

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

PRINTED: 06/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/09/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(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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{F 000} INITIAL COMMENTS

{F 000}

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance as alleged on 06/02/15.

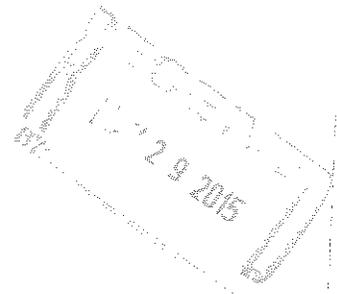
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 04/21/15 and concluded on 04/23/15. Deficiencies were cited with the highest Scope and Severity cited at an "E".	F 000		
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents were able to make choices regarding their likes and dislikes of food for one (1) of ten (10) sampled residents (Resident #6). Resident #6 was observed to receive an item on the resident's disliked food list on the lunch tray. The findings include: Interview with the Dietary Manager (DM) revealed the facility had no policy related to residents' food preferences; however, it would be her expectation staff would honor the resident's food preference requests. Review of Resident #6's disliked food list revealed the resident disliked peas, carrots.	F 242	See attached	5/23/15



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *LNA/CEO* (X6) DATE: *5/29/2015*

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F 242	<p>Continued From page 1 beans and greens.</p> <p>However, observation on 04/21/15 at approximately 12:20 PM, revealed Resident #6 received food which included green beans on the lunch tray. Continued observation revealed Resident #6 pushed the green beans aside to eat the other food on the lunch tray.</p> <p>Interview with Resident #6, on 04/21/15 at approximately 12:22 PM, revealed the resident did not like green beans, or any type of bean. Resident #6 revealed staff "always" brought him/her beans. Per interview, it didn't "matter what you write down", staff always brought it anyway.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 04/21/15 at 12:45 PM, revealed she gave Resident #6 the lunch tray, and the resident did not say anything to her about the beans when she delivered the tray. She stated she did not know if Resident #6's meal card noted the resident's "dislikes", and had not noticed "dislikes" on any of the residents' meal cards. CNA #1 revealed had she known Resident #6 had a dislike for green beans, she would have asked the resident if he/she wanted something different. Further interview revealed it was important residents received foods they liked because they could become malnourished or not eat anything at all if they didn't.</p> <p>Interview with the Dietary Aide, on 04/23/15 at 11:40 AM, revealed she placed the green beans on Resident #6's tray. She stated Resident #6 had a list of likes and dislikes on his/her meal card; however, she did not catch it when preparing the meal tray. Further interview</p>	F 242		
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F 242	<p>Continued From page 2</p> <p>revealed it was important residents received foods they liked because they would eat the food.</p> <p>Interview with the DM, on 04/21/15 at 12:31 PM, revealed the dietary staff were aware Resident #6 did not like green beans. She reported the resident should not have gotten green beans on his/her meal tray. The DM revealed it was important to honor Resident #6's food likes/dislikes because otherwise it could affect the resident's weight.</p> <p>Interview with the Director of Nursing (DON), on 04/23/15 at 7:00 PM, revealed she would have hoped staff would have observed the food items on Resident #6's tray and informed dietary the resident did not like the green beans. Per interview, then an acceptable food could have been substituted.</p> <p>Interview with the Administrator, on 04/23/15 at 7:15 PM, revealed her expectation was for staff to have honored Resident #6's food requests and changed the disliked food for something else.</p>	F 242		
F 248	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's activity calendars, it was determined</p>	F 248	See attached	6/2/15

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the facility failed to provide an ongoing program of activities designed to meet the interests and physical, mental, and psychosocial well-being of each resident.

Resident interviews revealed they would like more activities and observation of the facility's activity calendar revealed minimal activities scheduled.

The findings include:

Interview with the Director of Nursing (DON), on 04/27/15 at 11:10 AM, revealed the facility did not have a policy related to provision of activities by the facility.

Interviews with eight (8) residents, identified by the facility as alert and oriented, in the Group Interview meeting held on 04/21/15 at 3:00 PM, by the State Survey Agency, revealed the facility did not offer any activities in the evenings. The residents revealed they had spoken to the Activities Director regarding having more activities, such as, Bingo and Corn Hole; however, their requests had never been granted.

Review of the Activity Calendar for April 2015 revealed activities scheduled for 04/22/15 included: Bookmobile at 9:30 AM in the dining room; Resident Council at 10:30 AM in the dining room; Earth Day at 1:30 PM in the residents' rooms; Care Plan meetings scheduled at 2:00 PM in the activity's room; Mail also at 2:00 PM in the residents' rooms; and Banana Bread at 3:00 PM. Continued review of the Activity Calendar revealed no documented evidence of other activities scheduled after 3:00 PM.

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Observation of the dining room, on 04/22/15 at 9:40 AM, when the Bookmobile was scheduled, revealed no residents present in the dining room and the only staff present was a housekeeper who was mopping the floor.

Observation, on 04/22/15 at 2:50 PM, revealed dietary staff delivering a cart with snacks for the residents. Continued observation revealed State Registered Nursing Assistant (SRNA) #2 distributing the snacks, which consisted of banana bread and soda, to the residents.

Interview with SRNA #2, on 04/22/15 at 2:55 PM, revealed the snack which was being served was the only snack being offered to the residents between the noon meal and the evening meal.

Interview, on 04/23/15 at 3:15 PM, with SRNA #5, revealed the facility had activities during the day which included having bible study at 11:00 AM on Mondays, the beauty shop on Tuesdays, Wednesday consisted of a "variety" of things and she recalled "dogs" coming in on most Wednesdays. SRNA #6 added, "Wednesdays were often left open". Continued interview with SRNA #5 revealed on Thursdays, the facility's activities consisted of bingo and beauty shop, and on Friday's the facility had "Corn hole" and "Hymn Singing", in the evening. Per interview, she was not aware of any activities which were offered to the residents in the evenings and she reported she did not work on the weekends, therefore, was not aware of the weekend activities. She stated she was aware however, that the church scheduled to come on the weekends did not show up usually. According to SRNA #5, the facility's residents had complained to her about activities and that they would like to see more

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activities. Additionally, SRNA #5 agreed the facility could use more activities for the residents and stated, "But that's not my call."

