needed to be labeled so that the staff would know when to use the food and not cause any food bourne illness.</p> <p>Interview with the Cook, on 11/13/15 at 12:35 PM, revealed when food was opened it needed to be labeled and dated. The Cook stated the food needed to be labeled and dated to ensure the food was being used by the right time frame. The</p>	F 371	<p>F371 (continued)</p> <p>This training, conducted locally by the Lincoln Trail District Health Department, thoroughly prepares food service workers for proper sanitation and safe food handling. Current staff will be scheduled in phases to attend training sessions, which are available monthly beginning in January. All new Cook and Food Specialist hires will be required to obtain the PIC training within 90 days of hire. To monitor ongoing safe food storage compliance, the Clinical Nutrition Manager and FANS Supervisor will monitor storage areas for proper labeling, as well as daily checklist completion, twice weekly and follow up with individuals as indicated for accountability. The Clinical Nutrition Manager and FANS Supervisor will provide education, or bring in an outside vendor or entity to provide education, to all FANS staff at least annually.</p> <p>F371 ADDENDUM (12/15/15)</p> <p>The Clinical Nutrition Manager and FANS Supervisor will report results of food storage monitoring to the Nursing Facility Quality Committee for six months for further recommendations and follow up.</p>		



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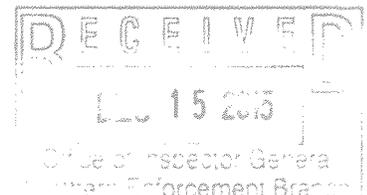
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/13/2015
NAME OF PROVIDER OR SUPPLIER NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701		
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F 371	Continued From page 16 Cook stated the meat should have been placed in a separate pan, labeled and dated. The opened meat could contaminate other food if placed under the meat. Interview with the Supply Tech, on 11/13/15 at 12:50 PM, revealed he stored the beans, pinto beans, noodles etc and no one had informed him to label and date the bins. He stated the supply of beans and noodles would be consumed between a month and six (6) months. The Supply Tech stated he had not received any training on storage and labeling since he had been working at the facility. Interview with the Supervisor of Food and Nutrition, on 11/13/15 at 12:30 PM, revealed the facility had seven days to utilize a food product when it was opened. The Supervisor of Food and Nutrition stated he could not guarantee the food if not dated because he would not know how long it had been opened. The Supervisor of Food and Nutrition stated meat should not be stored opened. The meat should have been taken out, washed, placed into a pan, wrapped and dated. He stated he was trying to prevent any food bourne illness. He stated the residents are compromised and do not want them to become sick. The Supervisor of Food and Nutrition stated the staff had not been educated within the last year on safe food storage and labeling. The Supervisor of Food and Nutrition stated that the bins of food were cleaned weekly and could have been cleaned better.	F 371			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520			



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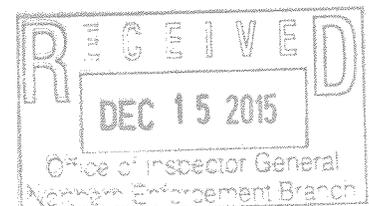
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F 520	Continued From page 17 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and review of the Quality Assurance (QA) meeting signature sheets, it was determined the facility failed to have the designated members in attendance and failed to conduct the QA meetings at least quarterly to identify quality deficiencies and implement appropriate plans of action. The findings include:	F 520	F520 On 11/20/15, the Director of the Nursing Facility, the Unit Manager, and the Vice President/Chief Medical Officer met to develop a plan to restructure and actualize a purposeful Nursing Facility Quality Committee. They thoroughly reviewed Nursing Facility Policy 6050-NF39 "Quality Assessment and Assurance Plan – Nursing Facility", a policy which was not presented to the surveyor at the time of the interview with the surveyor on 11/13/15. The policy, approved on 03/14, includes the required composition, duties, and responsibilities of the Nursing Facility Quality Committee. On 11/13/15, the Director of the Nursing Facility sent a standing meeting request through Microsoft Outlook to all team members for the second Friday of every 3rd month beginning in January, 2016. A meeting reminder will also be emailed to all participants by a Quality Management Secretary the week prior to each scheduled meeting. Medical Staff participants will receive a phone call reminder during the week prior to each scheduled meeting. An additional meeting is also scheduled for 12/4/15 for the team to identify priorities for ongoing quality assessment and activities, and to develop a plan for measurement and reporting of data. The team composition includes the Director of the Nursing Facility, the Medical Director, the Facility Administrator, the Unit Manager, the Manager of Clinical Outcomes, the Infection Preventionist, and designated Nursing Facility staff members. Additional members, including Medical Staff, may be added as needs or activities evolve. Specific standing agenda items will be included in each meeting, including resident feedback and staff feedback, and will also be used to guide the direction of improvement activities. The Unit Manager, who (continue)	12/5/15



