

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

PRINTED: 09/01/2010
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 07/28/2010
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NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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(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
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K 000	INITIAL COMMENTS	K 000		
	<p>Amended CMS 2567L issued to facility on 09/01/10.</p> <p>A life safety code survey was initiated and concluded on July 28, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. The facility failed to ensure that penetrations above fire/smoke barrier doors were properly sealed. This deficient practice affected two (2) of six (6) smoke compartments, staff and approximately twenty (20) residents. The facility has the capacity for 120 beds with a census of 89</p>	K 025	<p>K 025</p> <p>There were no residents affected by the deficient practice. As of 8/20/10, the Maintenance Director replaced the sealant with Fire Stop caulking which meets the NFPA guidelines for one-half hour fire resistance.</p> <p>All other areas were evaluated and the Maintenance Director identified one additional smoke barrier that will be in compliance by 8/25/10 with the Fire Stop caulking which meets the NFPA guidelines.</p> <p>The Maintenance Director/designee will conduct an audit on a quarterly basis for one year to evaluate smoke barriers for compliance.</p> <p style="text-align: right;">Completion Date: 8/25/10</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Blaine W. Daniels* TITLE: *Administrator* (X6) DATE: *9/8/10*

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

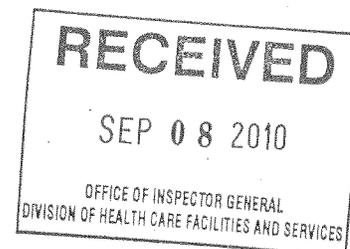
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If continuation sheet Page 1 of 14
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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K 025	Continued From page 1 has the capacity for 120 beds with a census of 89 the day of survey. The findings include: During the Life Safety Code survey on July 28, 2010, at 9:00am, with the Director of Maintenance, a large amount of flammable expansion foam was observed to be filled around a conduit that penetrated the fire/smoke barrier wall in the attic above the 200 cross-corridor doors. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility. An interview revealed the Director of Maintenance was not aware the expansion foam was an improper material to be used to seal gaps and penetrations in fire/smoke barrier walls. Reference: NFPA 101 2000 edition 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose.	K 025		



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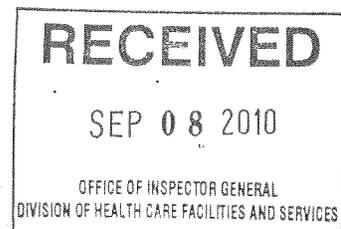
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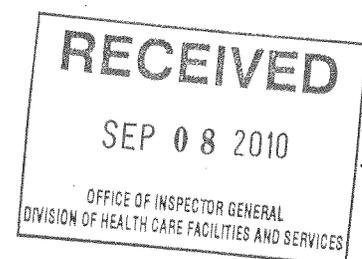
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K 025	<p>Continued From page 2</p> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a corridor door to a hazardous area was being held open in an approved manner.</p> <p>The findings include:</p>	K 025	<p>K 029</p> <p>There were no residents affected by the deficient practice. As of 8/20/10, the hold open device will be removed from doors that were identified as hazardous areas.</p> <p>The Maintenance Director did not identify any other areas out of compliance with this guideline.</p> <p>The Quality Assurance Nurse/designee will audit the areas on a biweekly basis for the first quarter and monthly thereafter to ensure compliance with the non-use of hold open devices for hazardous areas.</p> <p>Completion Date: 8/20/10</p>	
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K 029	<p>Continued From page 3</p> <p>During the Life Safety Code tour on July 28, 2010, at 12:10pm, with the Director of Maintenance, a corridor door leading to hazardous areas was observed to have a hold open device attached to the lower portion of the door. Doors to hazardous areas are not allowed to be held open in this manner. The Director of Maintenance stated this hold open device was approved for use on a previous survey.</p> <p>19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.</p> <p>7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door</p>	K 029		



