

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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	
(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 A standard health survey was conducted 10/02/12 through 10/04/12. A Life Safety Code Survey was conducted on 10/02/12. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct before imposition of remedies would be recommend.	F 000		
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined the facility failed to convey funds promptly within 30 days, for two (2) of five (5) discharged records reviewed. Unsampled Resident C and D. The findings include: There was no policy provided by the facility regarding conveyance of expired resident's funds to the individual administering the resident's estate. 1. Review of Unsampled Resident C personal fund records, on 10/04/12, revealed the resident had expired on 04/21/12; however, the final conveyance of funds of \$0.91 cents were not	F 160	F 160/ N32 SS=B The unsampled resident C expired on 4/21/12 and the final conveyance of funds in the amount of \$0.91 was refunded on 6/26/12. The unsampled resident D expired on 8/8/12 and the balance of \$90.03 was conveyed on 9/14/12. The Office Supervisor and Administrator conducted an audit on October 16, 2012 to reveal two residents that were affected by the deficient practice. The checks were issued to both estates on October 16, 2012 and mailed to the families.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *X Administrator X* (X6) DATE: *10/22/12*

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.

RECEIVED
If continuation sheet Page 1 of 13
OCT 22 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES

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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
--	--

(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 160 Continued From page 1
conveyed until 06/26/12, two months later.

Interview with the Administrator, on 10/04/12 at 11:00 AM, who was conducting the review in the absence of the Business office Manager, revealed there had been an issue with cutting a check for \$0.91 cents. The facility was waiting because they were trying to find another way to pay the money to the responsible person. The Administrator revealed there was a problem with setting up the estate for the resident.

2. Review of Unsampled Resident D personal fund records revealed the resident had expired on 08/08/12; however, the balance of \$90.03 had not been conveyed until 09/14/12, 5 days over the 30 day requirement.

Interview with the Administrator, on 10/04/12 at 11:00 AM, revealed they may have been waiting for all of the interest to get back to them from the quarterly account; however, the Administrator stated she was familiar with the regulation to disperse the funds within 30 days after discharge and should have done this. The Administrator stated a new business office manager, responsible for the funds, had just been hired June 11th, 2012.

F 160

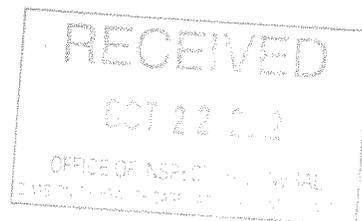
The Accounts Receivable Coordinator conducted an in-service on October 17, 2012 for the staff involved in the Resident Trust Accounts, which included the Administrator, Office Supervisor and Admissions Coordinator. The in-service consisted of a review of the federal guidelines. A post-test was administered to determine competency of the staff understanding of the guidelines. The Office Supervisor will conduct an audit weekly to ensure the facility has conveyed funds within 30 days.

F 225
SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;

F 225

The QA nurse and/or the Administrator will conduct a weekly audit of the resident trust accounts for one month to ensure compliance with 30-day refunds. The audits will be reduced to monthly for three quarters and assessed in risk management monthly to ensure compliance. Completion Date: 10/18/12



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
---	--

(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 225 Continued From page 2
and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

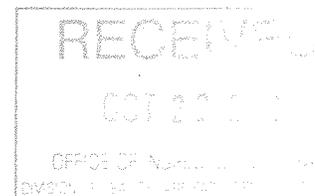
The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and review of the facility's Missing Articles Reports and policy Investigating Incidents of Theft and/or Misappropriation of Resident Property, it was determined the facility failed to report to officials in accordance with

F 225 F 225/N109
SS=D

The facility failed to report to OIG resident #4 investigation of missing wedding rings. The investigation material was copied and presented to the team leader on 10/3/12. Also, an unsampled resident E reported a wallet missing that contained \$12.00 dollars. The wallet was found and the twelve dollars was refunded to the resident. A copy of the investigation was also provided during the survey on 10/4/12.

The Administrator and Social Worker conducted an audit on 10/3/12 of the missing articles binder to ensure that no other issues were affected by the deficient practice. The findings revealed no other reportable issues regarding misappropriation of property.