Interview with SRNA #2, on 04/23/15 at 3:30 PM, revealed the activities which were offered to the residents were Bingo, Corn Hole, and Church. Per interview, she did not work on the weekends, but added there were no activities for the residents after 4:00 PM during the week except for the "Hymn Singing" on Fridays. SRNA #2 stated she thought the residents would benefit from having more activities, as the facility was their home and more activities would enhance their quality of life.

Interview with Licensed Practical Nurse (LPN) #3, on 04/23/15 at 4:20 PM, revealed there were not any activities during the evenings. LPN #3 stated she thought the last activity was about 2:00 PM, but on Friday afternoon, at approximately 5:00 PM, there was a hymn singing activity. LPN #3 further stated on Saturdays, the residents were given a word search for an activity and on Sundays a church group usually came to the facility.

Interview with LPN #2, on 04/23/15 at 4:25 PM, revealed residents had told her they wished they had more activities in the facility. LPN #2 stated there were not any activities on the weekends unless a volunteer came in on a Saturday or a church group would come in on a Sunday. Further interview revealed staff had discussed the residents' requests to have more activities during the Monthly Nursing Staff meetings.

Interview with the Activity Director, on 04/23/15 at 6:10 PM, revealed the Bookmobile activity in the

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F 248	Continued From page 6 dining room, involved the changing out of books; however, was not an activity where the residents were actively engaged. The Activity Director stated the Earth Day activity was a word search for the residents to perform independently, but the facility did not offer an alternative activity for those residents with visual impairments and could not participate in the independent activity. Per interview, the mail was usually delivered to the residents around 2:00 PM, so the facility scheduled the Mail as an activity also. The Activity Director revealed the afternoon snacks delivered to the residents were also scheduled as an activity. According to the Activity Director, she scheduled church groups to come to the facility on Sundays, but if the groups did not show up or cancelled, there was not another activity substituted for the residents. Further interview revealed even though she was aware of the residents' requests to have more activities, she was not able to provide the additional activities due to her current work load. The Activity Director stated if residents wanted more activities during the evenings, there were puzzles and other games available for them to use. Continued interview with the DON, on 04/23/15 at 6:30 PM, revealed she was unaware of the residents' requests for additional activities. The DON stated she could not remember the residents' concerns being discussed during the Monthly Nursing Staff meetings. Even though staff revealed in interview it was brought up. The DON further stated more activities should be offered if the residents did not feel there were sufficient activities for them. Interview with the Administrator, on 04/23/15 at 7:10 PM, revealed her expectation would be if	F 248			

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residents wanted more activities. the facility should offer the activities which the residents were requesting.

F 248

F 253 483.15(h)(2) HOUSEKEEPING & SS=E MAINTENANCE SERVICES

F 253

See attached

5/28/15

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide housekeeping and maintenance services to ensure a sanitary, safe, clean, and homelike environment for residents.

Observations on 04/21/15 and 04/22/15, revealed cracked tiles in the kitchen, holes in the ceiling in the residents' bathrooms, dust/dirt in the corners of the hallways and dining room, three (3) broken handrails along the side of the walls, unused wash cloths/towels and an opened package of "chux" in the shower room. Additionally, in the resident Group Interview a slow "draining drain" in the shower room was reported.

The findings include:

Interview with the Maintenance Director revealed the facility had no policy on maintenance requests; however, it was his expectation staff would report all maintenance concerns to the maintenance department.

Review of the facility's policy titled, "Cleaning

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F 253	Continued From page 8 Dining Room", revised December 2014, revealed the purpose of the policy was to maintain a clean, sanitary and clean environment for resident's, visitor's and staff. Per the Policy, the environmental services staff were responsible for assisting in infection prevention from the environment, and were to clean and sanitize the residents' environment. The Policy noted the Environmental Services Department personnel would clean the dining room on a daily basis and would dust mop the floor as per the policy. Review of the facility's policy titled, "Cleaning Patients Rooms", revised December 2014, revealed the purpose of the policy was to maintain a clean, sanitary and clean environment for resident's, visitor's and staff. The Policy revealed the environmental services staff were to clean and sanitize the environment and the residents' rooms would be cleaned on a daily basis. Further review of the facility's policy revealed environmental service would clean the floor and dust mop daily. Observations during tour of the facility, on 04/21/15 at 9:45 AM, revealed the bathrooms of residents' rooms 271, 270, 268, 264, 265, and 263 had a metal square on top of the ceiling in the bathroom to cover a "hole". Continued observation revealed the hole in the ceiling was still partly exposed. Observation of the dining room, on 04/21/15 at 12:05 PM, revealed dirt particles along the walls and cracked tile along the wall. Continued observation of the facility revealed dirt/dust particles throughout the hallways of the facility. Observation with Housekeeper #1, on 04/22/15 at	F 253		

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9:57 AM, revealed there were two (2) unused towels and five (5) unused wash clothes stored in the shower room, on top of a cart.

Observation with State Registered Nursing Assistant (SRNA) #2, on 04/22/15 at 3:30, revealed an opened bag of "chux" (a protective barrier pad) left in the shower room.

Interview with residents in the Group Interview with the State Survey Agency Surveyor, on 04/21/15 at 3:00 PM, revealed the residents present voiced concerns the sewer line in the shower room was backing up. The residents reported they were not sure if anything was ever done about this concern though.

Interview with Housekeeper #1, on 04/22/15 at 10:15 AM, revealed the unused towels and wash cloths should not have been left in the shower room. She they should have been thrown in the dirty laundry cart. Continued interview with Housekeeper #1 revealed she noticed the dirt particles along the dining room walls and in the hallways. Per interview, maintenance hired someone to clean the facility's floors at night and she was only responsible for the cleaning of the resident's rooms. Housekeeper #1 revealed she noticed the cracked tile in the dining area and stated the Maintenance Director would be the one who would repair it. She revealed she had not put in a work order for the cracked tile however.

