

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
SURVEY COMPLETION DATE October 19, 2012**

**PLAN OF CORRECTION**

**CFR 483.13(a) Right to be Free from Physical Restraints – The facility failed to ensure resident attained or maintained their highest practicable well-being in an environment that prohibited the use of physical restraints, failed to ensure the medical diagnosis for the restraint was on the physician order, failed to obtain the resident/responsible party's consent prior to the use of a restraint and failed to complete Least Restraint Assessment prior to the use of a lap buddy for one of ten sampled residents.**

**F 221 Right to be Free from Physical Restraints  
S/S=D**

**Completion Date: 12/10/12**

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

The resident (#4) had a Least Restrictive Restraint Assessment and physician order completed on 10/19/12. Consent for use with risks vs. benefits was discussed with POA and obtained verbally. Forms were ordered and will be completed (signed) at POA convenience after arrival.

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

An audit of all residents was completed to review use of any enablers and/or positioning devices by the interdisciplinary team and no others found to be affected.

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

The Physical Restraint Policy will be revised and implemented. The new policy includes the use of a Pre-Restraining Assessment form, a consent form and a quarterly Physical Restraint Elimination Assessment form. It also provides for monthly review of all residents utilizing a restraint. Education on the new policy and forms will be provided to ECF nursing and care plan team members by the DON of ECF and/or the ECF Charge Nurse.

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

Monthly reporting on restraint use, assessment(s) completion and to policy adherence will be made to the ECF QA Committee.



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**PLAN OF CORRECTION**

**CFR 483.15(h) Housekeeping and maintenance services – The facility failed to provide effective housekeeping and maintenance services to ensure a sanitary and orderly environment.**

**F 253 Housekeeping and Maintenance Services  
S/S=E**

**Completion Date: 11/08/12**

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

All resident rooms were visually inspected for dust balls and dirty heating/air conditioning. Those found were cleaned and re-inspected.

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

All residents had the potential to be affected but no other areas found to be affected.

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

The Environmental Services team members were re-educated to the daily cleaning procedures by the Environmental Services Coordinator and each team member given a copy of the cleaning policy and procedure.

The Physical Plant team members were educated on the proper cleaning and inspection of air conditioning and heating units.

The Environmental Services Coordinator will increase her quality inspection rounds which include a visual inspection of the resident room floors for procedural cleaning as well as the heating/air conditioning units for dust build-up. The Coordinator will also document the inspection results on the existing quality inspection form. The form results will trigger any further needed cleaning.

When the scheduled preventive maintenance, every 59 days, is performed on the units the completed visual condition will be documented on the computer software generated work order by the preventive maintenance provider and then followed up on by the Physical Plant Director.

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

The cleaning quality round results as well as the preventive maintenance results are reported to the hospital Performance Improvement Committee and the ECF QA Committee quarterly.

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**PLAN OF CORRECTION**

**CFR 483.20(b)(2)(ii) Comprehensive Assess after Significant Change – The facility failed to ensure a comprehensive assessment of a resident was conducted within fourteen (14) days after the facility determined or should have determined, that there has been a significant change in the resident's physical or mental condition for one (1) of twelve (12) sampled residents.**

**F 274 Comprehensive Assessment after Significant Change      Completion Date: 12/10/12  
S/S=D**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**  
The resident (#1) will have a Significant Change Assessment completed with an ARD date of 11/14/12 including review of the comprehensive care plan.

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

All residents had potential to be affected but no others found to be affected.

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

The Interdisciplinary team will be re-educated on criteria for determining a significant change. A formal review will occur during Standards of Care meeting held weekly with interdisciplinary team. The meeting time will be modified to accommodate attendance by Dietary Director.

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

Reporting on the number of significant change assessments to ECF QA Committee will be done monthly for three months then quarterly on an ongoing basis.

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**PLAN OF CORRECTION**

**CFR 483.20(d)(3)Right to Participate in Care Planning and Revision of Care – The facility failed to ensure the residents Comprehensive Plan of Care was reviewed and revise for one (1) of twelve (12) sampled residents.**

**F 280 Comprehensive Assessment after Significant Change      Completion Date: 12/10/12  
S/S=D**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**  
The resident (#1) will have a Care Plan Revision on 11/21/12 based on the significant change assessment completed with an ARD date of 11/14/12.

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

All residents had potential to be affected but no others found to be affected.

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

The Interdisciplinary team will be re-educated on criteria for determining a significant change and the need for revision of the care plan. A formal review will occur during Standards of Care meeting held weekly with interdisciplinary team. The meeting time will be modified to accommodate attendance by Dietary Director.

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

Reporting on the number of significant change assessments and care plan revisions to ECF QA Committee will be done monthly for three months then quarterly on an ongoing basis.

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**PLAN OF CORRECTION**

**CFR 483.25(c) Treatment/Services to Prevent/Heal Pressure Sores – The facility failed to ensure residents did not develop pressure sores unless it was clinically unavoidable for one (1) of twelve (12) sampled residents.**

**F 314 Treatment/Services to Prevent/Heal Pressure Sores                      Completion Date: 12/10/12  
S/S=D**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**  
The resident (#1) received a new physician order for treatment to affected area on R lateral heel. Daily inspections of site implemented until healed. ECF Charge Nurse will also check area weekly until healed.

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

All residents will receive thorough skin assessments by LPN and verified by the ECF Charge Nurse. The weekly skin assessments had been identified as a potential weak area and a new audit tool/process had just been implemented with the item added as new area to the September ECF QA agenda. The Charge Nurse checks each weekday morning the assessments scheduled for the prior day (on Monday, the weekend assessments are done) for completion and accuracy.

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

Weekly audits of the Treatment Administration Records for completion and accuracy will be completed by the ECF Unit Clerk and/or Charge Nurse. Findings will be reported to the interdisciplinary team weekly at Standards of Care meeting. Education will be provided to the ECF team members on policy, accurate assessments, documentation and follow up by the DON of ECF and ECF Charge Nurse.

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

The results of audits, education and assessments will be reported to the ECF QA Committee monthly for three months and then quarterly ongoing. We will continue to report all wound(s) status quarterly.

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**PLAN OF CORRECTION**

**CFR 483.25(h) Free of Accident Hazards/Supervision/Devices – The facility failed to ensure the environment remained as free from accidental hazards as possible as evidenced by two (2) medication carts observed to be unlocked and a cabinet with hazardous chemicals was observed to be unlocked.**

**F 323 Free of Accident Hazards/Supervision/Devices  
S/S= E**

**Completion Date: 12/15/12**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**  
The medication carts were serviced and plans made to keep behind locked door or nurses' station if lock malfunctions again until service personnel can repair. All cabinets were cleaned of all hazardous chemical items.

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

All residents had potential to be affected but no others found to be affected.

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

The Medication carts will be replaced with the purchase of new carts – purchase order to be placed within 30 days after adequate quotes obtained and approval process completed. The cabinets will be inspected by the Environmental Services Coordinator during routine quality control rounds. The DON of ECF will also do spot checks on a weekly basis for hazardous chemicals. Pharmacy personnel, DON of ECF and ECF Charge Nurse will do spot checks daily on the locking of the med carts.

**How The Facility Plans To Monitor Its Performance To Ensure Solutions Are Sustained:**  
The results of the audits will be reported to the ECF QA Committee monthly for three months and then quarterly.