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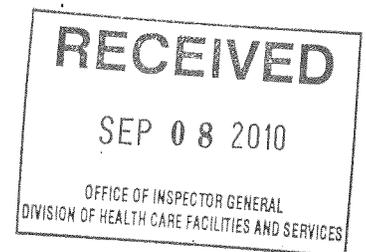
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K 029	Continued From page 4 release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system control panels were protected from unauthorized use as required. The findings include: During the Life Safety Code survey on July 28, 2010, at 10:20am, with the Director of Maintenance, a test of the fire alarm system	K 052	K 052 There were no residents affected by the deficient practice. As of 8/24/10, Able Alarm & Electronic Protection, Inc. will be reprogramming the annunciator panels in three locations to require a code in order to silence any function. Please reference attached letter provided by Able Alarm in regards to K. 052. Able Alarm & Electronic Protection, Inc will be reprogramming the panels on 8/24/10 to meet the NFPA guidelines. Able Alarm will monitor on a quarterly basis to ensure the panels continue to meet NFPA guidelines. Completion: 8/24/10	



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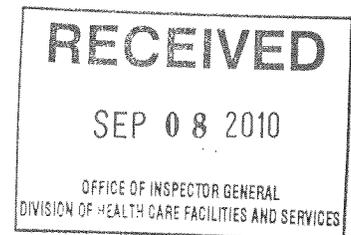
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K 052	Continued From page 5 revealed a fire alarm control panel located near the nurse's station. This panel was unprotected and could be accessible by unauthorized personnel. An interview revealed the Director of Maintenance was not aware fire alarm control panels should be protected from unauthorized use. An unprotected fire alarm control panel was also observed at the front foyer of the facility during the survey. Reference: NFPA 72 1999 edition 1-5.4.9 A means for silencing the trouble notification appliance(s) shall be permitted only if it is key-operated, located within a locked enclosure, or arranged to provide equivalent protection against unauthorized use.	K 052		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of <i>Water-Based Fire Protection Systems</i> . It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview the facility	K 056	K 056 No residents were found to be affected by the deficient practice. Brown Sprinkler will be installing sprinkler heads on the seven identified areas to meet the NFPA guidelines for the sprinkler system. Brown Sprinkler will have the installation completed by 9/8/10. No other areas were found to be non compliant with the current NFPA guidelines. Brown Sprinkler will audit the facility structures to ensure compliance with any overhangs exceeding four foot. The sprinkler company will make note on a quarterly basis for one year to ensure compliance.	Completion: 9/8/10



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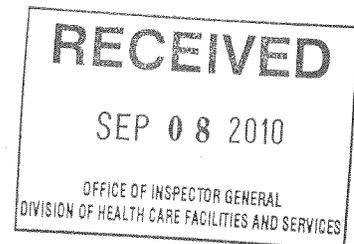
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K 056	<p>Continued From page 6</p> <p>failed to ensure that outside canopy and overhangs at the facility were sprinkler protected as required. This deficient practice affected four (4) of six (6) smoke compartments, staff and approximately fifty (50) residents. The facility has the capacity for 120 beds with a census of 89 the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on July 28, 2010, at 9:20am, with the Director of Maintenance, a combustible canopy approximately 6' X 18' located at the back of the kitchen was noted not to be sprinkler protected. Combustible canopies and overhangs exceeding four foot in width must be sprinkler protected. The Director of Maintenance stated he thought the canopy and overhangs would not be required to be sprinkler protected because the canopy and overhangs were not sprinkler protected when the building was built. During the survey three (3) other exterior exit canopy or overhangs were observed not to be sprinkler protected.</p> <p>Reference: NFPA 13 1999 edition</p> <p>5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested</p>	K 056		
K 062 SS=F		K 062	K 062 No residents were affected by the deficient practice. Brown Sprinkler Company conducted	



