

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

PRINTED: 09/22/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/08/2011
NAME OF PROVIDER OR SUPPLIER  THE JAMES B. HAGGIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330	
(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)	COMPLETION DATE
F 000	INITIAL COMMENTS  A standard health survey was conducted on 09/06-08/11. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	See attached	9/11/11
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced	F 278		

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.

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F 278	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, interview, and record review, the facility failed to complete an accurate assessment for one (1) of twelve (12) residents (Resident #1). The facility failed to accurately assess the cognitive status for Resident #1. A review of assessments completed by the facility's social worker on 02/06/11 and 08/02/11 revealed the resident was rarely/never understood." On two (2) occasions, 05/09/11 and 08/02/11, facility staff had assessed Resident #1 to be "usually understands/understood." Observations/interview with Resident #1 on 09/06/11, 09/07/11, and 09/08/11 revealed the resident was awake, alert and oriented at the times of the observations.</p> <p>The findings include:</p> <p>A review of the facility's policy for Assessment/Reassessment (dated July 1997) revealed all residents admitted to the facility would have a comprehensive assessment completed within 14 days of admission. An assessment of cognitive status was to be included in the MDS assessment.</p> <p>A review of the MDS 3.0 manual revealed staff were to conduct a brief interview to determine the resident's attention, orientation and ability to register and recall new information. According to the MDS manual, without an interview a resident might be mislabeled based on his/her appearance or assumed diagnosis.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 01/31/11 with diagnoses that included Parkinson's Disease, and Alzheimer's Dementia</p>	F 278		

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F 278	Continued From page 2 with Psychosis.  A review of the comprehensive admission MDS assessment dated 02/06/11, and a review of the quarterly MDS assessment dated 08/02/11, revealed facility staff assessed Resident #1 and noted the resident's cognition was moderately impaired and the resident was usually understood and usually "understands."  Observations of Resident #1 on 09/06/11 at 5:20 PM and 6:10 PM, on 09/07/11 at 8:45 AM, 9:30 AM and 10:30 AM, and on 09/08/11 at 9:40 AM, revealed the resident was awake, alert and exhibited oriented conversation at the times of the observations.  A review of assessments completed by the facility's social worker on 02/06/11 and 08/02/11 revealed the resident was "rarely/never understood." An interview with the facility Social Worker (SW) on 09/07/11 at 5:00 PM, and on 09/08/11 at 1:00 PM, revealed the SW had not conducted an interview with Resident #1 during the assessments. The SW stated, "I guess I just didn't want to wake him/her for the interview so I just talked to staff." The SW further stated Resident #1 is "able to talk to you and I am aware now that I should have interviewed" her/him.	F 278		
F 371 SS=E	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	F 371	See attached	10/4/11

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F 371	Continued From page 3  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Baking pans, skillets, and a stovetop was observed with a buildup of baked/burnt grease. In addition, three (3) dented food cans were available for use.  The findings include:  A review of the facility policy titled Dry Storage (undated) revealed equipment would be kept clean and in good repair. Additional review of the policy revealed damaged food containers would be stored in a separate and distinct area away from other food items.  A tour of the kitchen conducted on 09/06/11 at 2:20 PM, revealed a buildup of baked/burnt grease on baking pans, iron skillets, and the cook stovetop. Additional observations during the tour revealed three (3) dented cans of food stored in the can rack with undamaged cans and available for use.  An interview conducted with the Dietary Manager (DM) on 09/06/11 at 5:20 PM, revealed the stove was cleaned every week but the burnt-on/baked-on grease could not be removed. According to the DM, the baking pan and iron skillets were old and the dishwasher would not	F 371			

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F 371	Continued From page 4 removed the burnt-on/baked-on grease. In addition, the DM stated that dented cans were stored, available for use, and were utilized if the dents were not on the seam of the can.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide services to maintain a sanitary environment. Medication carts were observed to be soiled.  The findings include:  The facility did not have a policy/procedure regarding medication cart cleaning.  Observation of the medication carts located on Halls 2 and 3 on 09/08/11 at 4:00 PM, revealed the medication carts were heavily soiled with spills and pill debris.  An interview with the Charge Nurse on 09/08/11 at 4:00 PM, revealed the facility did not have a schedule or policy to ensure the cleanliness of the medication carts.	F 465	See attached	10/1/11

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
SURVEY COMPLETION DATE September 8, 2011**

**PLAN OF CORRECTION**

**483.20 (g) - (j) – Assessment- Accuracy/Coordination Certified - The facility failed to accurately assess the cognitive status for Resident #1.**

**F 278 S/S = D**

**Completion Date: 10/01/11**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**

A comprehensive review of Resident #1 with an updated interview of Resident #1 for cognitive reassessment and documentation was completed on 09/30/11. The MDS Coordinator and the Social Worker reviewed Resident # 1's record for consistency, accuracy. The ECF Charge Nurse reviewed the Resident #1 reassessment to assure compliance with completion and accuracy of assessment. The ECF Charge Nurse and ECF Coordinator certified the reassessment of Resident #1 on 09/30/11.