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**PLAN OF CORRECTION**

**CFR 483.35(i) Food Procure, Store/Prepare/Serve - Sanitary – The facility failed to store, prepare, distribute and serve food under sanitary conditlons.**

**F 371 Food Procure, Store/Prepare/Serve - Sanitary  
S/S= F**

**Completion Date: 12/10/12**

**Corrective Action For Residents Found To Have Been Affected By The Deficient Practice:**  
All dishes were washed and sanitized in the dish machine and allowed to air dry before being placed back into use or on shelf for storage on 10/17/12. Cross contamination education provided to the dietary team member by Dietary Director on 10/17/12.

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

Although 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:**

A policy addressing dish washing, sanitizing and drying will be developed and implemented by the Dietary Director. Dietary team members will receive education on the new policy by the Dietary Director. Education will be provided to dietary team members on hand washing and cross contamination by the Infection Control Coordinator. The Dietary Director will review the Kentucky Food Service Code Booklet and will attend in-service, "Operating a Safe/Sanitary Dietary Department on 11/15/12.

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

The dishwashing and sanitizing process will be monitored weekly for four weeks and then monthly on an ongoing basis by Dietary Director and/or Infection Control Coordinator. The results will be reported to the ECF QA Committee monthly for three months and then quarterly by the Dietary Director. The environmental rounds infection control checklist will be utilized to monitor the dietary department practices by the Dietary Director and/or Infection Control Coordinator weekly for four weeks and then monthly ongoing. This will be reported to the ECF QA Committee monthly for three months and then quarterly ongoing.

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**PLAN OF CORRECTION**

**CFR 483.35(i) Dispose Garbage & Refuse properly – The facility failed to ensure garbage and refuse containers were contained in dumpsters or compactors with lids to prevent the harborage and feeding of pests.**

**F 372 Dispose Garbage & Refuse Properly  
S/S=F**

**Completion Date: 11/14/12**

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

The uncovered trash dumpster was permanently removed.

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

All residents had the potential to be affected but none were found to be affected.

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

The Physical Plant Director is responsible for ordering any trash dumpsters to be delivered to hospital property. The Physical Plant Director will ensure any trash dumpster ordered and delivered on hospital property will have a lid for the trash dumpster.

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

The Physical Plant Director will monitor and any trash dumpster ordered and delivered on hospital property will be for renovations and the trash dumpster will have a lid and only stay on hospital property during the renovation and then promptly removed.

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**PLAN OF CORRECTION**

**CFR 483.60(b),(d), (e) Drug Records, Label/Store Drugs & Biologicals – The facility failed to ensure drugs and biologicals were stored in locked compartments as evidenced by two (2) medication carts observed to be unlocked.**

**F 431 Drug Records, Label/Store Drugs & Biologicals  
S/S=E**

**Completion Date: 12/10/12**

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

The medication carts were serviced and plans made to keep behind locked door or nurses' station if lock malfunctions again until service personnel can repair. All nurses were instructed to keep possession of keys at all times.

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

All residents had potential to be affected but no others found to be affected.

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

The Medication carts will be replaced with the purchase of new carts – purchase order to be placed within 30 days after adequate quotes obtained and approval process completed. Pharmacy personnel, DON of ECF and ECF Charge Nurse will do spot checks daily on the locking of the med carts and location of the keys.

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

The results of the audits will be reported to the ECF QA Committee monthly for three months and then quarterly.

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**PLAN OF CORRECTION**

**CFR 483.65 Infection Control, Prevent Spread, Linens – The facility failed to develop, implement, and maintain an Infection Control Program in order to prevent and control, to the extent possible, the onset and spread of infection within the facility. The facility failed to properly launder resident clothing to minimize contamination. Additionally, on initial tour bedpans were observed to be stored on the floor unlabeled and unbagged in the resident bathrooms. Tour of the beauty shop revealed used hair curlers and combs were dusty with hair in them.**

**F 441 Infection Control, Prevent Spread, Linens  
S/S=F**

**Completion Date: 12/10/12**

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

Area#1 the process/procedure was changed to involve hanging the clean laundry to the opposite wall and in the corner located five feet from the washer and dryer and out of the path of any transportation of any clean or dirty laundry. Area #2 the washer and dryer were switched places. The clean linen is hung three feet across from the washer/dryer while waiting to taken to resident rooms. All resident bedpans have been labeled, cleaned, covered, and stored in resident bathrooms. Combs and curlers in beauty shop have been cleaned and disinfected in accordance with The Kentucky State Board of Hairdressers and Cosmetologists statute KRS 317A.130.

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

All residents had the potential to be affected but none found to be affected.

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

The DON of ECF and the Environmental Services Coordinator will educate ECF and Environmental Services team members on the proper procedure for preventing cross contamination of resident linen. The Infection Control Coordinator will educate ECF team members on the proper procedure for labeling, cleaning, and storing resident bedpans. Periodic surveys of the ECF beauty shop will be performed by the Infection Control Coordinator to ensure proper practices are in place. The Beautician was educated on the proper procedure for cleaning and disinfection of combs and curlers as required by The Kentucky State Board of Hairdressers and Cosmetologists by the Infection Control Coordinator.

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

The DON of ECF and the Environmental Services Coordinator will monitor and report quarterly to the ECF QA Committee. The Infection Control Coordinator will monitor bedpan storage and report quarterly to the ECF QA Committee. Education on bedpan cleaning and storage will be provided to all ECF team members upon hire and annually. The Infection Control Coordinator will monitor and report quarterly to the ECF QA Committee

