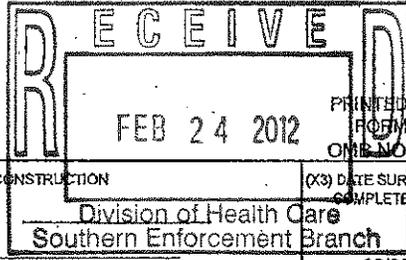


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED 02/03/2012
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 62 MAUDE ROAD, P O BOX 1718 INEZ, KY 41224		
(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 on 01/31/12-02/03/12. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	Martin County Health Care Facility does not believe and does not admit that any deficiencies exist. Martin County Health Care Facility reserves the right to contest survey findings through formal dispute resolutions, formal legal appeal proceedings, or any administrative legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds. Nor is meant to establish any standard of care, contact obligation or position, and Martin County Health Care Facility reserves all rights to raise all possible contentions and defenses in any type or civil or criminal claim, action, or proceeding. Nothing contained in this plan or correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileged which Martin County Health Care Facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to our residents.		
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, record review, and a review of the facility's policy, it was determined the facility failed to convey the resident's funds, and a final accounting of those funds, to the individual or probate responsible for the resident's estate within thirty days of death for two of eighteen sampled residents (Resident #15 and Resident #18). Resident #15 expired on 12/16/11, however, the facility failed to convey the resident's funds or account information until 02/01/12 (17 days after the acceptable timeframe of 30 days). Resident #18 expired on 10/30/11, however, the facility failed to convey the resident's funds or account information until 02/01/12 (63 days after the acceptable timeframe of 30 days). The findings include: A review of the facility's policy titled Resident	F 160			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *William J. Administrator* TITLE: *Administrator* (X6) DATE: *2/24/12*

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.

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F 160	<p>Continued From page 1</p> <p>Funds: Management of Personal Funds (dated 01/09/03) revealed it was the policy of the facility to manage the personal funds of a resident as requested by the resident. There was no timeframe regarding the conveyance of the funds after a resident's death in the policy.</p> <p>A review of the financial record for Resident #15 revealed the resident expired on 12/16/11. However, there was no evidence the facility had conveyed the balance of Resident #15's account to the person responsible for the resident's estate until 02/01/12 (47 days after the resident's death, which was 17 days after the acceptable timeframe).</p> <p>A review of the financial record for Resident #18 revealed the resident expired on 10/30/11. However, there was no evidence the facility had conveyed the balance of Resident #18's account to the person responsible for the resident's estate until 02/01/12 (93 days after the resident's death, which was 63 days after the acceptable timeframe).</p> <p>An interview conducted with the bookkeeper on 02/03/12, at 12:10 PM, revealed she had performed the duties of bookkeeper for six months and was not aware of the requirement for the resident's funds to be conveyed to the individual or probate responsible for the estate within thirty days.</p> <p>An interview conducted with the Administrator on 02/03/12, at 2:05 PM, revealed she was aware the funds should have been sent to the residents' families within 30 days. The Administrator stated bookkeeping records were monitored quarterly</p>	F 160	<ol style="list-style-type: none"> 1) It is and was on the day of the survey the policy of MCHCF that upon death of a resident that the facility must convey within 30 days the resident's funds; and a final accounting of those funds. The executor of the estate over resident #18 and #15 were mailed checks on 2/3/12 for the amount the resident had in their account at the time of their death. 2) All residents who have expired have had their personal funds account audited by the administrator. 3) At the end of each month the Bookkeeper will send a report to the Administrator detailing any resident who died during the month and the amount of the accounts. 4) As a part of the facilities ongoing CQI program, the bookkeeper will review all resident accounts on a quarterly basis. 5) 2/20/12 	

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F 160	Continued From page 2	F 160		
F 164 SS=D	<p>for accuracy, however, these accounts had not been identified as an issue.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility policy, the facility failed to provide</p>	F 164	<p>1) It is and was on the day of the survey the policy of MCHCF to maintain the residents rights to personnel privacy and confidentiality of his or her personal and clinical records. The residents in question were examined and interviewed and they were found not to have been adversely affected by the deficient practice.</p> <p>2) All nursing assistants have been educated on the facilities personal privacy and confidentiality of records policy.</p> <p>3) A full staff in-service on 2/24/12 conducted by the Director of Nursing on educating the staff on the requirement to pull privacy curtains while doing incontinence care and using sheet covers during med pass to ensure confidentiality of the resident's medical information.</p> <p>4) As a part of the facilities ongoing CQI program, the CQI Nurse will conduct monthly audits with 5% of facilities nurse aid staff during incontinence care to observe that resident privacy is maintained. After six months of compliance the audits will be conducted quarterly.</p>	

