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

PRINTED: 10/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185360		10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE	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 10/01/13 through 10/03/13. A Life Safety Code Survey was conducted on 10/01/13. 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 241/ N 113 Resident #4 was assisted back from the dining room. Employee #2 received in-service education on 10/3/13 related to respect of resident request. The Staffing Coordinator was also in serviced on 10/3/13 on respect of resident request. The Director of Nursing spoke to resident #4 on 10/4/13 related to the incident and explained that it will be monitored closer to prevent this from reoccurring.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide care in a manner to maintain dignity for one (1) of the nineteen (19) sampled residents (Resident #4). The facility failed to assist Resident #4 back to their room after notifying two (2) separate staff members. The staff responded to the resident, after being left waiting for forty-five (45) minutes for assistance, and surveyor intervention. The findings include: The facility did not provide a policy. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 10/09/01, with diagnoses of Paralysis, Stroke, and Chronic Pain. The facility assessed the	F 241	The Social Service Director and Social Service Assistant interviewed residents that ate in the dining room on 10/22/13. The interviews revealed that residents received items during meal service as requested. The interviews also revealed that residents were provided appropriate assistance with leaving the dining room as requested. The Social Service Director and Social Service Assistant conducted in servicing for all staff members related to resident rights and dignity. The method of in-service was a role-play of different scenarios that honor resident dignity. The staff members were given the opportunity for question and answer to ensure understanding. The in servicing will be completed by 10/23/13. The systemic change is that the Director of Nursing will designate the nurse assigned to 100 hallway or 500 hallway to monitor the dining room and ensure that request are being honored. This change was effective 10/4/13.	

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

x Stacie W. Darnell — x Administrator x 10/23/13

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

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F 241	Continued From page 1 resident using the Minimum Data Set (MDS), dated 09/06/13, as having a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. The facility assessed the resident as needing extensive assistance with transfers and required a wheelchair for transportation. Observations of Resident #4 during the evening meal, on 10/01/13 at 5:35 PM, revealed the resident had finished eating the meal and asked Certified Nursing Assistant (CNA) #2 to transfer him/her back to their room. CNA #2 informed the resident he needed to pass a few more meal trays and then would help the resident back to their room. At 5:45 PM, CNA #2 sat down and began feeding a dependant resident without notifying Resident #4 or asking someone else to assist the resident back to their room. At 6:05 PM, Resident #4 asked CNA #1 if he knew where CNA #2 went because he was supposed to help him/her back to their room. Without stopping to speak to the resident, CNA #1 told the resident that CNA #2 was feeding another resident and walked out of the dining room and down the hall without any further acknowledgement of the resident's need to go back to their room. At 6:20 PM, the resident continued to sit at the table with his/her head hanging down and occasionally looking around the room. LPN #2 responded forty-five (45) minutes later, after notification from the surveyor of Resident #4's requests to staff and lack of response. Interview with Resident #4, on 10/03/13 at 10:30 AM, revealed the resident felt like he/she was always last to be assisted out of the dining room and sometimes had to wait a long period of time. The resident revealed he/she was used to it and	F 241	The QA nurse or Social Service Assistant will monitor the dining room to ensure assistance is provided as requested weekly for four weeks, monthly for one quarter and quarterly for one year. The findings will be reviewed in the monthly Risk Management meeting to determine compliance. Completion Date: ~~10/23/13~~ 10/24/13	

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F 241	Continued From page 2 just felt "numb" about the whole thing. Interview with CNA #2, on 10/02/13 at 5:01 PM, revealed Resident #4 did ask for assistance while he was passing trays. The CNA revealed he asked the Staffing Coordinator, which he identified as the Staffing Supervisor, if he could leave to take the resident back to their room, but was told to pass a few more trays. The CNA revealed the last tray was for a dependant resident who required extensive assist , and he was then instructed to feed the resident. The CNA revealed he did intend on taking the resident back to his/her room, but was informed not to. The CNA revealed he should have gone back and told the resident about the delay. The CNA revealed he did overhear the resident asking another staff member where CNA #2 was and that he was supposed to help him/her back to the room. The CNA revealed he did not go ask someone to assist the resident as he was instructed to never leave a dependant resident alone at the table during a meal. However, the CNA did admit to there being another staff member at the same table assisting residents and he could have gone and asked for someone to assist the resident back to their room as requested. The CNA revealed this probably made the resident feel bad as he/she was forgotten about for all intensive purposes. The CNA revealed he should not have picked up another tray and immediately helped the resident. Interview with the Staffing Coordinator, on 10/03/13 at 11:30 AM, revealed CNA #2 asked her if he could leave the dining room while he was feeding a resident and she told him no. However, LPN #2 called for CNA #1 to come and assist that resident back to their room. The Staffing	F 241		