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

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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  10/19/2012
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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		
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Resident Restraint Policy (Effective 10/01/08), it was determined the facility failed to ensure residents attained and maintained their highest practicable well-being in an environment that prohibited the use of physical restraints, failed to ensure the medical diagnosis for the restraint was on the Physician's Order, failed to obtain the resident/responsible party's consent prior to the use of a restraint, and failed to complete a Least Restraint Assessment prior to the use of a lap buddy for one (1) of ten (10) sampled residents (Resident #4). Resident #4 was utilizing a lap buddy as an assistive device and per interview and record review Resident #4 was able to remove the device upon command; however, observation revealed Resident #4 was utilizing a lap buddy while up in a wheelchair and was unable to release his/her lap buddy upon command.</p> <p>The findings include:</p>	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE LNHA/CEO	(X6) DATE 11/15/12
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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 221	<p>Continued From page 1</p> <p>Review of the facility's Resident Restraint Policy (Effective 10/01/08), revealed the least restrictive method was to be utilized to enable residents to safely function within their environment. Restraints were a temporary or short term solution and never a planned long term option. A restraint would only be used when: 1. There was a real or potential threat to the safety of the resident or others. 2. An assessment and trial of alternatives to restraints had indicated that there were no other solutions. The policy further indicated the resident's and family's/responsible party's choices had been fully considered and the consent to physical restraint record had been completed. The purpose was to recognize the rights and dignity of each resident and to uphold the moral and legal responsibility of providing a safe environment while maintaining the philosophy of least restraint. The definition of a safety device was any device applied to a resident which by design was used solely for the purpose of positioning or enhancing resident function. Those devices were not considered a restraint if they enabled the resident to safely function within their environment and the resident could voluntarily remove the device successfully three times when asked. The definition of a restraint was any device or chemical which was used to stop aggressive or out of control behavior by affecting the functional ability of the resident. It was used to reduce the risk of injury to the resident or others. It was implemented only when other alternatives had been explored and had been deemed ineffective. The interdisciplinary team may utilize the least restrictive device when needed. Residents who utilized a safety device would be monitored every thirty (30) minutes and</p>	F 221		
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F 221	<p>Continued From page 2</p> <p>their device removed every two (2) hours to be repositioned and as needed. A least restraint assessment record would be obtained prior to restraint use. The assessment would be repeated if the rationale or contributing factors changed.</p> <p>Record review revealed the facility admitted Resident #4 on 03/28/11 with diagnoses which included Dementia, Advanced Alzheimers, Anxiety, Depression and Insomnia.</p> <p>Record review revealed no documented evidence a Least Restraint Assessment had been performed prior to the lap buddy's use on Resident #4. Further review revealed no documented evidence the resident/responsible party was informed of the risks versus benefits of the lap buddy prior to its use, nor was there evidence the resident/responsible party signed a consent form prior to the use of the lap buddy.</p> <p>Review of the Physician's Orders revealed an order, dated 03/29/11, as follows: Lap buddy while up in wheelchair for safety and positioning. Check every thirty (30) minutes, release every two (2) hours for ten (10) minutes. Review of the Readmission Orders, dated 03/19/12, revealed an order as follows: Lap buddy while resident up in wheelchair, resident could remove so this was not a restraint. The Physician's Order did not state the medical Diagnosis for the use of the lap buddy. Further review of the October 2012 Physician's Orders revealed orders as follows: Resident was to have lap buddy placed while up in chair related to fall risk; Check weekly to make sure resident could remove lap buddy on demand every Thursday.</p>	F 221		
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F 221	Continued From page 3  Review of the 03/06/12 Annual Minimum Data Set (MDS) Assessment revealed Physical Restraints, in regards to Resident #4, was listed as zero.  Review of the Comprehensive Care Plan (03/19/12) revealed Resident #4 required a lap buddy related to decreased safety awareness/fall risk. The lap buddy was not considered a restraint as the resident could remove it.  Review of the October 2012 Nurse Aide Care Plan revealed lap buddy placed when in wheelchair, resident could remove it his/herself, lap buddy to be removed during meals.  Review of the October 2012 Treatment Administration Record (TAR) revealed the resident was to have a lap buddy placed, while up in a wheelchair, related to fall risk and was to be checked every Thursday to make sure the resident could remove it upon demand. The TAR was marked that it was checked on 10/04/12 and 10/11/12.  Observation, on 10/18/12 at 12:00 PM, revealed Licensed Practical Nurse (LPN) # 3 asked Resident #4, repeatedly, to remove the lap buddy, however, the resident did not remove it.  Review of the October 2012 TAR, on 10/18/12 at 5:00 PM, revealed the TAR had initials that the resident was able to remove the lap buddy.  Interview, on 10/18/12 at 12:00 PM, with LPN #3 revealed the resident was able to remove the lap buddy, she had seen the resident remove it,	F 221		

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F 221	<p>Continued From page 4</p> <p>maybe two (2) or three (3) weeks ago. She further stated the resident removed it a lot. Further interview revealed she would ask the resident to remove the lap buddy and if the resident removed the lap buddy once she would not ask the resident to remove it again. She did not know it was the facility's policy to have the resident remove the lap buddy three (3) times on command.</p> <p>Interview, on 10/19/12 at 3:30 PM, with Registered Nurse (RN) #1 revealed she wasn't aware, until a couple of hours prior to the interview, that Resident #4 was unable to remove the lap buddy. She stated the resident had always taken it off for her. She further stated no one had told her the resident was unable to remove the lap buddy.</p> <p>Interviews with four (4) State Registered Nurse Aides (SRNA) #2, 3, 4 and 5, on 10/19/12 at 2:00 PM, 2:08 PM, 2:18 PM and 2:25 PM, revealed they did not check the resident every thirty (30) minutes and did not take the lap buddy off, for ten (10) minutes, every two (2) hours.</p> <p>Interview, on 10/19/12 at 4:05 PM, with the Director of Nursing (DON) revealed she was unaware Resident #4 was unable to remove the lap buddy until this week. She stated every Thursday the nurses were supposed to ensure the resident was able to remove the lap buddy and they should have notified her as soon as the resident was unable to do so. She further stated the family had not signed the consent for the restraint prior to the restraint use and she could not say the family knew the risks of restraints. Further interview revealed the Least Restraint</p>	F 221		

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F 221 Continued From page 5  
Assessment Record was also not completed prior to the restraint use. She stated the medical diagnosis for the restraint should have been on the Physician's Orders. Further interview revealed the Nurse Aide Care Plan should have instructed the aides to check the resident every thirty (30) minutes, to reposition the resident every two (2) hours and remove the lap buddy for ten (10) minutes.

F 221

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

F 253

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 effective housekeeping and maintenance services to ensure a sanitary and orderly environment. Observation during the survey revealed large dust balls under a resident's bed and a build up of dust on the heating/air conditioning units in the resident rooms and in the parlor.

The Findings Include:

Review of the facility's policy, titled "Cleaning Patient Rooms" dated 02/01/11, revealed all patient rooms should be cleaned on a daily basis. Further review of the facility's policy, under Section 9 titled "Clean Floor" revealed the resident floors are to be dust mopped and wet mopped daily starting with the farthest corner to

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F 253	<p>Continued From page 6 prevent build up.</p> <p>Review of the facility's cleaning schedule titled "Schedule #4 ECF West" (long term care resident rooms and common area), dated 03/23/12, revealed environmental services should start cleaning resident rooms at 7:00 AM and continue until breakfast was served at 8:00 AM. The cleaning schedule further revealed cleaning continued from 9:15 AM through 11:30 AM and again from 1:00 PM until 2:00 PM with notation on the schedule to "Pick up wet floor slngs".</p> <p>Observation, on 10/17/12 at 4:20 PM, revealed large (ranging from marble to jackball size) dust balls under the head of the bed in Resident #4's room, room #259. Continued observation revealed Resident #4 was in the room sitting in a wheel chair.</p> <p>Interview, on 10/17/12 at 4:20 PM, with Resident #4's spouse revealed he/she had observed the dust under the bed for several days and revealed a previous incident when staff completed work on the sink in Resident #4's room. The family stated the room was left with debris on the floor and someone cleaned it up after Resident #4's family called the House Keeping Supervisor to complain.</p> <p>Observation, on 10/18/12 at 4:30 PM, revealed the large dust balls remained under the head of the bed. Continued observation revealed dust or grime in the heating and air conditioning vent in Resident #4's room.</p> <p>Continued interview, on 10/18/12 at 4:30 PM, with Resident #4's family revealed they had previously</p>	F 253		
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F 253	Continued From page 7 asked for the vent to be cleaned and stated "if they cleaned it, it's dirty again".  Observation, on 10/19/12 at 9:50 AM, revealed a dust build up in the vents of the air conditioning and heating unit in Resident #4's room and the resident Parlor area.  Review of the facility's Preventive Maintenance Schedule for the HVAC unit in resident room #259, revealed the last completed maintenance was done on 09/03/12 and scheduled again on 10/25/12.  Interview, on 10/18/12 at 10:15 AM, with House Keeping Staff #3 revealed she was one of the staff responsible for sweeping and dusting the resident rooms. House Keeping Staff #3 further revealed the resident rooms should be swept and mopped daily per the facility's policy. Interview further revealed House Keeping Staff #3 had verified observing dust under the beds in the resident rooms after they were cleaned.  Interview, on 10/18/12 at 10:00 AM, with the Physical Plant Director, with the responsibility of environmental services, revealed the resident rooms should be cleaned daily per the facility's policy. Interview further revealed no documented evidence that the rooms were cleaned per policy on a daily basis.  Interview, on 10/19/12 at 1:30 PM, with the Physical Plant Director revealed the air conditioning and heating units in the resident Parlor and resident rooms were cleaned every fifty-nine (59) days. Interview further revealed the Physical Plant Director stated that the suction	F 253			