**The Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:**

All residents had the potential for inconsistency of the assessment and reassessment status related to accuracy, coordination, and certification. A comprehensive review of all resident records occurred on 09/08/11 for consistency, accuracy and certification. All records were compliant on 09/08/11 except Resident #1.

All residents have the potential to be affected and a comprehensive review of the comprehensive assessment and reassessment was conducted on 09/08/11 per the MDS Coordinator, Social Worker and the ECF Charge Nurse. The review of the current resident assessments revealed the comprehensive assessment, care coordination, communication and certification of a comprehensive assessment/reassessment of residents were complete. The MDS Coordinator, Social Worker and the ECF Charge Nurse planned a reassessment of Resident #1 and the assessment was completed on 09/30/11.

**Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practices Will Not Recur:**

The Chief Nursing Officer discussed the omission of the comprehensive cognitive assessment with the social worker on 09/07/11. The interview process must contain direct interview for all residents following the MDS criteria. The goal is to assess residents with direct interview to prevent the potential for mislabeling the resident based on his/her appearance or assumed diagnosis. The social worker will complete the cognitive assessment interview with a follow up

POC ECF 9/30/ 2011

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certification by the registered nurse. The registered nurse will be the ECF Charge Nurse or the Extended Care Coordinator.

The Assessment/Reassessment policy revised on 09/28/11 reflects the current MDS standards. The policy addresses the accuracy, coordination and certification of a comprehensive resident assessment. A registered nurse must conduct or coordinate each assessment with the appropriate participation of all health professionals. Each individual completing a portion of the assessment must sign and certify the accuracy of the portion of the assessment completed. The process will be included in a quality improvement plan to assure accuracy, coordination and certification of assessments completed.

On 09/19/11 and 09/20/11, multiple members of The James B. Haggin Memorial Hospital Extended Care Facility team attended an MDS 3.0 assessment concerning the new changes taking place on 10/01/11. Members of the team consisted of the ECF Charge Nurse, MDS Coordinator, Social Worker, and the Activities Director. The training educated the team members in all areas of the MDS assessments that require interviews for the comprehensive assessment. The team attended a MDS webinar on 09/22/11 that also discussed the upcoming changes to the MDS assessment.

The team received education and understanding of the application to perform a "Brief interview for Mental Status" during the interview process; if personal interview is unable to be performed due to cognition (attention, orientation, and ability to register and recall new information) of resident, a staff assessment will be completed. This will ONLY be if the resident is unable to participate in assessment. Upon attempting the interview, Social Worker will observe for any signs/symptoms of delirium. This information will be included in the revision of the revised Assessment/Reassessment policy.

During the interview assessment/reassessment; if resident's responses have been nonsensical OR no response occurs, the interview will stop and dashes will be placed allowing it to be seen that an interview was attempted and unable to be fully completed with resident involved. If resident is able to complete at least (4) four questions in Sec C; the interview is considered complete. If less than (4) four are answered, may proceed to staff assessment. This information will be included in the revision of the revised Assessment/Reassessment policy.

The MDS assessment will accurately reflect the resident's current status. A registered nurse will sign and certify that the assessment/reassessment is completed. Each area of the assessment/reassessment will be signed by the professionals who performed that area of the assessment/reassessment. This information was included in the revision of the revised Assessment/Reassessment policy on 09/28/11.

The revision of the Assessment/Reassessment policy will be presented for review and approval at the Quality Assurance Committee on 09/30/2011.

**How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:**

The ECF Charge Nurse and the ECF Coordinator will complete a check of all assessment/reassessment for accuracy, coordination and certification on admission of new residents and with the updated MDS schedule.

The compliance results of the check of all assessment/reassessment for accuracy, coordination and certification on admission of new residents and residents reassessed per MDS schedule will be an agenda item on the Quality Assurance Committee agenda for the next three months and then quarterly. Compliance to the monitor will be reported to the Committee.