Interview with Housekeeper #2, on 04/22/15 at 10:30 AM, revealed the dirt particles observed throughout the building was the responsibility of housekeeping staff. Housekeeper #2 revealed it was important the residents had a safe/clean environment to live in. She stated "that's why we

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F 253	<p>Continued From page 10 are here, for the residents."</p> <p>Interview with SRNA #2, on 04/22/15 at 3:30 PM, revealed she would alert her nurse if there was any maintenance concerns she identified. She reported a work order should have been put in for the broken handrails and cracked tile in the kitchen. Per interview, the cracked tile was a safety concern for residents; however, she stated she did not fill out a work order because she "never paid attention to that", but should have. Continued interview revealed she had noticed the dust particles around the facility, but had never reported it to anyone. SRNA #2 revealed residents had not notified her of the water backing up in the shower room, but, she had noticed the water did not drain well when she was giving residents' showers. Per SRNA #2, this had been a concern for about a month or two (2) now, and she reported she often got her shoes wet. Further interview revealed it was important to ensure residents had a clean environment because it staff's job to meet the needs of the residents.</p> <p>Interview with SRNA #3, on 04/22/15 at 3:50 PM, revealed the shower in the shower room did not drain well and the water built up during residents' showers. She stated it did not happen all of the time, but it was a concern for approximately a month now. SRNA #3 revealed she had noticed the dirt/dust particles along the walls throughout the facility, and had seen housekeeping clean the areas. However, she stated she had noticed not all of the housekeeping staff would clean the dirt/dust particles up. Per interview, it was important to keep the environment clean to prevent residents from getting sick, and stated "this is their home, we don't let our home get</p>	F 253		

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nasty, so we should not let theirs". SRNA #3 stated she did not check the resident handrails, but stated it was important the handrails were functional for the safety of the residents and visitors. Continued interview revealed for cracked tiles she would put in a work order; however, stated she had not put a work order in for the cracked tile in the dining room area, as she did not look for maintenance concerns. Per SRNA #3, revealed the "chux" observed in the shower room should not have been in the shower room, and would have to be thrown away due to possible cross contamination. Further interview revealed the unused towels or wash cloths should not be stored in the shower room, and stated they should have been thrown in the dirty laundry basket.

Interview with the Maintenance Director, on 04/22/15 at 2:45 PM, revealed the holes in the bathrooms were where the fire alarms used to be in the residents' bathrooms. He stated the holes should have been covered to create more of a homelike environment for the residents. Per interview, he was not made aware of the three (3) handrails loosened from the wall, but this should have been reported to him so he could repair them. He stated housekeeping staff was responsible for ensuring the dirt/dust particles were cleaned up off the floor. The Maintenance Director revealed staff was expected to keep the facility clean for residents. Further interview revealed he was also unaware of the cracked tile along the wall in the dining room, but should have been notified so it could be repaired. According to the Maintenance Director, his expectation was staff would put in a work order to inform him of the concerns they observed so he could fix the problems. He stated if he was not notified, he

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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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F 253 Continued From page 12
would not know of environmental issues unless it was reported to him.

Interview with the Minimum Data Set Coordinator (MDS), on 04/23/15 at 6:00 PM, revealed the hole in the ceiling should have been repaired to create a homelike environment for the resident's. Continued interview revealed she had noticed the dirt particles along the walls of the dining room, resident's rooms, and hallways which should have been addressed with the housekeeping department. The MDS Coordinator revealed the SRNA's should clean up the shower rooms after they have completed a resident's shower. She stated the wash cloths and towels and the opened package of chux should not have been left in the shower rooms and should have been placed with the dirty linen due to cross contamination. Further interview with the MDS Coordinator revealed she was not aware of the shower drain backing up and water not draining; however, a maintenance request should have been made to maintenance to address the concern.

Interview with the Director of Nursing (DON), on 04/23/15 at 6:30 PM, revealed the facility had a Preventive Maintenance Program which included staff notifying the maintenance department or supervising staff of any maintenance concerns when they observed them. The DON revealed it was her expectation staff fill out a work order or e-mail the maintenance department with any maintenance concerns in order to generate a work order, as per the maintenance program. Per interview, housekeeping and maintenance staff should clean up the dirt/dust particles observed throughout the facility, as "if left untouched, it could lead to an unsafe, unsanitary

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F 253	<p>Continued From page 13</p> <p>environment which could lead to bugs and virus". The DON stated it was her expectation the facility's environment be cleaned everyday. Continued interview with the DON revealed the facility had a concern with the sewer being backed up in the past, but was not aware it was still a concern. She reported staff should have alerted her if it was still a concern so maintenance could have been notified in order to address the problem. Further interview with the DON revealed she would have expected the holes in residents' bathrooms to be covered because it could be an infection control issue where rodents would have access to the facility. The DON revealed the unused wash clothes, towels and chux should have been removed from the shower area for infection control concerns.</p> <p>Interview with the Administrator, on 04/23/15 at 7:15 PM, revealed it was her expectation maintenance would complete environmental rounds of the facility and staff would voice any concerns they observed. She stated housekeeping had a schedule to clean the facility and she expected the housekeeping staff to follow their cleaning schedule.</p>	F 253		
F 274 SS-D	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by</p>	F 274	See attached	5/21/15

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F 274 Continued From page 14

implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the Resident Assessment Instrument (RAI) User Manual Version 3.0, it was determined the facility failed to complete a Significant Change Minimum Data Set (MDS) Assessment for one (1) of ten (10) sampled residents (Resident #2).

Record review revealed Resident #2 showed a decline in his/her Activities of Daily Living (ADLs) status which indicated a significant change had occurred; however, the facility failed to complete the Significant Change MDS Assessment as per the RAI User Manual.

The findings include:

Interview with the Director of Nursing (DON) on 04/12/15 at 4:20 PM, revealed the facility had no MDS policy; however, referred to the RAI User Manual for guidance on "significant change" in residents.

Review of the RAI User Manual Version 3.0 dated April 2012, revealed a significant change was a decline or improvement in a resident's status which would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, impacts more than one area of a resident's health status,

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F 274 Continued From page 15
and requires interdisciplinary review and/or revision of the care plan. Per the User Manual, if a resident experienced a decline in two (2) or more of the following areas which included: decline in an ADL physical functioning area where a resident was newly coded as extensive assistance, total dependence or activity did not occur; change in incontinence patterns or placement of indwelling catheter; or the resident's overall condition had deteriorated a Significant Change MDS Assessment was to be performed.

Record review revealed the facility admitted Resident #2 on 04/15/13, with diagnoses which include Diabetes, Hypertension, Dementia, Hypothyroidism and Anxiety. Review of Resident's #2's Quarterly MDS Assessment dated 12/17/14, revealed the facility had assessed Resident #2 to have been able to transfer and dress with extensive physical assist of two (2) persons and to be independent with eating requiring set-up only. Additionally, the Quarterly MDS Assessment revealed the facility assessed Resident #2 to require extensive physical assistance of two (2) staff to ambulate in his/her room.