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	

(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 225 Continued From page 3
State law through established procedures two (2) of four (4) incidents of misappropriation of property. Resident #4 had a set of wedding rings reported missing to the facility and Unsampled Resident E had twelve dollars (\$12) reported missing to the facility. Neither reports of misappropriation of property was reported to the Office Inspector General (OIG). In addition, the facility failed to conduct a thorough investigation.

The findings include:

Review of the facility's policy Investigating Incidents of Theft and/or Misappropriation of Resident Property, reviewed on 03/2011, revealed misappropriation of resident property was defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. In addition, the policy stated should an alleged or suspected case of misappropriation of resident property be reported, the facility administrator, or her designee, will notify the State Licensing and Certification Agency.

Review of the Missing Article Report form, dated 08/06/12, revealed the facility had been notified that a set of wedding rings (diamond and gold wedding band) belonging to Resident #4 were missing. Resident #4's family had reported the rings missing. The facility conducted a search of the facility but did not find the rings. However, the facility continued to view the missing rings as missing articles not misappropriation of property and did not report the allegation to the state authorities. In addition, continued review of the Missing Article Report, dated 08/28/12, revealed

F 225 The President of Loudon and Company conducted an in-service on 10/9/12 with the Administrator and also on 10/15/12 with the Social Service Department and Director of Nursing on reporting incidents of Theft and/or Misappropriation of resident property, also reviewed the regulatory requirement as well as discussed scenarios of reporting. The President gave scenarios to the participants in the in-service and we told him the action that we would take in a step-by-step process to report Theft and/or Misappropriation of Property.

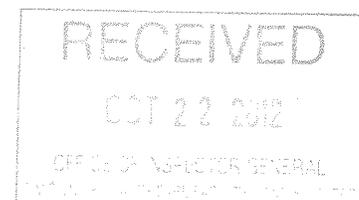
The QA nurse and/or Administrator will conduct weekly audits of missing articles to ensure compliance with reporting Theft and/or Misappropriation of resident property. The audits will be reduced to monthly for three quarters and assessed in risk management monthly to review compliance.



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

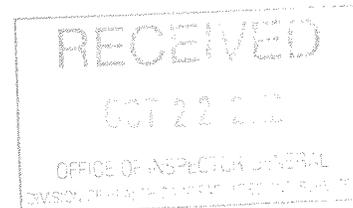
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095		
(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 225	Continued From page 4 Unsamped Resident E reported a wallet missing that contained \$12.00 dollars. The wallet was subsequently found; however, the twelve dollars (\$12) was missing from the wallet. The facility did not report the missing money. Interview, on 10/03/12 at 4:40 PM, with the Social Worker revealed she had filled out the Missing Article Report for the missing wedding rings of Resident #4. A search was conducted and staff members were interviewed. Some of the staff interviewed confirmed Resident #4 had the set of wedding rings, now reported missing. The rings were not found. She stated the Administrator was made aware of the missing rings. In addition, Unsamped Resident E reported a wallet with \$12.00 dollars missing; however, the Social Worker did not consider the missing money as a misappropriation of resident property. The facility had refunded the \$12.00 dollars. Interview with the Administrator, on 10/03/12 at 4:45 PM, revealed the facility viewed the missing wedding rings belonging to Resident #4 as a lost article, like clothing, and confirmed she did not report the incident to OIG or to Adult Protection Services (APS). She revealed a full search for the rings was conducted without success and the police were notified. She revealed since she could not identify a specific person that could have taken the rings, she did not consider the missing rings to be a reportable incident. The Administrator acknowledged she should have reported the missing rings. She revealed she had reported past incidents but she had failed to identify that this was a reportable incident, which the facility policy stated must be reported. Continued interview revealed the missing money	F 225			