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F 253	Continued From page 8 fans pick up air with dust and dirt particles from the floor at the bottom of the unit, the air flows through the unit, then the air blows out the top of the unit leaving the dust. The Physical Plant Director observed the build up in the vents of the Parlor area and Resident #4's room, stating he was more concerned about spores and mold than dust.  Interview with the Director of Nursing, on 10/19/12 at 5:55 PM, revealed there should not be a build up of dust in the vents of the resident areas.	F 253			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE  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 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 facility policy, it was determined the facility failed to ensure a comprehensive	F 274			

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F 274	<p>Continued From page 9</p> <p>assessment of a resident was conducted within fourteen (14) days after the facility determined, or should have determined, that there has been a significant change in the resident's physical or mental condition for one (1) of twelve (12) sampled residents (Resident #1).</p> <p>A Quarterly Minimum Data Set (MDS) was completed for Resident #1 on 08/12/12; however, the facility failed to recognize the resident had declined since the Admission MDS which was completed on 05/29/12. Resident #1 sustained weight loss from 198.5 pounds on 05/20/12 to 180.70 pounds on 8/06/12 which was a severe weight loss of 8.96 % in three (3) months. There was no documented evidence the facility had recognized the need for a significant change MDS, although on comparing the two (2) MDS's, the resident had also declined from 05/29/12 until 08/12/12, in the areas of ambulation, dressing, and hygiene.</p> <p>Continued review revealed the resident further declined since the Quarterly MDS which was completed on 08/12. The resident continued to have weight loss and sustained a weight loss from 210.5 pounds on 04/25/12 to 169.8. pounds on 10/07/12 which was a severe weight loss of 14.45 percent in 180 days. In addition, the resident had a further decline in the ability to ambulate. Also, the resident was having increased episodes of crying and tearfulness. There was no documented evidence the facility had completed a significant MDS after the 08/12 MDS, although the resident had declined in areas of weight loss and ambulation, and had a change in mood and behaviors.</p>	F 274		

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F 274	<p>Continued From page 10</p> <p>The findings include:</p> <p>Review of the facility "Resident Assessment Instrument (RAI) and Minimum Data Set (MDS), undated, revealed within fourteen (14) days of the resident's admission and after a significant change in the resident's physical, mental, or psychosocial well being, a comprehensive assessment of the resident's needs will be made by the Interdisciplinary Team. The purpose of the assessment was to describe the resident's capability to perform daily life functions and to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity.</p> <p>Review of the facility "Care Planning and Care Cards" policy, dated 06/11, revealed when a resident experienced a "change in status", a new MDS 3.0, CAAS (Care Area Assessment Summary) will be completed and the care plan will be revised to reflect current status.</p> <p>Review of Resident #1's medical record revealed diagnoses which included Dementia with Psychosis Behavior, Diabetes Mellitus, Depression, Anxiety, Agitation. Review of the Admission Minimum Data Set (MDS) Assessment dated 05/29/12, revealed the facility assessed the resident as having severe impairment in cognitive status, as requiring limited assistance with ambulation, extensive assistance with dressing, and extensive assistance with hygiene.</p> <p>Review of the Quarterly (MDS) dated 08/12/12, revealed the facility assessed the resident as</p>	F 274		
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F 274	<p>Continued From page 11</p> <p>having severe impairment in cognitive status, as requiring extensive assistance with ambulation, total assistance with dressing, and total assistance with hygiene. Further review revealed the facility assessed the resident as independent with locomotion, and as having a significant weight loss.</p> <p>Review of the Weight Flow Sheet revealed the resident's weight on 05/20/12 was 198.5 and the resident's weight on 08/06/12 was 180.7 which was a severe weight loss of 8.96 % in three (3) months.</p> <p>There was no documented evidence the facility had recognized the need for a significant change MDS, although the resident had a decline from 05/29/12 until 08/12/12, in the areas of ambulation, dressing, and hygiene, and had sustained severe weight loss.</p> <p>Observation of the resident on 10/17/12 at 11:05 AM, 12:00 PM, 12:30 PM, 2:00 PM, 3:00 PM, and 4:00 PM revealed the resident was sitting in a wheelchair in her/his room or in the hallway. There was no observation of the resident ambulating or wandering. The resident did not attempt to maneuver the wheelchair or to wheel self.</p> <p>Further review of the Weight Flow Sheet, revealed the residents weight on 04/25/12 was 210.5 and the resident's weight on 10/07/12 was 169.8. This is a 14.45 percent severe weight loss in 180 days.</p> <p>Review of the Physician's Orders dated 08/02/12 revealed orders to give an extra Celexa</p>	F 274		
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F 274	<p>Continued From page 12 (antidepressant medication) ten milligrams (10 mg's) and nursing staff to watch for improvement in mood and less crying in the next 10-14 days.</p> <p>Review of the Nurse's Note dated 08/07/12 at 2:10 PM revealed the resident was walking up and down the hall with episodes of tearfulness.</p> <p>Review of the Nurse's Note dated 08/07/12 at 5:25 PM revealed the resident continuously cried for thirty (30) minutes and redirection was attempted with snacks and ambulation.</p> <p>Review of the Nurse's Note dated 08/19/12, no time noted, revealed the resident continued to lose weight but was consuming 90 % of meals. Further review revealed the resident often cried for unknown reasons and ambulated in the hallway.</p> <p>Review of the Nurse's Note dated 08/21/12 revealed the resident was using the wheelchair for ambulation and would walk; however, ambulation was becoming less often.</p> <p>Review of the Nurse's Note dated 08/24/12 at 12:00 PM revealed the resident would have emotional ups and downs all day and would cry.</p> <p>Review of the Physician's Note dated 09/12/12 revealed the resident was no longer walking and was in the wheelchair.</p> <p>Review of the Physician's Note dated 09/14/12 revealed the resident went through a phase when she/he was angry and that had past. Impression: Pick's Dementia worsening slowly. The Note stated, would continue the same medication; on</p>	F 274		
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F 274	<p>Continued From page 13</p> <p>09/04/12 ordered Ativan (anti-anxiety medication) to help her/him be calm. The Note further stated, on 9/5/12 a urine showed four (4) + bacteria and Keflex (antibiotic medication) was ordered.</p> <p>The Nurse's Note dated 09/13/12 revealed the resident was no longer ambulating on the unit and a Physician's Order was received to discontinue the wanderguard.</p> <p>Review of the Nurse's Note written by the Director of Nursing (DON), revealed she had discussed with staff at Sanders Brown Center for Aging the resident's current symptoms and interventions including a review of acute conditlons, medications, sleeping, eating, and toileting habits and the Sanders Brown staff were to consult with the resident's Neurologist.</p> <p>Although the resident had further decline since the Quarterly MDS dated 08/12/12 including a decline in ambulation, increased epslodes of crying and tearfulness, and sustained a severe weight loss in the past 180 days, there was no documented evidence a significant change MDS had been completed.</p> <p>Interview on 10/18/12 at 10:30 AM with the Registered Dietician (RD), revealed the resident had a significant weight loss in the last 180 days which was unplanned. She stated the resident had gradually lost weight although she/he was eating well. She further stated she felt some of the weight loss was due to the resident's behavlor of continuously ambulating up and down the halls when agltated a few months ago, and also related to a decrease in edema of the lower extremities.</p>	F 274		
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F 274	<p>Continued From page 14</p> <p>Interview on 10/18/12 at 11:30 AM with Certified Nursing Assistant (CNA) #1, revealed she was assigned to the resident and cared for her/him frequently. She stated the resident had started whining and crying the past few months and staff tried to re-direct to calm her/him. She further stated the resident used to ambulate everyday; however, the resident had not ambulated for over two (2) months. She further stated the resident now needed two (2) assist to transfer and sometimes required the use of the hoier lift if she/he was unable to stand.</p> <p>Interview on 10/19/12 at 3:00 PM with the MDS Coordinator, revealed she agreed in comparing Admission MDS dated 05/29/12 and the Quarterly MDS dated 08/21/12, the resident had declined in the areas of ambulation, dressing, hygiene, and significant weight loss. Further interview revealed she had recognized since the Quarterly MDS dated 08/21/12 was completed the resident was no longer ambulating and was having continued weight loss. However, she thought there was just one (1) area of decline because the weight loss had not been significant since 08/12 to the present. However, the weight loss was significant for the past 180 days since 04/12.</p> <p>Interview on 10/19/12 at 5:30 PM with the DON, revealed the Attending Physician, Neurologist, and pharmacy collaborated and made recommendations regarding the resident's behaviors of crying and tearfulness over the past few months, requiring psychotropic medication changes. She further stated the resident had a recent decline in verbage and reaction to staff. Continued interview revealed the resident was no</p>	F 274		
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F 274	Continued From page 15 longer able to ambulate and was no longer having to wear a wanderguard due to no wandering behaviors. She stated the decline in the ability to ambulate was attributed to the disease process. She further stated the resident had a decline in weight loss which had been gradual and the facility was in consultation with Sanders Brown Center for Aging regarding the resident's overall decline.	F 274		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by:	F 280		