However, review of the Annual MDS Assessment dated 03/18/15, revealed the facility assessed Resident #2 to be totally dependent with transfers with two (2) person physical assist. Continued review of the Annual MDS Assessment revealed the facility also assessed Resident #2 to be totally dependent with eating with a one (1) person physical assist. Further review of the MDS revealed the facility assessed Resident #2 to no longer have the activity of ambulating in his/her room occur.

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F 274 Continued From page 16

Observation, on 04/22/15 at 8:55 AM and at 12:05 PM, revealed staff fed Resident #2 his/her breakfast and lunch meals.

Interview, on 04/22/15 at 11:20 AM, with Licensed Practical Nurse (LPN) #1 revealed Resident #2 had experienced a decline in his/her physical status and there should have probably been a Significant Change MDS Assessment performed. LPN #1 revealed Resident #2 went from being able to feed himself/herself to now being totally dependent on staff and had gone from occasionally incontinent of bowel and bladder to now being incontinent of bowel and bladder "most of the time, ninety-nine (99) percent of the time".

Interview with the MDS Coordinator on 4/22/15 at 11:30 AM, revealed she did not do a Significant Change MDS Assessment for Resident #2 as she had not anticipated the decline would last long and expected the resident would improve. However, since the decline lasted longer than the fourteen days (14) indicated in the RAI User Manual, a Significant Change MDS Assessment should have been completed.

Interview with the Director of Nursing (DON) at 4:20 PM, revealed Resident #2 should have had a Significant Change MDS Assessment completed, due to the resident having a decline in two (2) or more areas which had lasted longer than fourteen (14) days.

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F 323 Continued From page 17
F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

F 323
F 323

See attached

5/28/15

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:

Based on observation and interviews, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible.

Observation revealed the door leading to the laundry room, which contained potentially hazardous chemicals, was unlocked and unsecured allowing for the possibility of wandering residents to access the area and potentially hazardous chemicals.

The findings include:

Interview with the Maintenance Director revealed there was no policy on accident and hazards, but he stated all doors should be locked which contained hazardous materials.

Review of the list of wandering resident provided by the facility revealed the facility had identified four (4) residents who had the potential to wander, Resident #7 and Unsampled Residents E, F and G.

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F 323, Continued From page 18

Observation, on 04/22/15 at 9:55 AM, revealed the door, which had a punch keypad system, leading to the laundry room was unlocked if the door knob was turned. Continued observation revealed the door lead to the laundry room, which contained chemicals, such as, "Super Sani-Cloth's" (disinfectant/sanitizing disposable cloths) which were stored on a shelf, "Mimate Sanitation System Surguard Ultimate" (chemical sanitizer/disinfectant) and "Microtech Suds" (laundry detergent) were stored on the floor, behind the washing machine, and the "Shout" was stored on top of the shelf within the laundry room.

Review of the Material Safety Data Sheet (MSDS), titled "Shout Advanced Laundry Stain Remover", with a date issued of 11/30/2007, revealed that it may be harmful if swallowed. Aspiration into the lungs may cause chemical pneumonitis.

Review of the MSDS sheet, titled "Mimate Sanitation System Surguard Ultimate", dated April 2012, revealed the chemical may cause eye and skin burns and was harmful or fatal if swallowed.

Review of the MSDS sheet, titled "Microtech Suds", undated, revealed that if the product was ingested, it would be irritating to the mouth, throat and stomach, and would cause abdominal discomfort, nausea, vomiting, and diarrhea.

Review of the MSDS sheet, titled "Super Sani-Cloth", undated, revealed that if ingested, staff should consult a physician.

Interview with the Minimum Data Set (MDS) Coordinator, on 04/22/15 at 9:56 AM, revealed

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F 323 Continued From page 19

the door should have been locked. She reported she normally just put the code into the door. She stated she did not know the door did not catch. Continued interview with the MDS Coordinator revealed there were chemicals stored in the back that would be hazardous to the residents.

Interview with Housekeeper #1, on 04/22/15 at approximately 10:00 AM, revealed the door should be locked at all times so that residents would not get into the laundry area and hurt themselves.

Interview with the Maintenance Director, on 04/22/15 at 2:45 PM, revealed he was not aware the door was not catching. He reported he depended on staff to alert him when there were any maintenance concerns. Continued interview with the Maintenance Director revealed the door should have been locked.

Interview with the Director of Nursing (DON), on 04/23/15 at 6:30 PM, revealed it would have been her expectation that the door would have remained locked and added that maintenance should be doing environmental rounds. She reported that was why a lock was put on the door for the safety of the residents.

Interview with the Administrator, on 04/23/15 at 7:15 PM, revealed it would have been a safety hazard if a resident got into the laundry room. Continued interview with the Administrator revealed it was important that the doors were locked.

F 323

F 371 483.35(i) FOOD PROCURE,
SS=E STORE/PREPARE/SERVE - SANITARY

F 371 See attached

5/28/15

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F 371 Continued From page 20
The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 371

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to distribute and serve food under sanitary conditions as evidenced by dietary staff failed to check food temperatures at the point of service.

The findings include:

Observation during the second kitchen tour, on 04/22/15 at 11:15 AM, revealed hot food temperatures were checked prior to distribution to the tray line; however, continued observation revealed the Dietary Worker removed five (5) different food items at five (5) different intervals from the steamer and placed on plates without checking the temperature to ensure the food items were being served at the proper temperatures.

Interview with Dietary Worker #1, on 04/23/15 at 11:45 AM, revealed she took the temperature of all food items on the steam table to ensure food items were being served at the proper temperatures. The Dietary Worker stated she tried to take the temperature of all food items

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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 371	<p>Continued From page 21</p> <p>when taken out of the microwave and the steamer. Dietary Worker #1 further stated she had not taken the temperature of the food items taken out of the steamer during the observation of the tray line service on 04/22/15.</p> <p>Interview with the Dietary Manager, on 04/22/15 at 3:35 PM, revealed the facility did not have a policy related to obtaining temperatures of the food prior to being served. The Dietary Manager stated the practice was to obtain the temperatures of the majority of the food being served to ensure the food was being served at the proper temperatures. The Dietary Manager further stated it would not be possible to ensure all food items were being served at the proper temperature without first obtaining the temperature of the food items.</p> <p>Interview with the Director of Nursing (DON), on 04/23/15 at 6:30 PM, revealed dietary staff should be obtaining temperatures of food items to ensure food items were being served at the proper temperature to avoid injury.</p> <p>Interview with the Administrator, on 04/23/15 at 7:10 PM, revealed dietary services had strict guidelines regarding food handling and would expect the facility staff to follow these guidelines. The Administrator stated it would be important for the staff to take the temperature of the food prior to being served to ensure the foods were being served at the proper temperature.</p>	F 371		
F 411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p>	F 411	See attached	5/30/15

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F 411

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:

Based on Interview and record review, it was determined the facility failed to ensure residents received routine dental services to meet the needs of each resident for three (3) of ten (10) sampled residents, Residents #1, #2, and #7.