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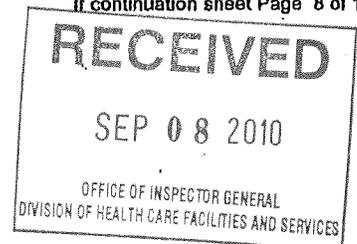
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K 062	Continued From page 7 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain their sprinkler system by NFPA standards. This deficient practice affected six (6) of six (6) smoke compartments, staff and all of the residents. The facility has the capacity for 120 beds with a census of 89 the day of the survey. The findings include: During the Life Safety Code tour on July 28, 2010, at 12:45pm, with the Director of Maintenance, a review of the facility's quarterly sprinkler system report revealed no record for a full flow sprinkler trip test. This test helps to ensure the sprinkler system is working correctly. The Director of Maintenance was not aware this test needed to be performed. Reference: NFPA 25 1998 edition 1-8 Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. 1-8.1 Records shall indicate the procedure performed	K 062	K 062 (Continued) the full flow sprinkler trip test on 8/13/10. The test concluded that the sprinkler system is working correctly. Brown Sprinkler will be conducting a full flow trip test on a three-year cycle and records will reflect the completion of the test. The Maintenance Director will conduct an audit of the records every three years to ensure compliance with the NFPA guidelines of a full flow trip test. Completion: 8/13/10	
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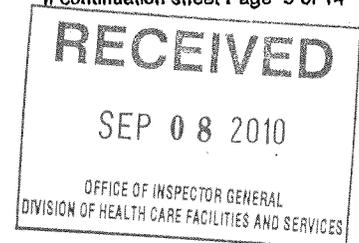
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K 062	Continued From page 8 (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 9-1* General. This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of valves, valve components, and trim. Table 9-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Trip test Annually Full flow trip test 3 years	K 062		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on an interview, the facility failed to ensure heat and air wall units were maintained by recommended manufactures standards. This deficient practice affected six (6) of six (6) smoke compartments, staff and eighty nine (89) residents. The facility has the capacity for 120 beds with a census of 89 the day of survey. The findings include:	K 067	K. 067 No residents were affected by the deficient practice. The Maintenance Director/designee will conduct a preventative maintenance of the internal components of each heat/air unit located in the facility to follow manufacturers' guidelines. This service will be completed by 9/10/10. The Maintenance Director/designee will conduct an annual maintenance of the internal components of all heat/air units within the building. Completion: 9/10/10	



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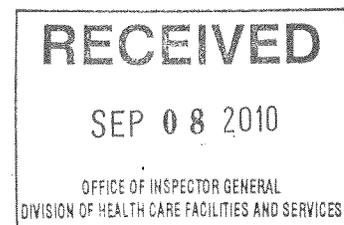
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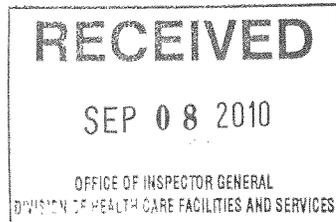
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<p>K 067</p> <p>K 076 SS=D</p>	<p>Continued From page 9</p> <p>During the Life Safety Code tour on July 28, 2010, at 9:30am, with the Director of Maintenance, an interview revealed that resident, office and other heat and air units located in the facility were maintained by changing the filter monthly. The Director of Maintenance stated no other maintenance was being performed on the units. Manufacture's recommend having periodic maintenance performed on internal components of these units so the unit will operate as intended. Not complying with the manufacture's <i>recommendations may cause conditions to exist</i> to create a potential fire hazard. An interview revealed the Director of Maintenance was not aware of the manufactures recommendations on the heat and air units at the facility.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by; Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards.</p>	<p>K 067</p> <p>K 076</p>	<p>K 0 76</p> <p>No residents were affected by the deficient practice. The supply clerk moved all combustible storage items located in each oxygen storage room to another location within the facility on 8/19/10.</p> <p>There were no other areas affected by the deficient practice.</p> <p>The Quality Assurance Nurse will monitor the oxygen storage rooms for combustibles on a biweekly basis for the first three months and once a quarter thereafter to ensure compliance.</p> <p>Completion: 8/19/10</p>	
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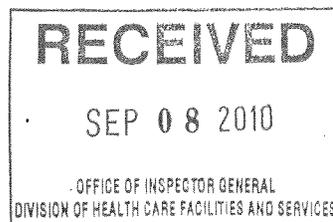
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/01/2010
FORM APPROVED
OMB NO. 0938-0391

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 07/28/2010
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 076	<p>Continued From page 10</p> <p>The findings include:</p> <p>During the Life Safety Code tour on July 28, 2010, at 11:15am, with the Director of Maintenance, seventeen (17) E size oxygen cylinder tanks were observed to be stored in the oxygen storage room. These tanks were within five (5) feet of combustible storage. Oxygen cylinders while in storage and in quantities greater than 300 cubic feet must be kept five (5) feet from combustibles. An interview revealed the Director of Maintenance <i>was not aware of this requirement. Quantities 300 cubic feet and less may follow the requirements of S&C-07-10.</i></p> <p>Reference: S&C-07-10</p> <p>Up to 300 cu ft of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse's station or in a corridor of a healthcare facility.</p> <p>This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in "crash carts" and in use on wheelchairs or gurneys.</p> <p>The term "PRN" means "as needed." An individual cylinder placed in a patient room for immediate use by a patient is not required to be</p>	K 076		