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

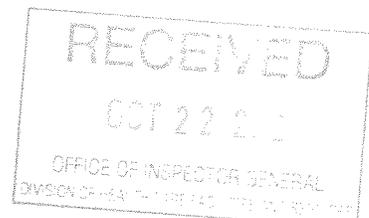
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	
(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 225	Continued From page 5 belonging to Unsampled Resident E was thought to have been misplaced and not that an actual person had taken the money. However, she revealed a search did not find the funds and the facility did not investigate nor report the missing money as required by law. Review of the facility's investigations of misappropriation of property revealed the facility had reported missing money to the OIG and conducted an investigation in June 2012. Continued interview with the Administrator, on 10/03/12 at 4:45 PM, revealed she did not know why she reviewed the allegations as missing articles instead of misappropriation of property except she could not identify an alleged person that could have taken the rings or money. She called the police and depended on their investigation. She stated the Social Worker was new and probably did not know to report the incidents.	F 225	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F 441/N 150 SS=E On 10/5/12 the Director of Nursing and Assistant Director of Nursing conducted an audit on resident's #1, #2, #5, and #8. None of the resident's were found to have current signs and symptoms of infections as evidenced by clinical assessment.



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

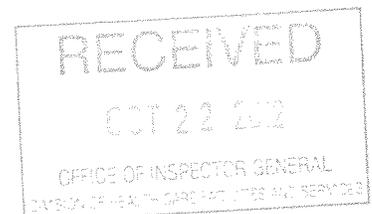
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	
(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)
F 441	<p>Continued From page 6</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy regarding Hand washing/Hand Hygiene, it was determined the facility failed to use appropriate hand washing technique during wound care treatment on three (3) of six (6) halls for four (4) of sixteen (16) sampled residents and five (5) unsampled residents. Residents #1, #2, #5, and #8. Wound Care Nurse # 1, #2, and LPN #1 were observed to omit hand washing between glove changes.</p> <p>The findings include:</p>	F 441	<p>The Infection Control Nurse has completed an audit on 10/11/12 of all resident's that could have been affected by the deficient practice. The audit revealed no evidence that infections were related to deficient practice.</p> <p>Infection Control Nurse, Director of Nursing, Assistant Director of Nursing and Staff Development Nurse conducted in servicing regarding the facilities hand washing policy. The in servicing started on 10/3/12 and will be completed by 10/22/12 for all nursing personnel and a post test was administered to ensure competency of personnel. The Infection Control Nurse developed a packet including hand hygiene for all new hires and an in-service will be conducted by the Infection Control Nurse or Staff Development every six</p>



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

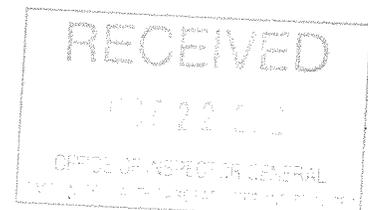
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	
(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 441	Continued From page 7 Review of the facility policy Hand Washing/Hand Hygiene, revised on December 2009, revealed employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: after handling soiled or used linens, dressings, bedpans, catheters and urinals; in most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visible soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: after handling used dressings, and contaminated equipment. 1. Record review for Resident #2 revealed the facility admitted the resident on 05/08/11, with diagnoses of Decubitus, Osteoarthritis, and Senile Dementia. Review of the last comprehensive assessment, dated 05/31/12, revealed the resident had multiple open areas and very fragile skin. The resident had open areas to the left thigh with a blister, right buttock, left heel, coccyx, and right buttocks. A wound vacuum had been ordered to the coccyx area and was to be changed three times a week. The resident was also incontinent and wore briefs as needed with incontinent care provided after each incontinent episode. Observation during the dressing change for Resident #1, on 10/03/12 at 9:30 AM, which was performed by Wound Care Nurse #2, revealed the soiled left hip dressing was removed, and gloves changed. However, the nurse did not wash her hands before donning the new gloves. The wound was cleansed with sea cleanser and the	F 441	months. The revised packet will be included in orientation as of 10/17/12. The Infection Control Nurse is participating in the Kentucky Long Term Care collaborative for infection control prevention. The Quality Assurance Nurse or Infection Control Nurse will observe 10 staff members during care and dressing changes to ensure proper hand washing techniques are being followed according to facility policy on a weekly basis for one month. The audits will be reduced to monthly for three quarters and assessed in risk management monthly to review compliance. Completion Date: 10/23/12