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F 164	<p>Continued From page 3</p> <p>personal privacy for one of eighteen sampled residents (Resident #2). Observation on 02/01/12, at 1:30 PM, revealed two Certified Nursing Assistants (CNAs) failed to pull the privacy curtain during incontinence care and as a result Resident #2 was exposed to the other resident in the room. In addition, the facility failed to ensure residents' health information was maintained in a private and confidential manner. Observations of the medication pass on the 100 Hallway on 01/31/12, from 3:05 PM through 3:20 PM, revealed the Medication Administration Records (MARs) were left opened on the medication cart in the hallway and, as a result, the residents' personal health information on the MAR was exposed to the public and other residents that passed by the cart in the hallway.</p> <p>The findings include:</p> <p>A review of the policy Resident Rights (dated 01/09/03) revealed the facility would "make every effort possible to assist residents with his/her rights to be treated with respect, kindness, and dignity."</p> <p>Observation on 02/01/12, at 1:30 PM, revealed CNA #8 and CNA #11 were in Resident #2's room performing incontinence care. The privacy curtain was not pulled closed between the beds of Resident #2 and the roommate and as a result Resident #2 was exposed to the resident's roommate. During the incontinence care, Licensed Practical Nurse (LPN) #2 came into the room, observed the privacy curtain open, and pulled the curtain closed between the two resident beds while the two CNAs continued to provide incontinence care for Resident #2.</p>	F 164	<p>As a part of the facilities on going CQI program, the CQI Nurse will conduct monthly audits with 5% of the facilities KMA's staff during med pass to ensure that the confidentiality of the resident's medical information is maintained. After six months of compliance the audits will be conducted quarterly.</p> <p>5) 2/25/12</p>		

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	<p>Continued From page 4</p> <p>Interview with CNA #8 and CNA #11 at 1:30 PM on 02/01/12, revealed both CNAs had been trained by the facility to pull privacy curtains between beds closed to ensure resident privacy was protected. The CNAs stated they knew they should have closed the curtain but failed to do so, leaving Resident #2 exposed.</p> <p>Interview with LPN #2 on 02/01/12, at 3:00 PM, revealed nurses conducted observations of CNAs performing job duties periodically and any problems identified were dealt with at the time through in-services, counseling, or disciplinary actions. The LPN stated privacy had not been an issue.</p> <p>Interview with the Director of Nursing (DON) on 02/03/12, at 11:00 AM, revealed all staff should pull privacy curtains closed to provide privacy during incontinence care.</p> <p>Observation of medication administration on 01/31/12, on the 100 Hall of the facility revealed at 2:50 PM, Kentucky Medication Assistant (KMA) #1 administered medications to the resident in resident room 110-B. The KMA was observed to take medications from the medication cart in the hallway, enter the resident's room, and leave the resident's Medication Administration Record (MAR) open on the medication cart and in plain view of individuals in the hallway, including one resident observed in the hallway near the medication cart. The KMA was also observed at 3:05 PM, to take the medications from the cart into resident room 102-B and as a result the resident's MAR was open and in plain view of two visitors observed in</p>				

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F 164	Continued From page 5 the hallway near the cart. The KMA was observed at 3:10 PM, to take medications from the medication cart in the hallway, enter resident room 104-A, and leave the MAR open and in plain view of two visitors and one resident in the hallway. The KMA was then observed to take medications from the cart at 3:20 PM, to the resident in room 108 and left the resident's MAR open and in plain view of two residents and two visitors in the hallway. An interview conducted with KMA #1 on 01/31/12, at 3:45 PM, revealed the KMA had been instructed by the facility to cover the MAR with a plastic cover while going into the resident rooms to protect the resident's privacy. The KMA stated she had forgotten to use the cover. An interview with the DON on 02/03/12, at 1:40 PM, revealed staff was to place a plastic cover on the MARs when they stepped away from the medication cart. The DON stated the facility did not monitor staff's compliance with this requirement and she was not aware staff did not utilize the plastic covers to cover the MARs in an effort to maintain privacy and confidentiality of the residents' medical information.	F 164			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282	1) It is and was on the day of the survey the policy of MCHCF that services provided or arranged by the facility are provided by qualified persons in accordance with each residents written plan of care. The resident in question was assessed by medical staff and was found not to have been adversely affected by the deficient practice. All residents have been assessed and are using appropriate assessed devices.		