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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  10/19/2012
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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 280	<p>Continued From page 16</p> <p>Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure the residents Comprehensive Plan of Care was reviewed and revised for one (1) of twelve (12) sampled residents (Resident #1). Resident #1 sustained a severe weight loss from 198.5 pounds on 05/20/12 to 180.7 pounds on 8/06/12 which was a 8.96 percent (%) loss in three (3) months. In addition the resident sustained a severe weight loss from 210.5 pounds on 04/25/12 to 169.8. pounds on 10/07/12 which was a loss of 14.45 % in 180 days. There was no documented evidence the Comprehensive Plan of Care had been revised to address the actual weight loss.</p> <p>The findings include:</p> <p>Review of the facility "Care Planning and Care Cards" Policy, dated 06/11, revealed the purpose of the policy was to provide interventions based on assessment of residents through care planning and care cards. Further review revealed the care plan will be updated as new needs/problems/concerns arise and formally reviewed by the Interdisciplinary Team at least quarterly.</p> <p>Review of Resident #1's clinical record revealed diagnoses which included Dementia with Psychosis Behavior, Diabetes Mellitus, Depression, Anxiety, Agitation. Review of the Admission Minimum Data Set (MD) dated 05/29/12 revealed the facility assessed the resident as having a significant weight loss. Review of the Quarterly (MDS) dated 08/12/12, revealed the facility assessed the resident as having significant weight loss.</p>	F 280		
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F 280	<p>Continued From page 17</p> <p>Review of the Nutrition Care Areas Assessment Summary (CAAS), dated 05/31/12 revealed the resident had to be fed all snacks and meals although the resident did feed herself some finger foods. Further review revealed the resident had an average intake of 47% with meals with an average of 1807 milliliters of fluid intake during the last three (3) days. The resident was on a therapeutic diet related to Diabetes Mellitus.</p> <p>Review of the Weight Flow Sheet revealed Resident #1's weight on 05/20/12 was 198.5 and the resident's weight on 08/06/12 was 180.7 which was a severe weight loss of 8.96 % In three (3) months.</p> <p>Further review of the Weight Flow Sheet, revealed Resident #1's weight on 04/25/12 was 210.5 and the resident's weight on 10/07/12 was 189.8 which was a 14.45 percent severe weight loss in 180 days.</p> <p>Review of the Dietary Consult written by the Registered Dietician (RD) on 06/12/12, revealed the resident's weight was 192 pounds which was a decrease of 6.3 % in one (1) month and the resident was consuming 33% of meals with 1847 milliliters of fluids daily for a three (3) day average.</p> <p>Review of the Dietary Consult written by the RD on 07/08/12 revealed the resident's weight was 180.3 pounds which was a decrease of 6.1% In thirty (30) days and a decrease of twenty-two (22) % in 180 days. Further review revealed the resident remained at 144% of her/his ideal weight of 125 pounds. The Consult stated the resident</p>	F 280		
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F 280	<p>Continued From page 18</p> <p>was consuming 75% of meals on average and consuming 1806 milliliters of fluids. Continued review revealed the weight loss likely related to fluid changes with decreased edema noted.</p> <p>Review of the Dietary Consult by the RD on 09/10/12 written by the RD, revealed the resident's weight was 174.1 pounds which was a decrease of 3.6% in 30 days, a decrease of 9.3% in 90 days, and a decrease of 22% in 180 days. The Consult stated Resident#1 was on antibiotics for UTI, and the resident was crying and aggressive.</p> <p>Review of the Dietary Consult written by the RD on 10/18/12 revealed the resident's weight was 169.8 pounds, a decrease of 19% in 180 days and intakes were good at 84% average meals.</p> <p>Interview on 10/18/12 at 10:30 AM with the Registered Dietician (RD), revealed the resident had an unplanned significant weight loss in the last 180 days, was consuming 77% of meals, and remained overweight. She stated the resident was meeting nutritional needs related to labs. Further interview revealed she did not complete care plans, but came to the facility two (2) times a month to address residents with nutritional needs, weight losses, and to address residents who were being assessed for an Admission, Quarterly, Annual, or Significant Change MDS.</p> <p>Interview on 10/19/12 at 3:00 PM with the MDS Coordinator, revealed she did have a Care Plan in place to address the resident's diagnosis of Diabetes; however, did not complete a care plan related to the resident's actual weight loss and nutritional status. Further interview revealed she</p>	F 280		
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F 280	Continued From page 19 agreed there should have been a Care Plan related to actual weight loss for this resident in order to have specific interventions in place to address this residents weight loss.	F 280		
F 314 SS=D	Interview on 10/19/12 at 5:30 PM with the DON, revealed had a decline in weight loss and should have had a Plan of Care in place to address this. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure residents did not develop Pressure Sores unless it was clinically unavoidable for one (1) of twelve (12) sampled residents (Resident #1).  Resident #1 was assessed by the facility as being at risk for pressure sore development. Review of the most recent skin assessment dated 10/14/12 revealed the resident had no pressure sores. However, observation on 10/18/12 at 9:45 AM, during a skin assessment revealed the resident had an unidentified area on the right lateral heel	F 314		