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

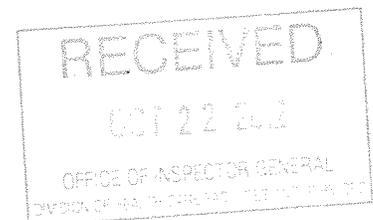
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	
(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 441	Continued From page 8 application of Santyl combined with Flagyl medications to the wound bed was completed. The nurse changed her gloves four separate times during the procedure. However, there was no evidence of hand washing throughout the procedure. Further observation revealed Wound Care Nurse #2 proceeded to the next area for the treatment of Duoderm to the left heel without washing hands. The treatment of Aqua Clear to the right heel was completed without hand washing between glove changes for each treatment, or after removing the soiled dressings. Interview with Wound Care Nurse #2, on 10/03/12 at 2:55 PM, revealed anytime gloves are soiled, they should be changed. The wound nurse stated she changed her gloves multiple times, and had attended wound care classes, and trained staff at the facility. However, she was not aware of the facility's policy to wash her hands after removing any soiled dressings. The Wound Care Nurse stated she had attended classes on hand washing at the facility; however, said it had been awhile. The wound care nurse stated she should have washed her hands per the facility policy. 2. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 03/19/12 with diagnoses of Muscle Weakness, Diabetes Mellitus, Depression, and Dementia. Review of the 03/25/12 admission comprehensive assessment, the facility had identified the resident at risk for pressure ulcer development due to the resident's inability to reposition self and incontinent of bowel and bladder. Review of the physician's orders, dated 08/28/12, revealed the left heel was to be cleansed with sea clens, apply	F 441	



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095		
(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 441	Continued From page 9 Santyl, and cover with foam, then secure with Kerlix bandage. In addition, the open area on the bottom of the resident's right outer foot (near the 5th toe) had a physician's order to apply Santyl ointment and cover with a gauze dressing. An Aquaderm dressing was ordered to cover the right heel area. Observation of a dressing change for Resident #8, on 10/03/12 at 10:30 AM, revealed Wound Care Nurse #2 removed the soiled dressing from the resident's left foot, and changed her gloves. However, the nurse did not wash her hands. Observation also included treatments to the bottom of the left heel, and the right outer foot. The nurse failed to wash her hands between the three treatments to the left and right heels. Interview with Wound Care Nurse #2, on 10/03/12 at 2:55 PM, revealed she should have washed her hands between wounds, and after removing any soiled dressings per facility policy. Interview with the Director of Nursing (DON), on 10/03/12 at 4:45 PM, revealed according to the facility policy, staff should be washing their hands after removing any soiled dressing. The DON stated the potential of not doing this would be, especially with multiple wounds, the spread of infections. The DON also stated that training on hand washing was provided upon hire and periodically, but only for the CNAs, not the licensed staff. 3. Observation during a skin assessment/wound treatment, on 10/03/12 at 2:35 PM, revealed	F 441			



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
--	--

(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
--------------------	--	---------------	---	----------------------

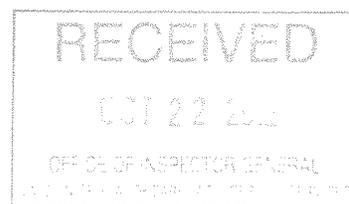
F 441 Continued From page 10

Resident #5 had several small, superficial open areas on the left buttock. Observation during the skin assessment revealed LPN #1 examined the resident's head, neck, arms, and trunk with gloved hands. When the nurse pulled down the resident's brief, she found the resident was incontinent of bowel. The Certified Nursing Assistant (CNA #2) present during the observation cleaned the resident while the nurse helped position the resident. After the CNA removed the soiled brief and cleaned the resident's buttocks, the CNA used her soiled gloves to straighten the lift pad and flecked a black substance off the lift pad onto the bottom sheet. The CNA then removed the soiled gloves but did not wash her hands. She applied clean gloves and rolled the resident back onto the soiled lift pad. LPN #1 did remove her soiled gloves but failed to wash her hands prior to donning clean gloves. The nurse then cleaned the resident's supra pubic catheter. Stool was noted on the shield dressing covering the wounds on the left buttock. The nurse used the same gloves to wipe at the stool but then removed the soiled wound dressing. She then removed her gloves and washed her hands.

Interview with LPN #1, on 10/03/12 at 3:30 PM, revealed she was unaware she had not washed her hands after removal of gloves from the skin assessment and cleaning of the supra pubic catheter. She stated she should have washed her hands when she removed the gloves.