The Social Worker will complete a quality improvement monitor related to cognitive assessment/reassessment of residents. The quality improvement monitor results will be added to the monthly agenda and reported to the Quality Assurance Committee.

The Quality Assurance Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, Safety Director and Dietary Director) will be responsible to review and ensure the process is in place and follows the plan of correction. Any deficiencies of assessment/reassessment accuracy, coordination or certification will be reported at the Quality Assurance Committee meetings on an ongoing basis by the ECF Coordinator or Administrator.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, Safety Director and Dietary Director) met on 9/30/11 and is scheduled to meet on 10/25/2011 to review measures and ensure systems are in place related to the Plan of Correction. The QA Committee will meet monthly for three months to ensure compliance, and quarterly thereafter.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
SURVEY COMPLETION DATE September 8, 2011**

**PLAN OF CORRECTION**

**483.35 (i) - FOOD PROCEDURE/ STORE/PREPARE/SERVE-SANITARY - The facility failed to- procure food from sources approved or considered satisfactory by Federal, State or local authorities, and store, prepare, distribute and serve food under sanitary conditions.**

**F 371 S/S=E**

**Completion Date: 10/04/11**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**

The Dietary Director removed the baking pans and skillets from use on 09/06/11. The baking pans were replaced with new pans and the old ones destroyed.

The skillet was removed from service on 09/06/11. The skillet was taken off site to be heat treated, removing the baked/burnt grease on 09/28/11.

The stove-top was taken off site on 09/28/11 to be heat treated, removing the baked/burnt grease on 09/28/11.

The baking pans were replaced with new pans on 09/16/11.

The damaged cans were removed from the dry storage stockroom and placed in a separate area away from the other food on 09/06/11. The damaged food items will be returned to the vendor.

The Dry Storage policy was revised on 09/29/11. The policy addresses the damaged canned food containers will be removed from the stockroom and stored in a separate area. Damaged food containers will be returned to the vendor. The revised policy will be presented for approval on 09/30/11 at the Quality Assurance Committee.

**The Facility Will Identify Other Residents Having the Potential to Be Affected by the Same Deficient Practice:**

All residents have the potential to be affected by the deficient practice. No residents were found to have been adversely affected. The Dietary Policies had previously been reviewed and updated in March 2010.

**Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practices Will Not Recur:**

The Dietary Director educated the department staff on the revision of the policy on 09/30/11 and completed by 10/04/11.

POC ECF 9/30/ 2011

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**How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:**

A checklist was developed on 09/28/11 for Dry Storage to monitor the area weekly by the Dietary director. The monitor requires the supplies be checked for compliance and non-compliant storage will be removed from the storage area. The results of the Dry Storage monitor will be an agenda item for the Quality Assurance Committee to report compliance.

The Cook Assignment checklist contains a schedule for weekly cleaning of the pots, pans and stove top. The checklist will be completed weekly by the Dietary Director and reported to the Quality Assurance Committee to report compliance.

The facility will effectively utilize the QA Committee to implement an effective action plan and to monitor the quality improvement process. The Dietary manager will report the compliance of the monitoring monthly to the QA committee and then quarterly.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, Safety Director and Dietary Director) met on 9/30/11 and is scheduled to meet on 10/25/2011 to review measures and ensure systems are in place related to the Plan of Correction. The QA Committee will meet monthly for three months to ensure compliance, and quarterly thereafter.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
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**PLAN OF CORRECTION**

**483.70(h) - Safe/Functional/Sanitary/Comfortable/Environment – The facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public as medication carts were soiled.**

**F 465 S/S = E**

**Completion Date: 10/01/11**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**

The medication carts were cleaned on 9/8/11. The facility will ensure the maintenance of sanitary medication carts through development of policy and procedure to monitor the cleanliness of the medication carts.

**The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Practice:**

All residents have the potential to be affected. No residents were found to have been affected.

**Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practice Will Not Recur:**

A policy to address the sanitary condition of the medication carts was developed on 09/27/11. The staff received education on the checklist and the change of shift checklist change to address documentation of the condition of the cart and maintenance of cleanliness on 9/27, 9/28 and 9/29/11.

A systematic review of all medication carts occur at change of shift twice a day. A checklist to record the review of the medication carts was developed on 09/27/11 and implemented on 09/29/11. The nurses on the shift in the evening/night will be responsible for cleaning the medication carts.