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F 241	Continued From page 3 Coordinator revealed she was not aware of how long Resident #4 had been waiting for assistance. Interview with LPN #2, on 10/03/13 at 1:50 PM, revealed he was not notified that Resident #4 needed help back to his/her room until he was informed by the surveyor. The LPN revealed he did call CNA #1 to come help, but it was to assist with passing trays, not to help a resident. The LPN revealed the resident should have been helped immediately. The LPN revealed a potential for the resident to feel ignored and not important. Interview with CNA #1, on 10/03/13 at 2:35 PM, revealed he was the CNA team leader for second shift. The CNA revealed he was still passing trays at the time the resident requested assistance, but thought he had told the resident he would be back. The CNA revealed he should not have just walked away and should have addressed the resident's need. The CNA felt the problem was a lack of communication. Interview with the Director of Nursing (DON), on 10/03/13 at 3:30 PM, revealed CNA #2 should have assisted the resident back at the time of the request. The DON felt the staff was nervous and did not follow through with communication. The DON revealed she does monitor the dining room and had not noticed a problem before.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	F 280/ N 192 The Falls Committee met on 10/3/13 regarding resident #9. The team updated the primary goal to state that resident #9 will have no falls. The additional approach for resident #9 included increased supervision on night shift.	

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F 280	Continued From page 4 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Goals and Objectives for Care Plans, it was determined the facility failed to revise a comprehensive plan of care for one (1) of the nineteen (19) sampled residents (Resident #9) after the resident sustained multiple falls. The findings include: Review of the facility's Goals and Objectives for Care Plans, Revised 04/2011, revealed care plans incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Goals and objectives are defined for a specific resident problem. When goals and objectives are not achieved, the resident's clinical record would be documented as to why and new goals would be established and modified	F 280	The facility Falls Committee conducted an audit of all residents identified as being high risk for falls. The care plans were updated to ensure all goals and approaches were appropriate in the prevention of falls. The completion date was 10/22/13. The Director of Nursing, Assistant Director of Nursing and Wound Nurse conducted an in-service with all nursing staff on how to identify those residents that are at high risk for falls. The in-service included guidelines for increased supervision for those residents and ensuring that all current safety devices are in place. The in-service was completed on 10/21/13. The systemic change was that the Director of Nursing revised the procedure of tracking falls. The Director of Nursing or the Assistant Director of Nursing will track all resident falls individually to identify any possible trends and risk. The tracking will be utilized to prevent repeated falls. The implementation date for this systemic change is 10/23/13. The facility Falls Committee will implement a Fall Scene Investigation Report that includes an immediate team huddle (within fifteen minutes at the scene of fall) to identify the root cause of each fall. The team will implement interventions appropriate to prevent further falls. The Director of Nursing in serviced all nurses on the completion of the Fall Scene Investigation Report by 10/23/13. The Care Plan team will review the report after each fall occurs to ensure the procedures were followed	

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F 280	Continued From page 5 accordingly. Review of Resident #9's clinical record revealed the facility admitted the resident, on 05/11/12, with diagnoses of Dementia, Anxiety, Psychosis, Chronic Pain and Stroke. The facility assessed the resident utilizing the Minimum Data Set (MDS), on 09/17/13, as having a Brief Interview for Mental Status (BIMS) score of seven (7) indicating the resident had severe impairment of cognitive function. Review of the MDS revealed the resident required extensive assist with bed mobility and transfers. The facility assessed the resident as being a high risk for falls and subsequently sustained a fall, on 07/04/13, 08/08/13, and 09/09/13. Review of Resident #9's comprehensive plan of care revealed the resident was a risk for falls and sometimes able to make needs known. The plan of care revealed the resident had no recent falls, but had fallen in the past with no major injury. The resident's comprehensive plan of care revealed no new interventions were added after each fall. The plan of care had a goal that the resident would be free of minor injury; however, there was not a goal to prevent the resident from falling. Review of the Rise and Shine list revealed Resident #9 was scheduled to get out of bed at 6:00 AM. Reveiw of the Nurse Aide Care Plan for Resident #9 revealed no mention of the resident having several falls from the bed. Review of the facility's event log for Resident #9's falls revealed all three (3) were a fall from the bed and occurred during the night.	F 280	correctly and that the care plan goal and approaches are updated and appropriate. The QA nurse or Infection Preventionist will audit the falls tracking log to ensure all trends were identified for individual residents and appropriate interventions were implemented. The audit will also consist of reviewing the care plan for updates to the goal and approaches after a fall. The audit will be conducted weekly for one month, monthly for one quarter and quarterly for one year. The findings will be reviewed in the Risk Management meeting each month to ensure compliance. Completion date: ~~10/23/13~~ 10/24/13	