Interview with CNA #2, on 10/03/12 at 3:35 PM, revealed she did not realize she had touched the lift pad and bed linens with soiled gloves. She acknowledged she had not washed her hand

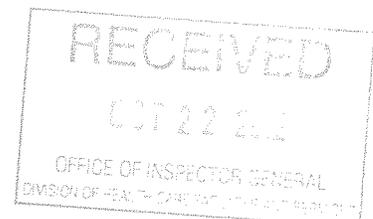
F 441



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

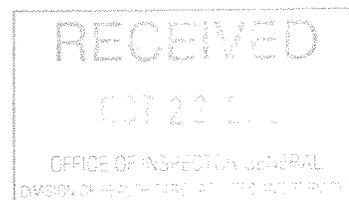
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	
(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 441	<p>Continued From page 11</p> <p>between glove change and did place the resident back onto the soiled lift pad.</p> <p>Review of Resident #5's clinical record revealed the resident experience recurrent urinary tract infections (UTI). The resident is currently taking antibiotic for UTI and history of positive urinalysis with the bacteria E-coli noted in the urine from the supra pubic catheter.</p> <p>4. Record review for Resident #1 revealed the facility admitted the resident on 10/28/08 with diagnosis of Malignant Neoplasm of the Vertebrae. Review of the MDS revealed Resident #1 was assessed at risk for pressure ulcers. Resident #1 had four opened areas: the right buttock, the right ischium, the left ischium and the left upper posterior thigh, with physician orders for treatment.</p> <p>Observation, on 10/03/12 at 8:50 AM, during the dressing change for Resident #1 that was performed by Wound Care Nurse #1, revealed a soiled dressing was removed, and gloves were changed without washing hands before applying a new dressing. Four (4) separate areas received wound care and the wound vacuum applied with no hand washing while gloves were repeatedly changed. Wound Care Nurse #1 washed her hands prior the initiation of the dressing change; however, did not wash her hands again until the dressing change (four (4) areas) was complete and the wound vacuum reapplied.</p> <p>Interview, on 10/03/12 at 2:40 PM, with Wound Care Nurse #1 revealed she was aware she had changed gloves without washing her hands while</p>	F 441	



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095		
(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 441	<p>Continued From page 12</p> <p>having moved from a soiled to a clean area. She stated she was not aware hand washing was required during a glove change while performing a dressing change. She revealed she had received clinical training on hand washing during her wound care training.</p> <p>Interview, on 10/03/12 at 5:15 PM, with the Infection Control Nurse revealed she was familiar with the policy on Hand Washing. She revealed the Nursing Competencies training for Infection Control did not include hand washing for licensed staff. She stated the only staff she educated on hand washing was the new staff during orientation. She indicated hands were to be washed during a dressing change each time your gloves were changed; especially after you touched something contaminated. She stated the reason to wash your hands between glove changes was to prevent the spread of infection or contamination of another area on the resident.</p> <p>Interview, on 10/03/12 at 5:20 PM, with the In-Service Coordinator revealed she did not conduct Hand Washing Competencies for nursing. In addition, she revealed there had not been an in-service within the last year on hand washing for licensed staff.</p>	F 441		



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S.C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1989, original building; 1997 building addition.

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type V Unprotected.

SMOKE COMPARTMENTS: Six (6) smoke compartments.

FIRE ALARM: Complete fire alarm system with heat and smoke detectors.

SPRINKLER SYSTEM: Complete, automatic dry sprinkler system.

GENERATOR: Type II generator installed in 1989. Fuel source is Natural Gas with a Letter of Reliability.

A standard Life Safety Code survey was conducted on 10/02/12. Gallatin Health Care was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has one-hundred and twenty (120) certified beds and the census was seventy-seven (77) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal

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

TITLE

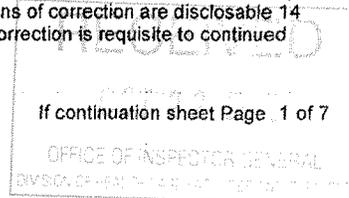
(X6) DATE

X Shain Darnold

X Administrator

10/22/12

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.