The findings include:

Interview with the Director of Nursing (DON), on 04/22/15 at 3:45 PM, revealed there was not a set procedure in place to ensure routine dental screenings by a qualified professional. The DON stated the residents were sent out to see a dentist on an "as needed" basis.

Review of Resident #1's medical record revealed the facility admitted Resident #1 on 01/15/10 with diagnoses which included Diabetes, Renal Failure, Hyperlipidemia, Gastroesophageal Reflux Disease (GERD), Anemia, Joint Pain, Obesity, Hypertension, Osteoarthritis, Anxiety, Hypothyroidism, Dementia, and Depression. The facility assessed Resident #1, in a Quarterly

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Minimum Data Set (MDS), dated 03/24/15, as being totally dependent on staff for personal hygiene. Review of Resident #1's Comprehensive Care Plan, with a review date of 03/23/15, revealed the facility assessed Resident #1 with a self-care deficit with an intervention to assist with oral care as needed. Review of the Physician's Orders, dated 03/25/15, revealed Resident #1 was to have dental care as needed. However, review of the record revealed no documented evidence Resident #1 had been seen by or given the opportunity to be seen by a dentist in the previous year.

Review of Resident #2's medical record revealed the facility admitted Resident #2 on 04/15/13 with diagnoses which included Diabetes, Anxiety, Hypertension, Hypothyroidism, Dementia, GERD, Restless Leg Syndrome, Chronic Diarrhea, and Depression. The facility assessed Resident #2, in an Annual MDS, dated 03/18/15, as being totally dependent on staff for personal hygiene. Review of Resident #2's Comprehensive Care Plan, with a review date of 03/16/15, revealed Resident #2 was to receive oral care twice a day and as needed and to report any pain and/or discomfort in the oral cavity to proper staff members. However, review of the record revealed no documented evidence Resident #2 had been seen by or given the opportunity to be seen by a dentist in the previous year.

Review of Resident #7's medical record revealed the facility admitted Resident #7 on 03/12/09 with diagnoses which included Hypertension, Parkinson's Disease, Anxiety, Hyperlipidemia, Acute Bronchitis, Dopamine Dyskinesias, Hallucinations, Delusions, Hypocalcaemia, Chronic Obstructive Pulmonary Disease, and

F 411

05-29-15 16:24 FROM-

859-734-5563

T-509 P0037/0085 F-619

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

185210

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

CIVIL NO. 0938-0391

(X3) DATE SURVEY COMPLETED

04/23/2015

NAME OF PROVIDER OR SUPPLIER

THE JAMES B. HAGGIN MEMORIAL HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE

464 LINDEN AVENUE
HARRODSBURG, KY 40330

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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F 411 Continued From page 24

F 411

Macular Degeneration. Review of Resident #7's Physician's Orders, dated 03/26/15, revealed Resident #7 may receive dental care as needed. The facility assessed Resident #7, in a Quarterly MDS, dated 02/17/15, as being totally dependent on staff for personal hygiene. Review of Resident #7's Comprehensive Care Plan, with a review date of 02/13/15, revealed Resident #7 was to be assisted with oral care twice a day and as needed. However, review of the record revealed no documented evidence Resident #7 had been seen by or given the opportunity to be seen by a dentist in the previous year.

Interview with Licensed Practical Nurse (LPN) #1 on 04/22/15 at 3:20 PM, revealed the facility did not have a set process in place for annual/routine dental screenings. LPN #1 stated if there was a need, the facility would then make arrangements for the residents to see a dentist.

Interview with the Administrator, on 04/23/15 at 7:10 PM, revealed she was unaware of the regulation requiring routine dental screenings by a qualified professional. The Administrator further stated she would expect the facility to comply with all regulations regarding annual dental screenings.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**F 242 CFR 483.15(b) Self-Determination – Right to Make Choices
S/S=D**

Completion Date: 5/23/15

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

Resident #6 had substitute provided at the lunch meal on 4/21/15. His preference card was updated also on 4/21/15 and again on 4/22/15 as he requested to modify again his dislikes.

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

All residents have potential to be affected; all residents will be re-interviewed by 5/22/15 and have updated food likes/dislikes sheet by the Dietary Director.

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

Dietary staff will refer to each individual preference card as tray is made and a second dietary team member on the tray line will verify compliance prior to tray going out of kitchen. Dietary staff will receive re-education regarding importance of likes/dislikes and following cards to ensure compliance by Dietary Director each shift as they work and was completed by 5/22/15. Extended Care Facility (ECF) nurses and aides received education regarding the importance of checking and following food preferences on meal cards and trays during the monthly staff meetings: aides on 5/12 & 13 and nurses on 5/19 & 20 by Kelly Workman, Director of Nursing (DON) of ECF.

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

The Dietary Director or Head Cook will perform checks at each meal for 1 week then 1 meal/day for 30 days, then 1 meal/week ongoing. Dietary Director will also attend 1 resident council meeting/quarter to ensure resident satisfaction starting on 5/27/15. Results of monitoring will be reported to the ECF Quality Assurance (QA) Committee by the Dietary Director to ensure continuing compliance monthly for three months and then quarterly. QA members are: Administrator, Chief Nursing Officer (CNO), Medical Director, DON of ECF, Charge Nurse, Performance Improvement (PI) Coordinator, MDS Coordinator, Dietary Director, Business Office Manager, Physical Plant Director, Pharmacist and Social Services.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**F 248 CFR 483.15(f)(1) Activities meet interests/needs of each resident
S/S=E**

Completion Date: 6/2/15

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

Increased the number and kind of activities offered for the very next calendar after survey (May 2015) by April 29, 2015; increased bingo to twice/week; added a craft several times this month and added several evening offerings based on survey findings and some of the resident interviews. Mail delivery and bookmobile were removed as well as a separate schedule for the snack choices has been made so as not to be confused with an activity. We purchased horseshoe game and craft supplies to enhance choices and offerings.