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F 280	Continued From page 6 Observations of Resident #9, on 10/01/13 at 1:49 PM; 10/2/13 at 10:07, and 10/02/13 at 3:30 PM, revealed the resident was lying in his/her bed , with the bed in a low position, a bed alarm was in place, and a mattress was on the floor next to the bed. Interview with the MDS Coordinator, on 10/03/13 at 4:05 PM, revealed she was responsible for developing and revising the care plans. The MDS Coordinator revealed she did not change the goal for the resident to not fall, because she was in the mindset that he/she was going to and just wanted to keep the resident safe. Therefore, no new interventions were added when the resident fell. The MDS Coordinator revealed they just were not thinking about trying to prevent another fall. Interview with the Director of Nursing (DON), on 10/03/13 at 3:30 PM, revealed the Falls Committee did what they thought was best for the resident in thinking they should prevent an injury when the resident fell.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	F 323/ N220 The Falls Committee met on 10/3/13 regarding resident #9. The residents fall assessment form was updated on 10/3/13 and the primary goal was changed to state that the resident would have no falls. The additional approach for resident #9 included increased supervision on night shift to prevent falls. On 10/22/13 the resident's plan of care was updated to include overnight briefs to be worn for maximum comfort between incontinent care.	

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F 323	Continued From page 7 Based on observation, interview, record review, and review of the facility's policy Fall Prevention Program, it was determined the facility failed to ensure one (1) of the nineteen (19) sampled residents (Resident #9) received adequate supervision and assistive devices to prevent falls. The findings include: Review of the facility's policy Fall Prevention Program, not dated, revealed the facility would assess each individual resident to determine their risk for falls and/or injuries and intervene with approaches to reduce the risk of injury. Review of Resident #9's clinical record revealed the facility admitted the resident, on 05/11/12, with diagnoses of Dementia, Anxiety, Psychosis, Chronic Pain and Stroke. The facility assessed the resident utilizing the Minimum Data Set (MDS), on 09/17/13, as having a Brief Interview for Mental Status (BIMS) score of seven (7) indicating the resident had severe impairment of cognitive function. Reveiw of the MDS revealed the resident required extensive assist with bed mobility and transfers. The facility assessed the resident as being a high risk for falls and in turn the resident sustained falls on 07/04/13, 08/08/13, and 09/09/13. Observations of Resident #9, on 10/01/13 at 1:49 PM; 10/2/13 at 10:07 AM, and 10/02/13 at 3:30 PM, revealed the resident was lying in his/her bed, which was turned with the left side against the wall, the bed was in a low position, a bed alarm was in place, and a mattress was on the floor next to the bed. Review of the facility's Accident Circumstance	F 323	The facility Falls Committee conducted an audit of all residents identified as being high risk for falls. The care plans were updated to ensure all goals and approaches were appropriate in the prevention of falls. The completion date was 10/22/13. The Falls Committee met and reviewed all residents to identify those requiring more frequent supervision than our general population to prevent he/she from falling. A program has been implemented to ensure staff can quickly identify the residents who require more frequent supervision. A star has been placed by the door of each resident that requires more frequent supervision. Additionally, the comprehensive care plan and nurse aide care plan have been updated to identify specifically what approaches the Falls Committee has implemented for each residents fall prevention goal. The Director of Nursing, Assistant Director of Nursing and Wound Nurse conducted an in-service with all nursing staff to identify those residents that are at high risk for falls. The in-service was completed on 10/21/13. The Director of Nursing on 10/4/13 made the systemic change to the fall prevention program. An addendum was added to the current fall prevention program to update the fall assessment form. This will identify potential changes in the residents risk for falls. This assessment will be completed upon admission, quarterly and has changes in the residents condition is identified.	