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F 314	<p>Continued From page 20</p> <p>which was described by the nurse as a Stage I non-blanchable red pressure sore which measured six (6) centimeters (cm's) in length x 3 cm's in width with a darker red center. After the area was offloaded for fifty-five (55) minutes the area was unchanged in appearance. Interviews with staff revealed they were unaware of the Pressure Sore. There was no documented evidence the facility recognized the change in the resident's skin in order to place interventions to promote healing.</p> <p>The findings include:</p> <p>Review of the facility's "Pressure Sore Prevention Policy and Procedure", revised 03/04, revealed a resident who enters the facility without a pressure sore does not develop a pressure sore unless the resident's clinical condition demonstrates that it was unavoidable. Further review, revealed residents who were at moderate to high risk for skin breakdown were to receive daily skin inspections and any abnormal findings would be reported to the charge nurse.</p> <p>Review of Resident #1's medical record revealed he/she had diagnoses which included Dementia, and Diabetes Mellitus. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/21/12, revealed the facility assessed the resident as having severe impairment in cognitive status, and as requiring extensive assistance with transfers, bed mobility, and ambulation.</p> <p>Review of the Braden Scale for Pressure Sore Risk, dated 08/20/12, revealed the resident scored a fourteen (14) which indicated the resident was at moderate risk for pressure</p>	F 314		
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F 314	<p>Continued From page 21</p> <p>related to; sensory impairment, constantly moist related to urine, limited mobility, and friction and shear with assistance in moving.</p> <p>Review of the Comprehensive Plan of Care, dated 09/17/12 revealed the resident was at risk for injuries/complications related to Diabetes Mellitus. The Interventions Included checking feet and reporting any areas. Further review revealed the resident was at risk for Pressure Ulcers related to a a history of redness and excorlation to the peri-area and anal area with interventions to report any red and excoriated areas to the nurse.</p> <p>Review of the most recent Weekly Summary dated 10/14/12 revealed the resident had no pressure sores and no skin breakdown. Interview, on 10/19/12 at 2:45 PM, with LPN #2 revealed she had done the skin assessment on 10/14/12 and she saw no skin breakdown at that time.</p> <p>Review of the Physician's Order,s dated 10/12, revealed the resident had orders for Granulex twice a day to both heels and heel protectors every shift as needed.</p> <p>Review of the Medication Administration Record (MAR), dated 10/12, revealed the Granulex was signed off as applied twice a day by the licensed staff, and the heel boots were not signed off for the month of 10/12.</p> <p>Observation of a skin assessment performed by Registered Nurse (RN) #1/Charge Nurse and Licensed Practical Nurse (LPN) #1, on 10/18/12 at 9:45 AM, revealed the right lateral heel had an</p>	F 314		
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F 314	<p>Continued From page 22</p> <p>area which RN #1 described as six (6) centimeters (cm's) length x three (3) cm's width and non-blanchable with a darker red center. She stated the area appeared to be a Stage I pressure sore and it had not been identified until the skin assessment. The nurses indicated staff had not reported any new areas of skin breakdown for Resident #1.</p> <p>Further observation after the resident's heel had been offloaded for fifty-five (55) minutes, on 10/18/12 at 10:50 AM with LPN #2, revealed the area continued to be red and the LPN described the area as a Stage I area.</p> <p>Interview, on 10/18/12 at 11:30 AM, with Certified Nursing Assistant (CNA) #1 who was assigned to the resident on the day shift for 10/17/12 and 10/18/12, revealed she had just given Resident #1 a bed bath about 10:00 AM prior to the skin assessment, and had not noted any new areas of skin breakdown or anything different about the resident's skin. She stated the resident received a complete bed bath each morning with lotion applied afterward to the skin including the heels. She stated, if she saw any new areas of skin breakdown, she was to report it verbally to the nurse assigned. Further interview revealed the resident normally would draw her/his legs up and rub the heels on the bed and the resident's heels were usually red. When asked if she had any training related to observing for skin breakdown, she stated it was sometimes reviewed in the CNA meetings which were held one time a month.</p> <p>Interview, on 10/19/12 at 11:00 AM, with LPN #3 revealed she had been assigned to Resident #1 on 10/17/12 and worked from 7:00 AM until 7:00</p>	F 314		
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F 314	<p>Continued From page 23</p> <p>PM. She stated she applied the Granulex to the resident's heels; however, she did not notice any areas of redness or skin breakdown at that time.</p> <p>Interview was attempted by phone multiple times; however, the surveyor could not reach LPN #4 who was assigned to Resident #1 on 10/17/12 from 7:00 PM until 7:00 AM.</p> <p>Interview with the Director of Nursing (DON), on 10/19/12 at 5:45 PM, revealed there was a failure by staff to recognize and report a change in the resident's right heel and the staff should identify changes in skin in order to change the interventions to promote healing. Further interview revealed the nurses should be inspecting the heels as they apply the Granulex which was ordered twice a day, especially with the resident's diagnoses of Diabetes Mellitus.</p>	F 314		
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Storage of Medications at Nursing Stations or Patient Care Areas Policy (Revised 11/07), it was determined the facility failed to</p>	F 323		

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F 323	<p>Continued From page 24</p> <p>ensure the environment remained as free from accidental hazards as possible as evidenced by two (2) medication carts observed to be unlocked and a cabinet with hazardous chemicals was observed to be unlocked. The medication carts were against the desk and the wall outside of the Nurses Station and the cabinet was in the Nurses Station.</p> <p>The findings include:</p> <p>Review of the facility's Storage of Medications at Nursing Stations or Patient Care Areas (Revised 11/07), revealed drugs were to be kept in locked storage when unattended and inaccessible to unauthorized individuals and controlled drugs were to only be accessible to licensed medical, nursing or pharmacy personnel.</p> <p>Observation, on 10/16/12 at 7:30 PM, revealed two (2) medication carts by the Nurses Station. The carts were both unlocked and the keys were in a drawer on the carts. Further observation revealed an unlocked cabinet, in the Nurses Station, with a bottle of Virex spray (a bactericide/virucide with precautions to keep out of reach of children and avoid contact with eyes), a can of Great Value Disinfectant Spray (precautions on the label to keep out of reach of children and flammable) and Onyx Professional Pure Acetone Nail Polish Remover Maximum Strength (precautions to keep away from children, Danger Flammable, do not breath vapors, harmful internally, if ingested, seek medical attention immediately and Contact Poison Control). The cabinet was accessible to residents when staff were away from the Nurses Station.</p>	F 323		