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

The interviewable residents were interviewed for preferences of kinds and times for activities by the Activity Director to be completed by May 27, 2015. The topic of activity offerings has also been discussed in group activities. The results of both interviews and group discussions will be used to form June calendar and will also be reviewed at resident council on 5/27/15, along with current calendar to see if changes are acceptable to residents.

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

The Activities Director will implement the desired changes for more activities and is responsible for planning all activities, including weekends. All of the input and feedback from interviews and meetings will be used on an ongoing basis to make additions or modifications to each month's activity calendar moving forward. The Activities Director has met with the local ministerial association to address the need for more and dependable involvement by the local churches. A request for more volunteer assignments to ECF has been given to the Auxiliary. Activity carts (2) with various choices are available on the floor for alternate activities at any time. This topic (activities) will be permanent for the resident council meetings for any modifications desired. The DON of ECF will review and verify calendar for the next month prior to going to print. ECF team members were educated on the need to provide activities of interest to all residents, the calendar modifications, the plan to update ongoing and the need to participate in and ensure weekend activities are carried out as planned by the DON of ECF on May 12, 13, 19 and 20, 2015.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY**

SURVEY COMPLETION DATE April 23, 2015

PLAN OF CORRECTION

**Continue - F 248 CFR 483.15(f)(1) Activities meet interests/needs of each resident
S/S=E**

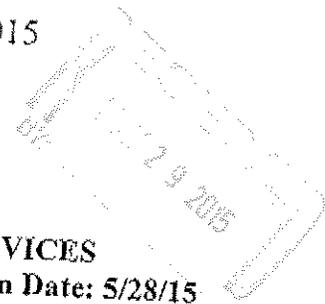
Completion Date: 6/2/15

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

The residents and/or family representatives (20%) will be surveyed through interview by Activities Director to monitor satisfaction with activity choices and offerings by 6/1/15 and ongoing monthly for 6 months and then quarterly. The DON of ECF or Charge Nurse will perform a quarterly audit regarding number, kinds, and times of activities and report results along with resident/responsible party survey results to the ECF QA Committee.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION



**F 253 483.15 (h) (2) HOUSEKEEPING AND MAINTENANCE SERVICES
S/S=E**

Completion Date: 5/28/15

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

- 1) The cracked floor tiles were replaced with new tiles on 5/13/2015.
- 2) Dust and dirt in the corner of the dining room was cleaned on 4/24/2015
- 3) Three loose hand rails were repaired on 4/24/2015
- 4) The slow shower drain was cleared on 4/24/2015
- 5) The gaps/holes in rooms 260, 264, 265, 266, 270 and 271 were repaired on 5/12/2015. Proper covers were placed over the ceiling junction boxes to cover the gaps the smaller covers made.

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

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

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

Items have been entered on the monthly quality inspection list to be completed by the Director of Physical Plant and/or Environmental Services Coordinator or their designee. The Physical Plant and Housekeeping team members received re-education on the importance of ensuring the facility's interior is maintained, areas of concern as above, and facility policies and procedures for maintaining a sanitary environment to prevent recurrence of deficient practice by Director of Physical Plant and Environmental Services Coordinator on 4/27/15. The ECF team members received education regarding cleaning/sanitizing of shower rooms and reporting areas of environmental concerns to Physical Plant team on May 12, 13, 19 and 20, 2015 by Director of Nursing of Extended Care Facility. There is no night floor cleaning staff.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**Continue - F 253 483.15 (h) (2) HOUSEKEEPING AND MAINTENANCE SERVICES
S/S=E
Completion Date: 5/28/15**

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

The Director of Physical Plant and Environmental Services Coordinator will perform monthly quality checks which consists of environmental rounds to inspect all areas for sanitary and good repair of the plant and document findings. The Environmental Services Coordinator will monitor and document the shower and resident rooms daily for one week, then weekly for thirty days and ongoing to ensure the deficient practice will not recur. The Director of Physical Plant will report these findings and monitors to the ECF QA committee to ensure compliance monthly for three months and then quarterly.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**F 274 CFR 483.20 (b)(2)(ii) Comprehensive Assess After Significant Change
S/S=D**

Completion Date: 5/21/15

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

A Significant Change Minimum Data Set (MDS) assessment was completed for Resident #2 on 4/29/15.

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

All residents were reviewed for change in status at the Standards of Care (SOC) meeting following end of survey. SOC is a weekly meeting held to review focused residents experiencing an acute need or other areas of concern such as weight loss, positioning or activity needs, etc. This is also where we discussed action plan to change the system described below. No other residents were affected.

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

The Systemic change put in place is the MDS Coordinator or Unit Clerk will bring each resident's Activities of Daily Living (ADL) Assessment for the 7 day lookback for MDS to the morning meeting prior to the data input of the MDS to compare it to the prior one as they come due. We will also increase our focus on change of condition as an area of review at weekly Standards of Care (SOC) meeting whose attendees are: DON of ECF, Charge Nurse, MDS Coordinator, Dietary Director, Restorative Nurse, Therapist, Activity Director, and Social Service representative. This will also include focus on ADL functional status. ECF team members were educated on accurately recording and reporting changes in ADL function as well as any changes in residents' condition during monthly staff meetings on 5/12, 13, 19 and 20, 2015 to ensure the needs of residents' are met and the deficient practice does not recur.

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

The Director of ECF or Charge Nurse will perform a quarterly audit on MDS assessments done each quarter and report results to the ECF QA Committee to ensure appropriately coded MDS assessments were completed and no significant change MDS assessments were missed.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**F 323 483.25 (h) (2) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
S/S=D**

Completion Date: 5/28/15

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

The punch door code lock was changed out for a new lock on 4/23/2015.

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

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

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

The punch code lock has been entered into the preventive maintenance electronic work order system by the Director of Physical Plant. The Physical Plant and Environmental Services team members were re-educated on ensuring the environment remains free of accident hazards as much as possible and ensuring door locks are functioning properly on 4/27/15 by the Physical Plant Director. The ECF team members were educated on ensuring the environment remains free of accident hazards as possible and ensuring door locks are functioning properly on May 12, 13, 19 and 20, 2015 by the DON of ECF.