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F 323	Continued From page 8 Assessment form revealed, on 07/04/13, the resident was found lying on the mattress on the floor, next to the resident's bed around midnight. The resident was found to have a small skin tear on the hand which was treated. Review of the facility's Event Log of the fall revealed no action was taken to prevent a further fall. Review of the Accident Circumstance Assessment, dated 08/08/13, revealed the resident was found on the floor mattress next to the bed at 4:30 AM with a wet incontinence brief. Review of the Event log revealed the resident rolled out of the bed, onto the mat bedside the bed. Further review of the event log revealed no new action/intervention was put into place because the mat was effective. Review of the Accident Circumstance Assessment, dated 09/09/13, revealed the resident was again found on the floor mattress next to the bed, at 04:15 AM, with a wet incontinence brief and a skin tear to the resident's toe. The facility's Event Log revealed the resident had rolled out of the bed onto the mat. Again the facility documented the mat was effective and did not initiate an action or intervention to prevent further falls. Interview with Certified Nursing Assistant (CNA) #3, on 10/3/13 at 2:52 PM, revealed she was not aware of the resident falling from the bed and performed only the routine safety checks. The CNA revealed the resident did like to go to bed early around seven (7) or (8) in the evening and was usually an early riser. Interview with the Director of Nursing (DON), on 10/03/13 at 1:35 PM, revealed the residents' falls	F 323	The QA nurse or Director of Nursing will audit the Star program to ensure interventions are implemented and evaluate the effectiveness. An additional audit will be completed to identify hazards within the environment to prevent avoidable accidents. This audit will be conducted by the QA nurse and involving an all discipline to monitoring hazards. The audits will be conducted weekly for one month, monthly for one quarter and quarterly for one year. The findings will be reviewed in the Risk Management meeting each month to ensure compliance. Completion date: 10/23/13	

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F 323	Continued From page 9 were reviewed during the morning meeting and the resident's current interventions were reviewed at that time. The DON stated the nursing staff and the CNA's provided feedback as to what interventions were working and which ones were not working to assist the Falls Committee in determining which interventions to put into place. Further interview, at 3:30 PM, revealed Resident #9 had a mattress on the floor to prevent injury when the resident fell from the bed. The DON revealed the interventions on the plan of care had been effective as the resident had only a few skin tears after his/her multiple falls from the bed. The DON stated she felt it was best for the resident to have a goal to prevent injury from falls as opposed to preventing the falls. The DON went on to explain the resident was already on one (1) hour safety checks; however, after she reviewed the plan of care and the Nurse Aide Care Plan, the DON revealed she was mistaken. The DON further stated she had noticed the time correlation with the falls occurring around 4:00 AM, but did not feel it was appropriate to put him/her as an early riser on the Rise and Shine list because he/she could get up whenever he/she wanted and did not need to be on the list. Interview with the MDS Coordinator, on 10/03/13 at 4:05 PM, revealed the facility did have a Falls Committee and she did attend the meetings. The MDS Coordinator revealed she brought the charts to the meeting and the care plans for review. The MDS Coordinator stated she was responsible for development and revision of the resident's plan of care. The MDS Coordinator indicated she was in the mind set that the resident was going to try and get out of the bed and fall, so she was more focused on preventing an injury instead of trying to prevent the fall from happening in the first	F 323		

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F 323	Continued From page 10 place. The MDS Coordinator revealed no new interventions or actions were put into place because the resident was not injured despite having fallen out of bed several times.	F 323		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 11/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	185360		R 11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE	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 Based upon impementation of the acceptable POC, the facility was deemed to be in compliance, 10/24/13 as alleged.	{F 000}		

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

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

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

PRINTED: 10/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185360		10/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 10/01/13. Gallatin Health Care was found not to be in compliance with the requirements for participation in Medicare and Medicaid.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wallace W. Daniel | TITLE: Administrator | (X6) DATE: 10/23/13