The compliance to sanitary condition of the carts will be reported through the QA Committee monthly for three months and then on a quarterly basis.

**How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:**

The ECF Coordinator or ECF Charge Nurse will perform a weekly audit of all medication cart checklists and change of shift checklists. The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, and Dietary Director) met on 09/30/11 and is scheduled to meet on 10/25/2011 to review measures and ensure systems are in place related to the Plan of Correction. The QA Committee will meet monthly for three months to ensure compliance.

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	09/07/2011

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NAME OF PROVIDER OR SUPPLIER  THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330	Division of Health Care Southern Enforcement Branch
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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: 1947, 1962, 1978, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Second Floor wing of a two story, Type I Unprotected</p> <p>SMOKE COMPARTMENTS: Four smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system</p> <p>GENERATOR: Type I generator installed in 1982, fuel source is diesel</p> <p>A standard Life Safety Code survey was conducted on 09/07/11. The James B Haggin Memorial Hospital was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for 110 beds and the census was 108 on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Earl S. Matros (Chief) TITLE: LNHA/CEO (X8) DATE: 10/5/11

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

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K 000	Continued From page 1	K 000		
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, visitors, and staff. The facility is licensed for 34 beds with a census of 32 on the</p>	K 018	See attached	10/1/11

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K 018	<p>Continued From page 2 day of the survey.</p> <p>The findings include:</p> <p>Observation on 09/07/11 between 1:00 PM and 4:00 PM, with the maintenance staff revealed the corridor door to resident rooms 268, 263, and 250 would not latch. The corridor door to resident room 267 was blocked from closing by the trashcan.</p> <p>Interview on 09/07/11 between 1:00 PM and 4:00 PM, with the maintenance staff person revealed he was unaware the doors would not latch, and that the trashcan was being used to hold the door open.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with</p>	K 018		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/22/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
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NAME OF PROVIDER OR SUPPLIER  THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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K 018	<p>Continued From page 3</p> <p>19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.</p> <p>19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.</p> <p>A.19.3.6.3.3 Doors should not be blocked open by furniture, doorstops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 018		
K 072 SS=F		K 072	See attached	10/1/11

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NAME OF PROVIDER OR SUPPLIER  THE JAMES B. HAGGIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330	
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K 072	<p>Continued From page 4</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards. The deficient practice had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for 34 beds with a census of 32 on the day of the survey.</p> <p>The findings include:</p> <p>Observations on 09/07/11 at 2:55 PM, with the maintenance staff revealed that trash carts, linen carts, lifts, and med carts were being stored in the East and West Wing corridors.</p> <p>An interview on 09/07/11 at 2:55 PM, with the maintenance staff revealed the facility lacked storage space.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072		

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NAME OF PROVIDER OR SUPPLIER  THE JAMES B. HAGGIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330	
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K 147 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for 34 beds with a census of 32 on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 09/07/11 between 1:00 PM and 4:00 PM, with the maintenance staff revealed:</p> <ol style="list-style-type: none"> <li>1) An open electrical junction box located inside the generator.</li> <li>2) Medical equipment plugged into a power strip, and an extension cord in use located in room 268.</li> <li>3) A receptacle located at the West nurses' station was missing the outlet cover.</li> <li>4) An extension cord in use located in room 257.</li> <li>5) Piggy-backed power strips located in the Activity/Social Services office.</li> <li>6) Open electrical junctions located above the drop ceiling near the Activity Director's office.</li> </ol> <p>Interview on 09/07/11 between 1:00 PM and 4:00 PM, with the maintenance staff revealed they</p>	K 147	See attached	10/1/11

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K 147	<p>Continued From page 6</p> <p>were unaware of the extension cords and power strips being misused. They were also unaware of the open wiring above the drop ceiling.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147		
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**THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
SURVEY COMPLETION DATE September 8, 2011**

**PLAN OF CORRECTION**

**CFR: 42 CFR 483.70(a) Life Safety from Fire – the facility failed to have no impediment to the closing of the doors or to have doors provided with a means suitable for keeping the doors closed.**

**K 018 NFPA 101 Life Safety Code Standard  
S/S=D**

**Completion Date: 10/01/11**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**

This facility maintenance department implemented corrective measures on 09/08/11 repairing corridor doors of resident rooms 268, 263, and 250 to assure the doors would latch. The trashcan was removed from the doorway of room 267 on 09/08/11.