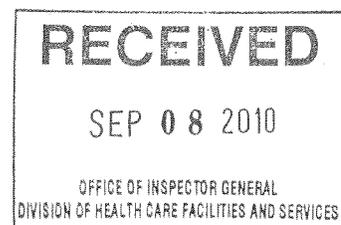
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185380	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2010
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K 076	Continued From page 11 stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room. Reference: NFPA 99 1999 edition 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m ³ (300 ft ³) but less than 85 m ³ (3000 ft ³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following	K 076		



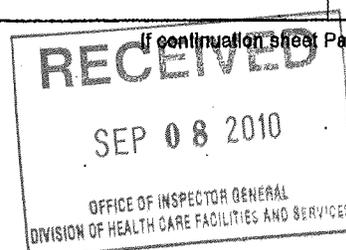
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2010
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K 076	Continued From page 12 wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to guard against an electrical hazard by not securing an electrical panel box in a corridor of the facility. This deficient practice affected one (1) of six (6) smoke compartments, staff and approximately sixteen (16) residents. The facility has the capacity for 120 beds with a census of 89 the day of the survey. The findings include: During the Life Safety Code tour on July 28, 2010, at 10:00am, with the Director of Maintenance, an electrical panel box located in the 200 wing was noted to be missing a safety cover inside the panel box. This safety cover prevents accidental contact of live parts in the panel box. An interview with the Director of Maintenance revealed he was not aware the safety cover was missing. Reference: NFPA 70 1999 edition 110.27 Guarding of Live Parts.	K 147	K 0147 No residents were affected by the deficient practice. The Maintenance Assistant corrected the missing safety cover on the 200 hall electrical box by placing a spare breaker in the slot on 7/30/10. There were no other areas affected by the deficient practice. The Quality Assurance nurse will monitor the electrical boxes to ensure compliance of guarding against any electrical hazards biweekly for the first quarter and monthly thereafter. Completion: 7/30/10		



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K 147	Continued From page 13 (A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface. (B) Prevent Physical Damage. In locations where electric equipment is likely to be exposed to physical damage, enclosures or guards shall be so arranged and of such strength as to prevent such damage. (C) Warning Signs. Entrances to rooms and other guarded locations that contain exposed live parts shall be marked with conspicuous warning signs forbidding unqualified persons to enter.	K 147			



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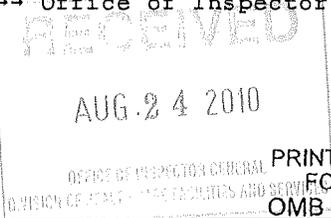
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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F 000	INITIAL COMMENTS	F 000		
F 250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure medically-related social services were provided to terminally ill residents to ensure they obtained or maintained the highest practicable, mental, and social well being for six (6) of eighteen (18) sampled residents. The facility failed to coordinate the spiritual and comfort needs for Residents #1, #2, #4, #12, #13, and #17.</p> <p>The findings include: Record review of Resident #12's chart on 07/29/10 at 8:30am revealed there was no input from social services on the medical care plan related to spiritual or resident comfort needs. Interview with the MDS coordinator on 07/28/10 at</p>	F 250 F 250/N 130	<p>1. The medically-related social service needs provided for residents #1, #2, #4, #12, #13 and #17 were reviewed and an end of life comprehensive care plan was implemented to include each resident's spiritual, emotional and mental support in conjunction with hospice services. The social service director assessed each resident for spiritual needs. Churches or clergy of those residents or families that expressed the desire to have further spiritual guidance will be contacted by 8/25/10. The social service director and bookkeeper coordinate services for any financial issues and assist with funeral arrangements that need to be met when requested. An audit was completed on 8/18/10 to identify any residents that need assistance with funeral arrangements or financial issues. The family of resident #13 was contacted for funeral arrangements and the information was provided for the record. A depression scale assessment was completed on residents #1, #2, #4, #12, #13 and #17 to identify any change in mood or adjustment to the facility and counseling will be provided by a licensed social worker by 8/20/10 for those residents with clinical manifestations of depression.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Maie D. Sample* TITLE: *Administrator* (X9) DATE: *8/20/10*