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000 Continued From page 1
Regulations, 483.70(a) et seq. (Life Safety from Fire)

K 000

Deficiencies were cited with the highest deficiency identified at E level.
CFR: 42 CFR 483.70(a)

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 029

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

K 029
SS=D

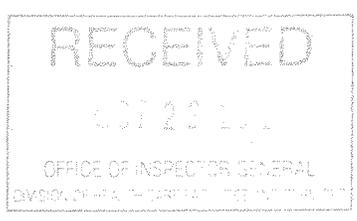
There were no residents affected by the clean linen room not having a self-closing device installed on the door.

The systemic change was that a closure was installed on 10/3/02 on the clean linen room and an audit by the Maintenance Director revealed no other storage rooms required self-closing devices. The Maintenance Director will conduct a monthly check on self-closing devices to ensure proper closure of the door.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, approximately twenty (20) residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was seventy-seven (77) on the day of the survey.

The Maintenance Director will conduct an audit of the self-closing devices monthly and report findings to the

The findings include:



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 029 Continued From page 2

Observation, on 10/02/12 at 9:52 AM, with the Maintenance Supervisor revealed the door to the Clean Linen Room adjacent to Nurse Station A, did not have a self-closing device installed on the door.

Interview, on 10/02/12 at 9:52 AM, with the Maintenance Supervisor revealed the Clean Linen Room had previously been converted from an Office, a non-hazardous classification, not requiring a self-closing device.
Reference:

NFPA 101 (2000 Edition).

19.3.2 Protection from Hazards.

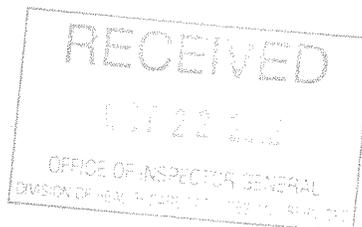
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
- (3) Paint shops
- (4) Repair shops
- (5) Soiled linen rooms
- (6) Trash collection rooms
- (7) Rooms or spaces larger than 50 ft² (4.6 m²),

K 029

Risk Management meeting each month to ensure compliance.

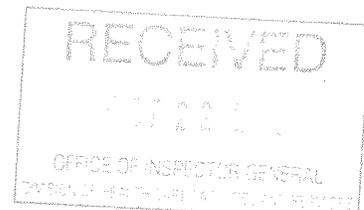
Completion Date: 10/4/12



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

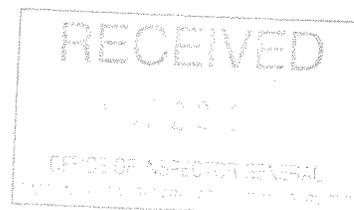
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 029	Continued From page 3 including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	
K 066 SS=E	NFFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K 066 SS=E There were no residents affected by not having a fire extinguisher or a fire blanket in the courtyard. Simplex Grinnell installed the fire extinguisher on 10/3/12 and the Maintenance Director installed the smoking blanket on 10/3/12. The items are clear and visible for use to all visitors and staff members.



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

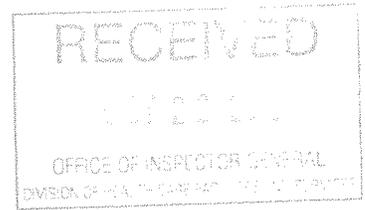
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide emergency equipment in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect each of the six (6) smoke compartments, residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was seventy-seven (77) on the day of the survey. The findings include: Observation, on 10/02/12 at 10:43 AM, with the Maintenance Supervisor revealed the exterior, enclosed courtyard used as the resident's designated smoking area, was not equipped with a fire extinguisher and a fire blanket. Interview, on 10/02/12 at 10:43 AM, with the Maintenance Supervisor revealed he was not aware of the requirement to provide a fire extinguisher and fire blanket in the resident's designated smoking area. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exiting conference on 10/02/12 at 4:45 PM. Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and	K 066	The QA nurse or Maintenance Director will audit the smoking blanket to ensure its availability weekly for one month and then monthly for three quarters. The fire extinguisher will be monitored on a monthly audit as part of Maintenance logs. The audits will be assessed in risk management monthly to review compliance.	Completion Date: 10/4/12



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 066	Continued From page 5 shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Subject: Alert: Smoking Safety in Long Term Care Facilities	K 066		



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

PRINTED: 10/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2012
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095	
(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)