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F 282	<p>Continued From page 6</p> <p>Based on observation, interview, record review, and a review of facility policies, the facility failed to ensure services were provided to one of eighteen sampled residents (Resident #2) in accordance with the resident's plan of care. Documentation revealed the facility had developed a plan of care with interventions for Resident #2 that included a soft waist belt and a pressure alarm while the resident was in the wheelchair. However, the soft waist belt and pressure alarm were not in place on 11/28/11, and Resident #2 sustained a fall with no injuries.</p> <p>The findings include:</p> <p>Review of the facility policy Fall Program (undated) revealed the facility would update and follow the care plan related to interventions to prevent avoidable falls.</p> <p>A review of Resident #2's medical record revealed staff had completed a pre-restraining assessment on 11/07/11, with the recommendation for a soft waist belt to be utilized while the resident was in a wheelchair due to the resident's decrease in safety awareness. A review of the medical record revealed facility staff had completed a comprehensive assessment of Resident #2 on 11/14/11, and had developed a comprehensive care plan, dated 11/04/11, that indicated the resident had been assessed to require a personal alarm and a soft waist belt while up in a wheelchair related to the resident's history of falls with injury prior to admission, confusion, the resident being oblivious to safety needs, and having falls since being admitted to the facility. According to the facility, the resident was unable to remove the soft waist belt and</p>	F 282	<p>2) All residents were assessed for proper utilization of assistive devices and all were found to be in accordance with each residents written plan of care.</p> <p>3) A full staff in service on 2/24/11 conducted by the Director of Nursing on following the facilities fall program and the utilization of assistive devices.</p> <p>4) As a part of the facilities ongoing CQI program the CQI Nurse will do monthly audits on 100% of the residents who require assistive devices to ensure proper utilization.</p> <p>5 2/25/12</p>		

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F 282	<p>Continued From page 7 personal alarm.</p> <p>A review of an accident/incident report revealed Resident #2 had been sitting up in a wheelchair and facility staff found the resident lying on the floor of the resident's room on 11/28/11. The incident report revealed the resident did not have a soft waist belt or a personal alarm on when he/she fell from the wheelchair. Resident #2 was sent to the local Emergency Room on 11/28/11, and returned to the facility on the same day with no injuries noted from the fall.</p> <p>Observations of Resident #2 on 02/01/12, at 11:00 AM, revealed the resident to be in a wheelchair with a soft waist belt and personal alarm in place. The resident was in the physical therapy room and was sitting in the wheelchair. On 02/02/12, at 12:00 PM, Resident #2 was self-pedaling down the hallway in the wheelchair with the soft waist belt and personal alarm in place.</p> <p>Interview with the Occupational Therapy Assistant (OTA) on 02/03/12, at 11:00 AM, revealed the OTA transported Resident #2 in a wheelchair to the therapy room for a one to one therapy session on 11/28/11, at 9:30 AM. The OTA did not place the personal alarm or soft waist belt on Resident #2. The OTA stated that after the therapy session the activity aide transported Resident #2 by wheelchair out of the therapy room without the personal alarm or soft waist belt being in place. The OTA stated, "I thought the Activity Aide was going to put Resident #2 back into bed." Based on interview with the OTA, after the resident was transported out of the therapy room the resident sustained a fall from the</p>	F 282			

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F 282	Continued From page 8 wheelchair. The OTA received counseling about safety interventions being put into place for all residents. Interview with the Activity Aide on 02/03/12, at 11:15 AM, revealed Resident #2 had completed therapy on 11/28/11, at 10:00 AM, and she transported the resident to the activity room in a wheelchair. The Activity Aide stated Resident #2 "always" wore a soft waist belt and alarm and she had not "paid attention" and failed to determine if the soft waist belt or alarm was in place. The Activity Aide said she took the resident to the activity room and then left the room to get another resident for the activity. According to the Activity Aide Resident #8 did not always stay in the activity room and must have wheeled his/her self to his/her room and fallen from the wheelchair. The Activity Aide stated the resident had fallen from the wheelchair because the soft waist belt and personal alarm were not in place. The Activity Aide stated, "Now I check every resident for their fall interventions."	F 282			
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.	F 323	1) It was and is the policy of MCHCF on the day of the survey that the facility ensure that the resident environment remains free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. The resident in question was assessed by medical staff and was found not to have been affected by the deficient practice.		