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F 323	<p>Continued From page 25</p> <p>Interview, on 10/16/12 at 7:40 PM, with Licensed Practical Nurse (LPN) #4 revealed the medication carts should be locked and usually were locked or they were turned around with the drawers against the wall. She stated the keys should not be in the medication cart drawer. She further stated the locks on the carts would "stick" so the nurses would leave the carts unlocked but would turn the carts around with the drawers toward the wall. Further interview revealed the narcotics were supposed to be double-locked but were only single-locked when the carts were unlocked. She further stated the medications could be hazardous to residents, visitors and staff.</p> <p>Observation, on 10/17/12 at 10:15 AM, revealed maintenance repairing the lock of the cabinet in the Nurses Station.</p> <p>Interview, on 10/17/12 at 10:15 AM, with LPN #1 revealed the cabinet should have been locked due to the hazardous chemicals. She stated maintenance was trying to fix it and she did not know how long the lock had been broken. She further stated the facility had seven (7) wandering residents.</p> <p>Observation, on 10/17/12 at 4:15 PM, revealed nine (9) unlocked drawers on the medication cart for the middle hall.</p> <p>Interview, on 10/17/12 at 4:15 PM, with LPN #3 revealed the medication cart drawers should have been locked, the rest of the medication cart drawers were locked. She stated the drawers were not shut adequately enough to lock. She stated the medications could be hazardous to residents.</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>Observation, on 10/18/12 at 2:35 PM, revealed two (2) unlocked drawers on the medication cart.</p> <p>Interview, on 10/18/12 at 2:35 PM, with LPN #5 revealed the drawers should have been locked, she didn't know why they weren't. She further stated the medications could be hazardous to residents.</p> <p>Interview, on 10/16/12 at 8:30 PM, with the Director of Nursing revealed medication carts were supposed to be locked, narcotics should be double-locked and medications could be harmful to the residents. She further stated the medication cart keys should not have been in the medication cart drawers. Further interview revealed she was aware the locks would stick; however, the nurses knew they should not leave the medication carts unlocked, they should call maintenance if the locks were stuck. She stated the facility had one resident, in a wheelchair, who wandered.</p>	F 323		
F 371 SS=F	<p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced</p>	F 371		

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F 371	<p>Continued From page 27</p> <p>by: Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Observation of initial tour of the kitchen, on the evening of 10/16/12, revealed a dietary assistant was drying dessert dishes with a paper towel. Also, observation in the kitchen, during meal preparation on 10/17/12, revealed a dietary assistant opened the lid to the trash with her bare hand and without washing her hands, opened the refrigerator and obtained a container of liquid margarine and placed it on the prep table. The dietary staff member then coughed into her hand and went to wash her hands. Further observation revealed the same dietary staff member again opened the lid to the trash can with her bare hands to throw away a paper towel, then without washing her hands, went to the prep table and poured liquid margarine into a container. She proceeded to spread the margarine on the bread.</p> <p>The findings include:</p> <p>Review of the facility's "Safety and Sanitation Policy", revised 09/12, revealed all dietary services personnel would practice safe hygiene food handling techniques. Interview with the Dietary Manager, on 10/18/12 at 12:30 PM, revealed the facility had no policy related to drying dishes.</p> <p>1. Observation on initial kitchen tour, on 10/16/12 at 7:45 PM, with the Dietary Manager revealed Dietary Assistant #1 was drying dessert dishes with a paper towel. When the Dietary Manager was questioned at the time of the observation,</p>	F 371			

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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 371	<p>Continued From page 28</p> <p>she stated she had told staff they could dry the dessert dishes, cups, glasses with paper towels and thought she had talked to the health department about this. She stated she would check the policy.</p> <p>2. Further observation during meal preparation, on 10/17/12 at 11:30 AM, revealed Dietary Assistant #2 opened the trash can lid with her bare hands and without washing her hands, opened the refrigerator and obtained a container of liquid margarine which she took to the prep table. Further observation revealed Dietary Assistant #2 coughed into her hand and then went to wash her hands. She then proceeded to move the trash can lid so she could throw away the paper towel in which she dried her hands, and proceeded to the prep table. Dietary Assistant #2 poured the liquid margarine into a container and proceeded to spread the margarine on bread.</p> <p>Interview, on 10/17/12 at 11:40 AM, with Dietary Assistant #2 revealed she should have washed her hands each time she touched the trash can lid.</p> <p>Interview, on 10/17/12 at 11:45 AM, with the Dietary Manager who was watching tray line revealed she had not noticed the dietary assistant to touch the trash can lid. She stated usually the trash can lid was pushed to the side so part of the trash can was open and items could be thrown in the trash can without touching it. Further interview revealed she watched tray line each day she worked and had noted no concerns related to infection control. Record review and further interview with the Dietary Manager revealed she audited the tray line for portion sizes and food</p>	F 371		

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F 371 Continued From page 29  
temperatures; however, there was no audit related to infection control. Further interview, on 10/18/12 at 12:30 PM, revealed she thought it was sanitary to dry the glasses and dessert dishes with paper towels due to the condensation which would build up if left to dry to air. She stated she could find no policy or information related to this.

F 371

F 372 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  
SS=F

F 372

The facility must dispose of garbage and refuse properly.

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 ensure garbage and refuse containers were contained in dumpsters or compactors with lids to prevent the harborage and feeding of pests.

The Findings Include:

Review of the facility's policy titled "Trash Disposal" dated 02/01/11, revealed all trash should be handled to maintain a sanitary and safe environment. Additionally, the policy stated, the environmental services team members were responsible for proper disposal. Further review of the facility's policy, revealed the open top dumpster was for debris such as wood, metal and plastic.

Observation, on 10/16/12 at 9:30 PM, revealed the facility's large open top trash dumpster behind

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F 372	Continued From page 30 the facility near the oxygen cylinder was uncovered and contained multiple black plastic trash bags.  Observation, on 10/17/12 at 4:00 PM, revealed the facility's large trash dumpster behind the facility, near the oxygen cylinder contained multiple large black trash bags, several fast food bags and soda containers. This dumpster did not have a cover creating an environment accessible to rodents, flies and roaches.  Interview with the Physical Plant Director, on 10/17/12 at 4:00 PM, revealed there was trash in the large black trash bags that should have been in a closed container to prevent the harborage and feeding of pests. Further interview revealed the dumpster was for construction and building materials and should not have been used for trash because it did not have a lid. Additionally, the Physical Plant Director revealed there were no construction projects in progress. The Physical Plant Director stated that the "neighbors" put trash in the dumpster and it was difficult to monitor.	F 372		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be	F 431		

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F 431	Continued From page 31 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation and interview It was determined the facility failed to ensure drugs and biological were stored in locked compartments as evidenced by two (2) medication carts were observed to be unlocked.  The findings include:  Review of the facility's Storage of Medications at Nursing Stations or Patient Care Areas Policy (Revised 11/07) revealed drugs were to be kept in locked storage when unattended and should be	F 431		

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F 431	<p>Continued From page 32</p> <p>inaccessible to unauthorized individuals and controlled drugs should be accessible only to licensed medical, nursing or pharmacy personnel.</p> <p>Observation, on 10/16/12 at 7:30 PM, revealed two (2) medication carts by the Nurses Station. The carts were both unlocked and the keys were in a drawer on each of the carts.</p> <p>Interview, on 10/16/12 at 7:40 PM, with Licensed Practical Nurse (LPN) #4 revealed the medication carts should be locked and usually were locked or they were turned around with the drawers against the wall. She further stated the locks on the carts would "stick" so the nurses would leave the carts unlocked but would turn the carts around with the drawers toward the wall. Further interview revealed the narcotics were supposed to be double-locked but were only single-locked when the carts were unlocked.</p> <p>Observation, on 10/17/12 at 4:15 PM, revealed nine (9) unlocked drawers on the medication cart for the middle hall.</p> <p>Interview, on 10/17/12 at 4:15 PM, with LPN #3 revealed the medication cart should have been locked.</p> <p>Observation, on 10/18/12 at 2:35 PM, revealed two (2) unlocked drawers on the medication cart.</p> <p>Interview, on 10/18/12 at 2:35 PM, with LPN #5 revealed the drawers should have been locked, she didn't know why they weren't.</p> <p>Interview, on 10/16/12 at 8:30 PM, with the Director of Nursing revealed medication carts</p>	F 431		