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



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NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41096
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F 250	<p>Continued From page 1</p> <p>11:20am revealed once a Hospice plan of care was initiated Social Services provided no spiritual or comfort measures.</p> <p>Observation of Resident #13 on 07/28/10 at 10:50am revealed the resident was up in a wheelchair, had a flat affect and was not responsive to greetings.</p> <p>Review of the clinical record for Resident #13 revealed the resident was admitted to the facility with diagnoses of Dementia with Behavior Disturbance, Mute, and Dysphagia. The facility completed an admission Minimum Data Set (MDS) assessment on 03/31/10 which revealed the resident had a moderate cognitive deficit in the ability to make daily care decisions. The resident had episodes of tearfulness, restlessness and wandering about the facility. On 05/26/10, the facility completed a significant change MDS assessment which revealed the resident had greatly declined and required extensive assistance by staff for daily care. The resident was no longer able to make any care decisions. On 06/03/10, the physician ordered hospice intervention and the resident was admitted to a hospice program.</p> <p>Review of Resident #13's social service notes, revealed no evidence the facility acknowledged the resident's terminal condition and provided medically-related social services in conjunction with hospice services.</p> <p>Interview with the Social Service Coordinator on 07/29/10 at 3:05pm revealed the facility did not offer any counseling for spiritual, emotional or mental support for residents. She revealed residents' churches/ministers were never notified</p>	F 250	<p>2. All other residents were assessed for medically related social service needs related to end of life care. An end of life comprehensive care plan was implemented to include each resident's spiritual, emotional and mental support needs. The social service director assessed each resident for his or her individual spiritual needs. Churches or clergy of those residents or families that expressed the desire to have further spiritual guidance will be contacted by 8/25/10. The social service director and bookkeeper coordinate services for any financial issues and assist with funeral arrangements that need to be met when requested. A depression scale assessment was completed on residents with an end of life condition to identify change in mood or adjustment to the facility and counseling will be provided by a licensed social worker by 8/20/10 for those residents with clinical manifestations of depression.</p> <p>3. The facility's systemic change was developing an end of life comprehensive care plan. A depression scale assessment will be completed within one week of admission or when end of life care is anticipated.</p> <p>4. The QA nurse/designee will conduct a biweekly audit of the depression scale, end of life comprehensive care plan and funeral arrangements for three months and monthly thereafter to ensure compliance. The findings will be presented to the Quality Assurance committee monthly.</p> <p style="text-align: right;">Completion date: 8/25/10</p>	
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NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 499 CENTER STREET WARSAW, KY 41095
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F 250	<p>Continued From page 2</p> <p>when a resident was admitted to the facility. She stated finances were not addressed by social services nor was the family offered support with making funeral arrangements. She stated the hospice staff did meet with her and let her know if she needed to do anything for a resident; however, no interventions were coordinated with the hospice staff.</p> <p>Observation of Resident #2 on 07/27/10 at 11:00am revealed the resident resting in bed, using oxygen per nasal canual at 3 liter per minute.</p> <p>Review of the medical record for Resident #2 revealed the resident was admitted on 10/09/09 with diagnoses including Diabetes, Senile Dementia, and Chronic Obstructive Pulmonary Disease. The resident was discharged home in March 2010, but was readmitted back to the facility on 04/05/10 due to a decline in status at home. The facility received an order for Hospice care on 06/10/10 as requested by the resident and family.</p> <p>A review of the Comprehensive Care Plan for Resident #2 revealed there was no evidence the facility provided medically related social services related to the residents decline in function, adjusting to being readmitted to the facility, and end of life adjustments regarding Hospice care. There was no evidence that the resident was care planned for mood by the facility.</p> <p>Interview with the Social Service Coordinator on 07/29/10 at 3:40pm, revealed, she does care plan for residents in need of psychosocial, spiritual and financial needs. The Social Worker stated she would be surprised if she did not do a care plan</p>	F 250		
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