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F 323	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, a review of facility investigations, and a review of facility policies, the facility failed to ensure adequate supervision and assistive devices were provided for one of eighteen sampled residents (Resident #2). Documentation revealed that based on the resident's comprehensive assessment Resident #2 was at risk of falls and required the use of a soft waist belt and a pressure alarm when up in a chair. However, on 11/28/11, staff failed to implement the fall interventions and Resident #2 sustained a non-injurious fall from a wheelchair.</p> <p>The findings include:</p> <p>A review of the facility policy Fall Program (undated) revealed all interventions for falls would be put into place and documented for each resident.</p> <p>Review of the medical record for Resident #2 revealed a comprehensive care plan dated 11/04/11, and a comprehensive assessment dated 11/14/11, that indicated the resident was at risk for falls and interventions had been recommended. A review of the comprehensive care plan revealed the recommended fall interventions included the use of a pressure alarm and a soft waist belt when the resident was up in a wheelchair. However, a review of an accident/investigation report revealed Resident #2 sustained a fall on 11/28/11, after staff failed</p>	F 323	<ol style="list-style-type: none"> 2) All residents were assessed for proper utilization of assistive devices and all were found to be in accordance with each residents written plan of care. 3) A full staff in service on 2/24/12 on conducted by the Director of Nursing on following the facilities fall program and utilization of assistive devices. 4) As part of the facilities ongoing CQI program, the CQI nurse will do monthly audits on 100% of the residents who require assistive devices to ensure proper utilization. 5) 2/25/12 		

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F-323	Continued From page 10 to ensure the soft waist belt and the personal alarm were in place for the resident. Resident #2 was sent to the local Emergency Room on 11/28/11, and returned on the same day with no injuries identified. Interview with the Occupational Therapy Assistant (OTA) and the Activity Aide on 02/03/12, at 11:00 AM and 11:15 AM, revealed Resident #2 had been taken to the Therapy Department on 11/28/11, in a wheelchair for therapy. Continued interview revealed after the resident completed the therapy session the Activity Aide assisted Resident #2 to the activity room in a wheelchair. The OTA and the Activity Aide stated they did not ensure Resident #2's fall interventions of a soft waist belt or personal alarm were in place, and Resident #2 sustained a fall from the wheelchair. Interview with the Director of Nursing (DON) on 02/02/12, at 5:00 PM, revealed staff was to ensure all fall interventions were put into place for each resident that had been identified to be at risk for falls. The DON acknowledged the OTA and the Activity Aide had failed to implement fall interventions for Resident #2 at the time of the resident's fall.	F 323			
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 366	1) It is and was on the day of the survey the policy of MCHCF to provide food substitutes of similar nutritive value to residents who refuse food served. The resident was assessed by staff and was found not to have been adversely affected by the deficient practice. No other resident dislikes have been served to the residents.		

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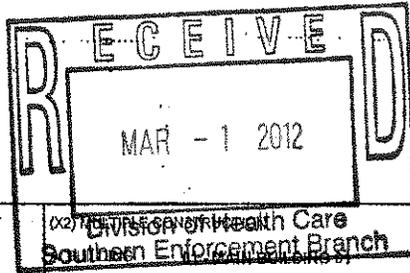
PRINTED: 02/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/03/2012
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 62 MAUDE ROAD, P O BOX 1718 INEZ, KY 41224	
(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 366	<p>Continued From page 11</p> <p>and policy review, it was determined the facility failed to ensure food preferences were honored for one of eighteen sampled residents (Resident #10). Observation of the noon meal on 01/31/12, at 1:10 PM, revealed Resident #10 was served cooked carrots; however, a review of the meal card for Resident #10 revealed the resident disliked carrots.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Alternate Foods" (no date) revealed substitutions would be provided for any food dislikes of the resident.</p> <p>A review of the medical record for Resident #10 revealed the facility had admitted the resident on 11/20/08, with diagnoses that included End Stage Renal Disease with Dialysis, Hypertension, Diabetes Mellitus, Depression, and Congestive Heart Failure. In addition, the medical record revealed a physician's order for the resident to receive a No Concentrated Sweets, No Added Salt, Low Potassium diet with chopped meats.</p> <p>Based on the facility's comprehensive assessment Resident #10's cognition was impaired. An interview with Resident #10's spouse on 01/31/12, at 1:10 PM, revealed Resident #10 did not like gravy. The resident's spouse also stated he/she had told the staff several times of the resident's dislike for carrots but the staff continued to send carrots on the resident's tray.</p> <p>Observation of the lunch meal on 01/31/12, at 1:10 PM, revealed the resident was served cooked carrots. A review of the resident's tray</p>	F 366	<p>2) All resident dislikes have been reviewed by the Dietary Manager and all dislikes have been highlighted on the tray care for easy identification for the next 3 months.</p> <p>3) A Dietary staff in-service was conducted by the Dietary Manager on 2/24/12 on following a residents likes/dislikes when receiving a meal tray and proper procedure on food substitutions.</p> <p>4) As a part of the facilities ongoing CQI program the Dietary Manager will do monthly audits on 50% of the meal trays to ensure that the resident isn't receiving any foods that they do not prefer. After six months of compliance the audits will be conducted quarterly.</p> <p>5) 2/25/12</p>	