**The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Practice:**

All residents' rooms have the potential to be affected. The residents affected were in rooms 268, 263, 250 and 267. The remainder of the corridor latches for resident rooms was intact and functional with the life safety code. No other trashcans or equipment were blocking corridor doors.

**Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practice Will Not Recur:**

The maintenance and nursing staff will ensure that the corridor doors are not blocked open by furniture, doorstops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. This will be done on a continual basis. The change of shift checklist requires all shifts to complete rounds, the door latches will be checked each shift for proper closure. Any equipment obstructing closure will be removed. The staff will initiate a work order for any door latches that are found in noncompliance.

**How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:**

The facility will effectively utilize the QA Committee to implement an effective action plan and to monitor the implemented plans for maintaining the door closure latches on the rooms of all residents. Maintenance will report to the QA committee the number of corridor doors that required repair. The monitor will be reported monthly for three months and then quarterly. A systematic review of all door latch functions will be conducted by maintenance checks weekly and a compliance monitor reported to the QA Committee monthly for three months and then quarterly.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, Safety Director and Dietary Director) met on 09/30/11 and is scheduled to meet on 10/25/2011 to review measures and ensure systems are in place related to the Plan of Correction. The QA Committee will meet monthly for three months to ensure compliance and then quarterly.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
SURVEY COMPLETION DATE September 8, 2011**

**PLAN OF CORRECTION**

**CFR: 42 CFR 483.70(a) Life Safety from Fire – The facility failed to have means of egress continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.**

**K 072 NFP 101 Life Safety Code Standard  
S/S=F**

**Completion Date: 10/01/11**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**

All hallways were cleared of equipment except for what was in use at that time.

**The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Practice:**

All residents have the potential to be affected but none were adversely affected.

**Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practice Will Not Recur:**

All equipment will be stored out of the hallways at all times except when in active use. The change of shift checklist requires all shifts to complete rounds; the addition of monitoring hallways has been added and will be checked each shift. Any equipment obstructing hallways will be relocated. Education for team members regarding this item was done at the monthly meetings on 9/27 & 9/28/11.

**How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:**

The ECF Coordinator or ECF Charge Nurse will perform a weekly audit of all change of shift checklists to ensure this is carried out. Walking rounds will also be completed by the ECF management team to ensure hallways remain clear.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, and Dietary Director) met on 09/30/11 and is scheduled to meet on 10/25/2011 to review measures and ensure systems are in place related to the Plan of Correction. The QA Committee will meet monthly for three months to ensure compliance.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
SURVEY COMPLETION DATE September 8, 2011**

**PLAN OF CORRECTION**

**CFR: 42 CFR 483.70(a) Life Safety from Fire – The facility failed to ensure electrical wiring was maintained according to NFPA standards.**

**K 147 NFPA 101 Life Safety Code Standard  
S/S=F**

**Completion Date: 10/01/11**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**

The open electrical junction box located inside the generator was repaired on 9/9/11.  
The power strip and extension cord was removed on 9/8/11 from room 268.  
The outlet cover for receptacle located at West nursing station was repaired on 9/8/11.  
The extension cord in room 257 was removed on 9/8/11.  
The piggy-backed power strips located in the Activity/Social Services office were repaired on 9/30/11.  
The open electrical junction located above the drop ceiling near the Activity/Social Services office was repaired on 9/9/11.

**The Facility Will Identify Other Residents Having The Potential To Be Affected By The Same Practice:**

All residents had the potential to be affected but no other areas found to be affected.

**Measures To Be Put In Place Or Systemic Changes Made To Ensure The Deficient Practice Will Not Recur:**

A Preventive Maintenance program with observation rounds of unit for electrical issues including the use of extension cords, proper use of power strips (no medical equipment), receptacles, outlets, and general wiring will be implemented and completed weekly by the Physical Plant Director. Education for the team members was completed on 9/28 & 9/29/11 at regular monthly meetings. The existing policy reviewed and updated by the CNO and Physical Plant Director.

**How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:**

The Physical Plant Director will report on the observation rounds and any compliance issues at the monthly QA meetings.

The QA Committee (Administrator, CEO, CNO, PI Coordinator, Medical Director, ECF Coordinator, Charge Nurse, Pharmacist Consultant, and Dietary Director) met on 09/30/11 and is scheduled to meet on 10/25/2011 to review measures and ensure systems are in place related to the Plan of Correction. The QA Committee will meet monthly for three months to ensure compliance.