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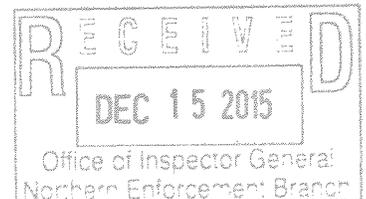
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/13/2015
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F 520	Continued From page 18 The facility did not provide a policy for the Quality Assurance Committee. Interview with the Vice President/Chief Medical Officer, on 11/13/15 at 10:16 AM, revealed the Nursing Facility's QA was incorporated into the hospital's QA and had no specific policy for the Skilled Nursing Facility (SNF). Review of the QA signature sheets revealed the Skilled Nursing Facility held a QA meeting on 12/29/14, August 2015, and 11/10/15. However, the 11/10/15 QA meeting only consisted of two (2) members and no physician representative. Interview with the Vice President/Chief Medical Officer and Director of Medical Inpatient Services (new Director of Nursing over the Skilled Nursing Facility), on 11/13/15 at 10:16 AM, revealed there had been no QA meetings from December 2014 to August 2015 because they were new in their positions and were unaware of the requirements. The Vice President stated it was his responsibility to conduct the QA meetings because he was responsible for the oversight of the SNF. He stated there had been many leadership changes and it had fallen through the cracks. He stated he recently had a discussion regarding the QA process with the Director of Nursing and the Unit Manager. The Director of Nursing stated she had just recently become aware the QA committee had to be separate from the hospital's QA and must meet at least quarterly. She stated she then set up a schedule to ensure the QA meetings were being held, but failed to identify certain members had to be present. She stated the Unit Manager and herself were the only QA members present at the 11/10/15 QA meeting. The Vice President stated the SNF had a Medical Director	F 520	F520 (continued) routinely rounds with the Nursing Facility residents and staff to discuss staff concerns, ideas for improvement, and overall feedback regarding quality of care on the unit, will report this feedback to the committee. The Unit Manager, with support from the Quality Management Secretary, will be responsible for ongoing maintenance of the meeting calendar, meeting attendance, and recording of the meeting minutes. F520 ADDENDUM (12/15/15) No residents were identified by the deficient practice. The Nursing Facility Policy 6050-NF39 "Quality Assessment and Assurance Plan - Nursing Facility" was on the electronic policy manual for the Nursing Facility. The effective date was 1/2010 and most recent revision date 3/2014. The Vice President/Chief Medical Officer interviewed had not been informed about the Nursing Facility policy for quality assessment and assurance at the time of the survey. During the Nursing Facility Quality Committee meeting on 12/4/15, the policy was reviewed and discussed by all the members. The policy includes the required membership, and roles, duties, and responsibilities of the committee members. All Nursing Facility Quality Committee meetings will include an attendance roster for each member to sign. The committee chair will review attendance at the beginning of each meeting to ensure the presence of the Director of nursing services, a physician, and a minimum of three staff from the nursing facility, as defined per policy. Signature sheets will be filed with meeting minutes for reference. All Nursing Facility policies will be reviewed by the Quality Committee every two years or more often when indicated by process changes or regulatory statutes.		



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F 520	Continued From page 19 but had not been asked to attend the QA meetings.	F 520			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/24/2015
NAME OF PROVIDER OR SUPPLIER NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701		
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{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/24/15 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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.

**FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)**

PROVIDER NUMBER K1 185427	FACILITY NAME NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL	SURVEY DATE *K4 11/13/2015
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K6 DATE OF PLAN APPROVAL 01/01/1954	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u>	<input checked="" type="checkbox"/> B A BUILDING B WING C FLOOR D APARTMENT UNIT
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LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 12 SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: 1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: 4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: 7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: e.g 2.5

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: 3 K56: 3

*K9 : FACILITY MEETS LSC BASED ON: *(Check all that apply)*

A1 <input checked="" type="checkbox"/>	A2 <input type="checkbox"/>	A3 <input type="checkbox"/>	A4 <input type="checkbox"/>	A5 <input type="checkbox"/>
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> FULLY SPRINKLERED PARTIALLY SPRINKLERED NONE (All required areas are sprinklered) (Not all required areas are sprinklered) (No sprinkler system)
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*MANDATORY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/13/2015
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1954, 1967, 1979, 1983, 1989, 1993, 2005</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Six stories, Type I (332)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete, automatic, wet sprinkler system.</p> <p>GENERATOR: Type I, 510KW generator installed in 2005. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 11/13/15. The facility was found to be in compliance with the Requirements for Participation in Medicare in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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