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

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K 000	Continued From page 1 Fire) Deficiencies were cited with the highest deficiency identified at E level. CFR: 42 CFR 483.70(a)	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, approximately forty-five (45) residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was ninety-two (92) on the day of the survey. The findings include: Observation, on 10/01/13 at 1:25 PM, with the	K 025	K 25 The facility did not have any residents affected by the smoke barriers that would not resist the passage of smoke on 600 hallway. The systemic change was the Maintenance Director sealed the area with Metacaulk 1000 fire stopping sealant. The Maintenance Director audited all areas of building to ensure compliance and that was achieved on 10/3/13. The Administrator in serviced the Maintenance Director and Maintenance Assistant on 10/22/13 to ensure compliance with proper sealing of smoke barriers. The Maintenance Director will conduct an audit of all pipes, conduits, ducts, cables, wires and all service equipment that pass through floors and smoke barriers to ensure they are properly sealed to prevent passage of smoke. This audit will be completed bi-weekly for one month and quarterly for one year. The results will be reviewed during Risk Management on a monthly basis to ensure compliance. Completion Date: ~~10/22/13~~ 10/23/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 025	Continued From page 2 Maintenance Supervisor revealed the fire resistant, rated smoke barrier located in the 600 Hall, had been penetrated above the ceiling by newly installed data lines. The space around the penetrations had not been filled with a material not rated equal to the smoke barrier and could not resist the passage of smoke. Interview, on 10/01/13 at 1:25 PM, with the Maintenance Supervisor revealed he was unaware of the penetrations in the smoke barrier. Reference: NFPA 101 (2000 Edition). 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. (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 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. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		

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K 029 Continued From page 3

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

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

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 three (3) of six (6) smoke compartments, approximately sixty (60) residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was ninety-two (92) on the day of the survey.

The findings include:

1. Observation, on 10/01/13 at 10:27 AM, with the Maintenance Supervisor revealed the Electrical Room located in the Service Hall, had the electrical conduits penetrating the ceiling, sealed with a non-rated sealant.

Interview, on 10/01/13 at 10:27 AM, with the

K 029
K 029 K 29

The facility did not have any residents affected by the three smoke compartments that failed to meet the requirements in accordance with NFPA standards.

The Maintenance Director sealed the conduit located in the Electrical Room with an approved fire rated caulk on 10/3/13. He also audited other areas of the building that could be in violation and revealed all other areas in compliance. The Medical Records Room along with the Clean Linen Room was corrected by 10/3/13 with self-closing devices. An audit of all potential hazardous rooms revealed compliance with self-closing devices. The Administrator on 10/22/13 to ensure understanding of potential hazardous areas and the use of approved fire rated caulk conducted an in-service with the Maintenance Director and Maintenance Assistant.

The Maintenance Director will audit bi-weekly for one month and quarterly for one year to ensure compliance with self-closing devices and use of approved sealant. The results will be reviewed during Risk Management on a monthly basis to ensure compliance.

Completion Date: ~~10/22/13~~ 10/23/13

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K 029	Continued From page 4 Maintenance Supervisor revealed he was not aware of the penetrations being sealed with a non-rated sealant. 2. Observation, on 10/01/13 at 11:02 AM, with the Maintenance Supervisor revealed the door to the Medical Records Room located in the Atrium, did not have a self-closing device installed on the door. Further observation, on 10/01/13 at 12:02 PM, with the Maintenance Supervisor revealed the door to the Clean Linen Room located in the 400 Hall, did not have a self-closing device installed on the door. Interviews, on 08/07/13 at 11:02 AM and 12:02 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for the doors to the Medical Records Room and the Clean Linen Rooms to be equipped with self-closing devices. 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	K 029		

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K 029	Continued From page 5 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), 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 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the path of egress was maintained in accordance with NFPA	K 038	K 38 The facility did not have any residents affected by the exit access. The Maintenance Director and Maintenance Assistant removed the shelf on 10/21/13. The Maintenance Director conducted an audit of the building to ensure that all means of egress were free of obstructions and impediments. The audit on 10/1/13 revealed compliance with all other exits. The Maintenance Director will conduct a bi-weekly audit for one month and quarterly for year on all exits. The findings will be reviewed in the monthly Risk Management meeting to ensure compliance. Completion Date: ~~10/21/13~~ 10/22/13	

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K 038	Continued From page 6 standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, approximately twenty-five (25) residents, staff, and visitors. The facility has one -hundred and twenty (120) certified beds and the census was ninety-two (92) on the day of the survey. The facility failed to ensure the means of egress were free of obstructions and impediments. The findings include: Observation, on 10/01/13 at 2:22 PM, with the Administrator revealed the Reception counter top projected nine (9) inches into the required clear, egress width. Interview, on 10/01/13 at 2:22 PM, with the Administrator revealed she was not aware of the countertop reducing the required clear, egress width. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.	K 038		