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

The Director of Physical Plant will ensure the device is entered into the preventive work order system, performed by the Physical Plant team and documented. He will audit the preventive maintenance of the door locks weekly and report the status monthly for three months and then quarterly to the ECF QA Committee for the next year.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

F 371 CFR 483.35(i) Food Procure, Store/Prepare/Serve - Sanitary

S/S=E

Completion Date: 5/28/15

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

Dietary Director re-educated the dietary worker regarding taking food temperature at point of service on 4/22/15. She also alerted ECF team members on 4/22/15 to note and report any symptoms of GI upset.

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

All residents had potential to be affected; none were adversely affected.

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

Dietary Director will ensure there is adequate amount of thermometers available at each meal. Dietary staff will check temperature at each station prior to serving portions. Dietary Director and/or Head Cook will ensure compliance prior to tray going out of kitchen. Dietary staff will receive re-education regarding temperature checks of point of service to occur at all meals from Dietary Director by 5/27/15.

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

The Dietary Director or Head Cook will perform checks to ensure thermometers have been placed in foods prior to service at each meal for 1 week then 1 meal/day for 30 days, then 1 meal/week ongoing using an audit checksheet. Temperatures will not be recorded on this sheet as they are already recorded on meal temperature log. Results of monitoring will be reported to the ECF QA Committee by the Dietary Director to ensure continuing compliance monthly for 3 months then quarterly.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**CFR 483.55(a) Dental Services F 411
S/S=D**

Completion Date: 5/30/15

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

Residents #1, 2 and 7 will receive a routine dental exam by a qualified professional from dental service provider Onhealthcare whose contract was signed on 5/29/15 as soon as they can complete new service processing.

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

All residents who have not had a routine exam will receive one as quickly as can be provided by the new service provider. The Charge Nurse and/or DON of ECF will ensure the exams are received. If a resident and/or responsible party refuses this service, it will be documented by Onhealthcare and by the nurse caring for the resident or the Charge Nurse or DON of ECF. This will entail procuring a contract for dental services which was obtained and signed with Onhealthcare on 5/29/15.

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

The Facility procured dental services to provide annual and routine scheduled services for all residents through Onhealthcare with contract signed on 5/29/15. Education was provided to all ECF team members on May 12, 13, 19 and 20, 2015 on the need to provide dental services for all residents and to continue to assess oral cavities and status of teeth and dentures and to document/report same in the medical record. The new dental provider will give any further specific education as soon as possible. The admission packets will include the necessary forms to set up all new residents for dental services.

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

The Director of ECF or Charge Nurse will perform a quarterly audit of resident records on dental services and report results of all of the residents that have received and/or refused dental care to the ECF QA Committee to ensure residents receive appropriate dental care and the deficient practice will not recur.

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 100762	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 6/9/2015
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Name of Facility THE JAMES B. HAGGIN MEMORIAL HOSPITAL	Street Address, City, State, Zip Code 464 LINDEN AVENUE HARRODSBURG, KY 40330
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix N0116 Reg. # 902 KAR 20:300-6(2)(c) LSC	Correction Completed 05/23/2015	ID Prefix N0125 Reg. # 902 KAR 20:300-6(5)(a) LSC	Correction Completed 06/02/2015	ID Prefix N0134 Reg. # 902 KAR 20:300-6(7)(a)2. LSC	Correction Completed 05/28/2015
ID Prefix N0182 Reg. # 902 KAR 20:300-7(2)(c)3. LSC	Correction Completed 05/21/2015	ID Prefix N0219 Reg. # 902 KAR 20:300-8(7)(a) LSC	Correction Completed 05/28/2015	ID Prefix N0283 Reg. # 902 KAR 20:300-10(8)(b) LSC	Correction Completed 05/28/2015
ID Prefix N0303 Reg. # 902 KAR 20:300-13(1) LSC	Correction Completed 05/30/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: <i>Sherry Hamilton</i>	Date: 06/09/15
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor:	Date:
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor:	Date:
CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/23/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING _____	(X3) DATE SURVEY COMPLETED R 06/01/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(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}

An offsite revisit was conducted and based on an acceptable Plan of Correction (POC), the facility was deemed to be in compliance, 05/09/15 as alleged.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(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

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1947, 1962, 1978, 1986

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: Second Floor wing of a two (2) story, Type I Unprotected

SMOKE COMPARTMENTS: Four (4) smoke compartments

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

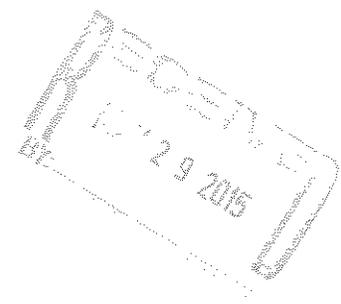
SPRINKLER SYSTEM: Complete automatic wet sprinkler system

GENERATOR: Type I generator installed in 1982, fuel source is diesel

A Standard Life Safety Code Survey was conducted on 04/21/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for thirty-four (34) beds. The census the day of the survey was thirty-three (33).

Deficiencies were cited with the highest deficiency identified at an "F" level.

K 000



The findings that follow demonstrate

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

LNHA / CEO

(X6) DATE

5/29/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	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 ensure smoke barriers were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twelve (12) residents, staff and visitors. The findings include: Observation on 04/21/15 at 11:45 AM, with the Maintenance Director, revealed the smoke barrier at the Activity Room had three (3) penetrations. Interview, with the Maintenance Director at the time of observation, revealed he was not aware the penetrations were present and the facility did not have a monthly inspection for penetrations of	K 025	See attached	4/25/15

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(X-1) 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 025 Continued From page 2
the smoke barriers. Further interview, revealed the facility did check for penetrations after any above ceiling work was completed. The last work completed was ten (10) months ago to replace an air conditioning coil.

The findings were acknowledged by the Administrator during the exit conference.

K 025

Reference: NFPA 101 (2000 Edition)
8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.
8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.
Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.

K 047 See attached

4/25/15

K 047 SS=E
NFPA 101 LIFE SAFETY CODE STANDARD
Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(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 047 Continued From page 3

K 047

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain exits, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty-three (23) residents, staff and visitors.

The findings include:

Observation, on 04/21/2015 at 11:10 AM, with the Maintenance Director, revealed the exterior exit from Stairwell # 3 did not have an exit sign, showing the correct way to the exit from the stairwell. Further observation, revealed the next closest exit was greater than the allowed 150 feet travel distance. Interview, with the Maintenance Director at the time of observation, revealed he had never noticed the exterior door did not have an exit sign.