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F 431	Continued From page 33 were supposed to be locked, narcotics should be double-locked. She further stated the keys should not be in the medication cart drawers.	F 431			
F 441	483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and	F 441			

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F 441	<p>Continued From page 34</p> <p>transport linens so as to prevent the spread of infection.</p> <p>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 develop, implement, and maintain an Infection Prevention and Control Program in order to prevent, and control, to the extent possible, the onset and spread of infection within the facility. The facility failed to properly launder resident clothing to minimize contamination. Additionally on initial tour bedpans were observed to be stored on the floor unlabeled and unbagged in the resident bathrooms. Tour of the beauty shop revealed used hair curlers and combs were dusty with hair in them.</p> <p>The findings include:</p> <p>1. Review of the facility's policy for resident laundry was the Center for Disease Control's 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, revealed textiles and laundry should be handled, transported, and laundered in a safe manner.</p> <p>Observation during environmental tour, on 10/17/12 at 4:00 PM, revealed two areas in the Extended Care Unit to contain washer and dryer units used for resident laundry services. Area #1, located in the beauty shop, had the washer on the right of the dryer with clean laundry hanging just above and touching the washer. Area #2, located</p>	F 441		
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F 441	<p>Continued From page 35</p> <p>in the back shower room, had the dryer to the right of the washer with a twenty (20) inch clearance from the wall to the dryer door. Dirty and or soiled laundry would need to pass in the direct path of clean laundry with possible cross-contamination.</p> <p>Interview, on 10/18/12 at 10:00 AM with the facility's Plant Operations Director revealed water temperatures were not taken in the resident laundry. The facility's Plant Operations Director stated the facility followed the Center for Disease Control's guidelines for hot water and hot dryer to kill the bacteria.</p> <p>Review of the facility's laundry detergent manufacturer recommendations revealed the Liquid Oxygen Bleach agent used by the facility to be most effective when used in water temperatures of one hundred and sixty (160) degrees or more. Further recommendations revealed the Compac detergent used by the facility did not document that it was effective against micro-organisms.</p> <p>Interview, on 10/19/12 at 2:15 PM, with the laundry chemical distributor, revealed the water temperatures need to be one hundred and forty (140) degrees to one hundred and sixty (160) degrees to be effective against micro-organisms.</p> <p>Interview, on 10/18/12 at 10:15 AM, with House Keeping #3 revealed she was responsible for resident laundry and used the laundry units in the shower room. Interview further revealed Keeping #3 did not think it was sanitary to have the clean and soiled clothing close together.</p>	F 441	

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F 441	<p>Continued From page 36</p> <p>Interview, on 10/18/12 at 1:55 PM, with the Infection Control Nurse revealed that it would be an infection control issue to cross the clean fabric with the soiled fabric during the laundry process.</p> <p>2. Observation during initial tour, on 10/16/12 at 7:45 PM, revealed multiple resident bathrooms contained bedpans that were uncovered, unlabeled, and stored on the resident bathroom floor.</p> <p>Observation, on 10/19/12 at 10:00 AM, revealed resident rooms #250, #257 and #260 to have a used, uncovered and unlabeled bedpan sitting on the floor in the bathroom. Resident room #255 had a used uncovered unlabeled bedpan on top of a bedside toilet in the bathroom.</p> <p>Interview, on 10/19/12 at 5:55 PM, with the Director of Nursing revealed bedpans should be cleaned and placed in a bag or container and then placed in the resident bathroom.</p> <p>3. Observation during environmental tour, on 10/17/12 at 4:00 PM, revealed used combs, and curlers in the beauty shop that were dusty and dirty with hair.</p> <p>Interview, on 10/19/12 at 2:30 PM, with the Beautician revealed the curlers were not disinfected between resident use.</p> <p>Interview, on 10/18/12 at 3:20 PM, with the Infection Control Nurse revealed the combs and curlers were not being disinfected or sanitized between resident use could be an infection control issue.</p>	F 441			

**THE JAMES B. HAGGIN MEMORIAL HOSPITAL  
EXTENDED CARE FACILITY  
SURVEY COMPLETION DATE October 19, 2012**

**PLAN OF CORRECTION**

**CFR 483.70(a) Life Safety from Fire – The facility failed to ensure single station smoke detectors installed in the facility were installed according to National Fire Protection Association (NFPA) standards.**

**K 130 NFPA 101 Miscellaneous  
S/S=F**

**Completion Date: 11/05/12**

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

All single station smoke detectors were moved, remounted and measured to meet the 12" from ceiling NFPS standard.

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

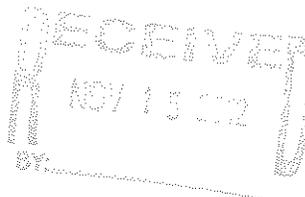
All residents have the potential to be affected but none were adversely affected.

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

The single station smoke detectors are permanently secured to the walls.

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

The single station smoke detectors will be monitored by maintenance team members when checked monthly and also when the batteries are changed yearly or as needed.



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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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1947, 1962, 1978, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Second Floor wing of a two story, Type I Unprotected</p> <p>SMOKE COMPARTMENTS: Four smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system</p> <p>GENERATOR: Type I generator installed in 1982, fuel source is diesel</p> <p>A standard Life Safety Code survey was conducted on 11/02/11. The James B Haggin Memorial Hospital 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 four (34)</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *LNHA/CEO* (X6) DATE *11/15/12*

any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that the 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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(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	K 000		
K 130 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure single station smoke detectors installed in the facility were installed according to National Fire Protection Association (NFPA) standards. Smoke detectors must be installed properly to ensure their reliability to detect smoke during a fire. The deficiency had the potential to affect thirty four (34) residents, staff and visitors.  The findings include:  Observation, on 11/02/2012 at 6:00 PM, revealed single station smoke detectors in resident rooms installed by the facility. The single station smoke detectors were improperly installed. The single station smoke detector was installed approximately 36 inches down the wall from the ceiling. Single station smoke detectors must be installed no more than 12 inches down a wall and no closer than 4 inches from the ceiling. The observations were confirmed with Maintenance Staff.  Interview, on 11/02/2012 at 6:00 PM, with the Maintenance Staff, revealed he was not aware of	K 130		

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

PRINTED: 11/05/2012  
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  11/02/2012
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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	<p>Continued From page 2</p> <p>the requirements for the proper installation of the single station smoke detectors.</p> <p>Reference: NFPA 72 (1999 edition) 2-3.4.3.1 Spot-type smoke detectors shall be located on the ceiling not less than 4 in. (100 mm) from a sidewall to the near edge or, if on a sidewall, between 4 in. and 12 in. (100 mm and 300 mm) down from the ceiling to the top of the detector. (Refer to Figure A-2-2.2.1.)</p>	K 130		
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