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K 038	Continued From page 7 Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below. Reference: S&C-12-21-LSC	K 038	K 45 The facility did not have any residents affected by the single lighting fixture at the exit point of 100 hallway. The Maintenance Director switched the single light fixture to a double light fixture on 10/2/13. The Maintenance Director will audit the exit areas to ensure proper lighting weekly for one month and monthly for one year. The finding will be discussed in Risk Management meeting monthly to ensure compliance. Completion Date: 10/2/13	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of the six (6) smoke compartments, approximately twenty (20)	K 045		

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K 045	Continued From page 8 residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was ninety-two (92) on the day of the survey. The facility failed to provide the required level of illumination outside the exit for egressing. The findings include: Observation, on 10/01/13 at 11:34 AM, with the Maintenance Supervisor revealed the 100 Hall emergency exit did not have an exterior light fixture for egress that provided the required illumination level for each exit discharge. The exit was equipped with a light fixture with only one bulb. All other emergency exits were illuminated with two (2) bulb fixtures. Interview, on 10/01/13 at 11:34 AM, with the Maintenance Supervisor revealed he was not aware of the requirement for exterior light fixtures for emergency egress to have two (2) bulbs. Reference NFPA 101 (2000 edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes	K 045		

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K 045	Continued From page 9 of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, approximately thirty (30) residents, staff and visitors. The facility has one-hundred and twenty (120) certified beds and the census was ninety-two (92) on the day of the survey. The facility failed to ensure escutcheon plates were installed at all sprinkler heads. The findings Include: Observation, on 10/01/13 at 11:56 AM, with the Maintenance Supervisor revealed there was an escutcheon plate missing on one (1) sprinkler head located in the 300 Hall Conference/Social Services Room. Interview, on 10/01/13 at 11:56 AM, with the Maintenance Supervisor revealed he was unaware of the escutcheon plate missing at the sprinkler head. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development.	K 062	K 62 The facility did not have any residents affected by the missing escutcheon plate on a sprinkler head. The Maintenance Director placed an escutcheon plate on the sprinkler head on 10/22/13. The Maintenance Director conducted an audit of all sprinkler head escutcheon plates to ensure compliance on 10/2/13. The audit revealed compliance and no residents were affected. The Administrator in serviced the Maintenance Director on the requirement of escutcheon plates. The in-service was conducted on 10/22/13. The Maintenance Director will audit all sprinkler heads bi weekly for one month and monthly for one year to ensure compliance. The findings will be reviewed in the monthly Risk Management meeting.	10/23/13

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185360		10/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALLATIN HEALTH CARE	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 062	Continued From page 11 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062		
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, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, approximately forty (40) residents, staff, and visitors. The facility has one-hundred and twenty (120) certified beds and the census was ninety-two (92) on the day of the survey. The findings include: 1. Observation, on 10/01/13 at 12:56 PM, with the Maintenance Supervisor revealed the hydrocollator (therapy equipment containing hot water) located within the Physical Therapy Storage Room, was not plugged into a ground fault circuit interrupter (GFCI) outlet as required in wet areas. Interview, on 10/01/13 at 12:56 PM, with the	K 147	K 147 The facility did not have any resident affected by the deficient practice. The Maintenance Director installed a ground fault receptacle on 10/2/13 for the hydrocollator. The Administrator conducted an in-service with all staff regarding the appropriate use of power strips and that medical equipment is to be plugged directly to a wall outlet. The in-service was completed as of 10/22/13 The Maintenance Director will audit all outlets bi weekly for one month and quarterly for one year to ensure compliance with approved equipment. The findings will be reviewed in the Risk Management meeting monthly to ensure compliance. Completion Date: ~~10/22/13~~ 10/23/13	

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	185360		10/01/2013

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

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K 147	Continued From page 12 Maintenance Supervisor revealed he was not aware of the hydrocollator being plugged into a standard electrical outlet and acknowledged the requirement of medical equipment containing water to be plugged in a GFCI outlet. 2. Observation, on 10/01/13 at 1:11 PM, with the Maintenance Supervisor revealed medical equipment (an oxygen concentrator) was plugged into a power strip located in Resident Room 610. Interview, on 10/01/13 at 1:11 PM, with the Maintenance Supervisor revealed he was aware of the requirements for the usage of power strips; however, he was not aware of medical equipment being plugged into a power strip located in Resident Room 610. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

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DIVISION OF HEALTH CARE FACILITIES INVESTIGATIONS

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

PRINTED: 11/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	185360		R **11/05/2013**

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

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{K 000}	INITIAL COMMENTS Based upon impementation of the acceptable POC, the facility was deemed to be in compliance, 10/24/13 as alleged.	{K 000}		

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

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