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NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 62 MAUDE ROAD, P O BOX 1718 INEZ, KY 41224		
(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 366	<p>Continued From page 12 card specified a dislike of carrots.</p> <p>An interview conducted with State Registered Nursing Assistant (SRNA) #12 on 02/03/12, at 11:20 AM, revealed the SRNA stated she was the SRNA who delivered the lunch tray to Resident #10 on 01/31/12. The SRNA stated she had been instructed to check the resident's tray card prior to delivering the tray. The SRNA also stated she could not remember checking the resident's tray card prior to delivering the tray to Resident #10. The SRNA stated, "I guess I forgot."</p> <p>An interview conducted with the Dietary Manager (DM) on 02/03/12, at 10:30 AM, revealed she interviewed all residents, or their representatives, in the facility at least once every year and more often if there was a resident complaint, for food likes and dislikes. The DM stated she placed the information on the resident's tray card for use by the dietary staff during the tray line. The DM also stated Resident #10 should not have received carrots and the resident's food preferences should have been honored. In addition, the DM stated she monitored the tray line once every week to ensure the accuracy of the food served to residents and had not identified food preferences as being a problem.</p>	F 366			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) TITLE AND/OR HEALTH CARE FACILITY NAME (SEE INSTRUCTIONS) Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED 02/01/2012
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 62 MAUDE ROAD, P O BOX 1718 INEZ, KY 41224	

(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	INITIAL COMMENTS BUILDING: 01 PLAN APPROVAL: 1991 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (111) SMOKE COMPARTMENTS: Five COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II Diesel generator A life safety code survey was initiated and concluded on 02/01/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000	Martin County Health Care Facility does not believe and does not admit that any deficiencies exist. Martin County Health Care Facility reserves the right to contest survey findings through formal dispute resolutions, formal legal appeal proceedings, or any administrative legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds. Nor is meant to establish any standard of care, contact obligation or position, and Martin County Health Care Facility reserves all rights to raise all possible contentions and defenses in any type or civil or criminal claim, action, or proceeding. Nothing contained in this plan or correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileged which Martin County Health Care Facility offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to our residents.	
K 025 SS=E	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	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Beth Amlett, administrator* TITLE: *administrator* (X6) DATE: *3-1-12*

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.

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NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 62 MAUDE ROAD, P O BOX 1718 INEZ, KY 41224	
(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 025	<p>Continued From page 1</p> <p>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 access doors in the fire/smoke wall assembly in the attic area. This deficient practice affected four of five smoke compartments, staff, and approximately forty residents. The facility has the capacity for 72 beds with a census of 68 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 02/01/12, at 10:40 AM, with the Director of Maintenance (DOM), an access door located in a fire/smoke barrier wall in the attic area of the 100 Wing was observed to be removed from the wall and lying on top of the ceiling joists. This type of access door is designed for the specific purpose to help prevent fire/smoke from spreading to other areas of the building in a fire situation. During the survey an access door leading to the 400 Wing was observed to be left open. This door would not close and latch when tested. The 200 and 300 Wing fire/smoke barrier walls were not reasonably accessible for inspection. Fire/smoke barrier walls must be reasonably accessible for</p>	K 025	<ol style="list-style-type: none"> 1) It is and was on the day of the survey the policy of MCHCF to maintain access doors in the fire/smoke wall assembly in the attic area. A complete review of the area in question was made by the DOM and all the access doors in the attic area were maintained. Additional attic access points were established (in Hall 2 shower room). No residents were harmed by the deficient practice. 2) A complete review of the attic was made and no other fire/smoke violations were found. 3) After every vendor/contractor utilizes the facilities attic space the DOM will make a walk thru in the attic to ensure that the fire/smoke barrier has not been compromised. 4) As a part of the facilities on going CQI the DOM will conduct a monthly audit of the attic area to ensure that the fire/smoke barrier has not been compromised. 5) 3/01/12 	

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NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 62 MAUDE ROAD, P O BOX 1718 INEZ, KY 41224		
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K 025	Continued From page 2 Inspection and maintenance purposes. An interview with the DOM on 02/01/12, at 10:40 AM, revealed the facility recently had contractors in the attic and the DOM did not check to see if the fire/smoke barrier wall had been compromised. The DOM stated it was hard to maintain the attic areas due to the limited number of access points in the facility.	K 025			