Observation on 04/21/2015 at 11:25 AM, with the Maintenance Director, revealed the horizontal exit from the Skilled Nursing Unit to the Hospital did not have an exit sign, showing the correct way to the exit from the corridor. Interview, with the Maintenance Director at the time of observation, revealed he had never noticed the exterior door did not have an exit sign.

Observation on 04/21/2015 at 11:35 AM, with the Maintenance Director, revealed the exterior exit from Stairwell # 4 did not have an exit sign, showing the correct way to the exit from the stairwell. Further observation, revealed the next closest exit was greater than the allowed 150 feet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(X1) 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 047	<p>Continued From page 4</p> <p>Travel distance. Interview, with the Maintenance Director at the time of observation, revealed he had never noticed the exterior door did not have an exit sign.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.6.2.1 The travel distance between any room door required as an exit access and an exit shall not exceed 100 ft (30 m). Exception: The maximum travel distance shall be permitted to be increased by 50 ft (15 m) in buildings protected throughout by an approved, supervised automatic sprinkler system. 19.2.6.2.2 The travel distance between any point in a room and an exit shall not exceed 150 ft (45 m). Exception: The maximum travel distance shall be permitted to be increased by 50 ft (15 m) in buildings protected throughout by an approved, supervised automatic sprinkler system.</p>	K 047		
K 062 SS=F	<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 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure control valves for the sprinkler system were identified,</p>	K 062	See attached	5/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(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 062 Continued From page 5
according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, thirty-four (34) residents, staff and visitors.

K 062

The findings include:

Observation, on 04/21/15 at 11:02 AM, with the Maintenance Director, reveled a control valve on the sprinkler system was not identified with a sign. Interview, with the Maintenance Director at the time of observation, revealed he was not aware the control valve for the sprinkler system was missing the required signage.

The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 25 (1998 Edition)
9-3.2* Each control valve shall be identified and have a sign indicating the system or portion of the system it controls.

K 130 NFPA 101 MISCELLANEOUS
SS=F OTHER LSC DEFICIENCY NOT ON 2786

K 130 *See attached*

4/24/15

This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure single station smoke detectors were inspected, according to National Fire Protection Association (NFPA) standards. The deficiency had the

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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(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 130 Continued From page 6
potential to affect three (3) of four (4) smoke compartments, thirty-four (34) residents, staff and visitors.

The findings include:

Review of the smoke detector inspection and maintenance records on 04/21/15 at 12:20 PM, with the Maintenance Director, revealed the facility did not have documentation for inspection or maintenance of the single station smoke detectors located in all resident rooms. Interview, with the Maintenance Director at the time of review, revealed he was not aware of any inspection or maintenance records for the single station smoke detectors.

Observation, on 04/21/15 at 12:24 PM, with the Maintenance Director, revealed the single station smoke detector located in Room 252, was not equipped with a battery and would not function when tested. Interview, with the Maintenance Director at the time of observation, revealed he was not aware the single station smoke detector did not contain a battery for operation.

The findings were acknowledged by the Administrator during the exit conference.

Reference: NFPA 72 (1999 Edition)
7-1.1 Scope. Chapter 7 shall cover the minimum requirements for the inspection, testing, and maintenance of the fire alarm systems described in Chapter 1, 3, and 5 and for their initiation and notification components described in Chapter 2 and 4. The testing and maintenance requirements for one and two-family dwelling

K 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185210	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EAST WING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2015
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NAME OF PROVIDER OR SUPPLIER THE JAMES B. HAGGIN MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 464 LINDEN AVENUE HARRODSBURG, KY 40330
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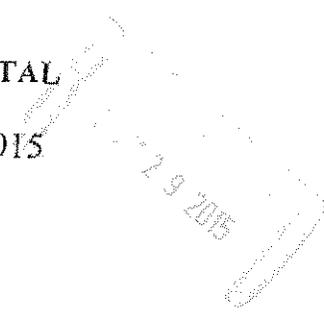
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 130 Continued From page 7
 units shall be located in Chapter 8.
 Single station detectors used for other than one- and two-family dwelling units shall be tested and maintained in accordance with Chapter 7. More stringent inspection, testing, or maintenance procedures that are required by other parties shall be permitted.
 Reference: NFPA 101 (2000 Edition)
 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.

K 130

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION



**KO 25 CFR: 42 CFR 483.70(a) NFPA LIFE SAFETY CODE STANDARD
S/S=D**

Completion Date: 4/25/15

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

The three (3) smoke barrier penetrations were filled complete with drywall mud on 4/24/15.

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

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

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

The Director of Physical Plant will monitor and enforce the above ceiling permit policy.

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

The Director of Physical Plant will monitor, follow up and document any above ceiling work causing potential wall penetrations and personally inspect area after completion of work.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**CFR: 42 CFR 483.70 (a) NFPA LIFE SAFETY CODE STANDARD KO 47
S/S=E Completion Date: 4/25/15**

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

The Director of Physical Plant installed two continuously lit exit signs in stairwells #3 and #4 on 4/22/15.

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

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

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

Quarterly preventive maintenance will be performed on the signs.

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

The Director of Physical Plant will monitor and maintain the exit signs by adding the newly installed signs to the existing preventive maintenance program through the electronic work order system.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**KO 62 CFR: 42 CFR 483.70(a) NFPA LIFE SAFETY CODE STANDARD
S/S=F**

Completion Date: 5/9/15

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

The Director of Physical Plant installed the proper control valve identification signs on the fire pump to sprinkler system to include main valve shut off sign on 5/8/15.

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

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

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

The identification signs have been included on the quarterly fire and sprinkler inspection check off list to be completed by Simplex Grinnell.

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

The Director of Physical Plant will monitor and document quarterly through the existing fire and sprinkler system inspections performed by the certified vendor Simplex Grinnell.

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL
EXTENDED CARE FACILITY
SURVEY COMPLETION DATE April 23, 2015**

PLAN OF CORRECTION

**KO 130 CFR: 42 CFR 483.70 (a) NFPA LIFE SAFETY CODE STANDARD
S/S=F**

Completion Date: 4/24/15

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

The Director of Physical Plant removed all individual resident room smoke detectors permanently on 4/23/15.

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

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

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

The Director of Physical Plant removed all individual resident room smoke detectors permanently on 4/23/15.

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

The Director of Physical Plan verified and ensured all individual smoke detectors were permanently removed by visual inspection and documented through the completed electronic work order.