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

PRINTED: 12/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185327		11/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF SPENCER COUNTY	625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended A Recertification Survey was initiated on 11/12/14 and concluded on 11/14/14. The facility was found not meeting the minimum requirements for recertification and deficiencies were cited at the highest scope and severity of an F. An Abbreviated Survey was initiated on 11/13/14 and concluded on 11/14/14 to investigate KY22475. The Division of Health Care substantiated the allegation with related deficiencies cited.	F 000	This plan of correction is submitted per requirement by State but does not constitute admission by the provider of any fact or conclusion set forth in this statement of deficiency.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's Abuse Policy, it was determined the facility failed to have system in place to ensure narcotics were accounted for and secure from misappropriation for one (1) of three (3) unsampled residents. (Unsampled Resident A). In addition, the facility failed to ensure one (1) of five (5) employees was checked for abuse, neglect and misappropriation of property findings prior to employment. (Employee #3).	F 224		

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

X | X Administrator | X 12/8/14

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 224	Continued From page 1 The findings include: Review of the facility's policy regarding Abuse, dated April 2013, revealed the Nurse Aid Abuse Registry was searched for findings prior to permanent employment. The facility investigated all allegations of abuse, neglect and misappropriation. 1. Review of a facility investigation report, dated 10/03/14, revealed sixty (60) Oxycodone-APAP 7.5-325mg tablets were delivered to the facility on 09/27/14 at 1:26 AM for Unsample Resident A. The pharmacy delivered the drugs divided among two (2) cards. The first card contained thirty (30) Oxycodone and was designated as Card 1 of 2. The second card contained thirty (30) Oxycodone and was designated as Card 2 of 2. The drug delivery ticket revealed the Oxycodone were accepted by Licensed Practical Nurse (LPN) #5 then released to Registered Nurse (RN) #5. RN #5 was providing care for Unsampled Resident A that night and had possession of the medication cart for that group of residents. Further review revealed the Oxycodone count for Card 1 of 2 was zero, on 10/02/14 at 7:00 AM, and Card 2 of 2 needed to be found so the resident could receive medication later in the day. Card 2 of 2 could not be located by the nursing staff and the Director of Nursing (DON) was notified and arrived at the facility to initiate an investigation. It was discovered that RN #5 had signed for Card 1 of 2; however, Card 2 of 2 and the sign out sheet were not located. In addition, it was discovered that Card 2 of 2 was not logged in on the accountability sheet. The accountability sheet documents the delivery of cards of	F 224	F224 1. On 11/14/2014 the Human Resources Director checked the Nurse Aide Registries in the two (2) other states where employee # 3 lived/worked and the findings were negative. 2. Education will be provided to the Human Resources Director by the Administrator on the company policy pertaining to abuse registry checks by 12/12/2014 3. A 100% audit will be completed by the Human Resources Director on all current employee files no later than 12/12/2014 to ensure all employee files contain abuse registry checks in all states of residency/employment for that employee. The administrator will review completed files for all new potential employees, prior to start date, to ensure all present and prior states of residency/employment have been checked. These audits will be ongoing. 4. Results of the abuse registry check audits will be reviewed by the Quality Assurance Committee or Sub Committee, consisting of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services Director, Activities	12/23/2014

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F 224	Continued From page 2 narcotics and the discarding of empty cards. Both number of cards in the medication cart and the number of pills in each card were supposed to be counted by two (2) nurses during shift change. Nurses were interviewed by the facility and drug screens were performed, also on RN #5, and all were negative. All medication carts in the facility were searched and the Oxycodone was not located. RN #5 denied taking the narcotics; however, since she failed to add Card 2 of 2 to the accountability sheet and the circumstances were questionable, RN #5 was terminated by the facility. Interview with the DON, on 11/13/14 at 1:37 PM, revealed the nurses often did not count all the narcotics in the locked tray on the medication cart. She stated they counted narcotics cards if they were in use, not the ones waiting to be used. She stated every narcotic and every narcotic card needed to be counted every shift. She indicated she was unsure of when the narcotics might have disappeared. She stated she was responsible to ensure the nurses performed their duty of counting narcotics and that narcotics were secure. Interview with the DON, on 11/13/14 at 4:55 PM, revealed all the medication carts were searched and the narcotics counts were correct. She reviewed the drug delivery tickets and accounted for all the narcotics except for the Oxycodone Card 2 of 2 for Unsampled Resident A. She stated the facility did not substantiate the allegation of misappropriation of Resident A's narcotics. Interview with RN #5, on 11/13/14 at 5:18 PM, revealed she had been trained on abuse	F 224	Director, MDS Coordinator and Unit Manager on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified, changes can occur to the process through the quality assurance committee. F224 (continued) 1. On 10/02/14 Resident A's Oxycodone 7.5/325 mg was replaced at facility cost. Medication record reviews were conducted by the Director of Nursing on 10/02/14 to ensure no doses had been missed for the resident. Resident A did not miss any prescribed doses. On 10/02/14 a pain assessment was completed by the charge nurse for resident A, and no pain issues were identified. 2. On 10/02/14, a 100% audit was completed by the Director of Nursing and Staff Development Coordinator of all narcotic cabinets, and were consistent with narcotic count sheets and pharmacy delivery manifests. No other	

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F 224	Continued From page 3 prevention by the facility. She stated the facility policies were not followed for narcotic counts. She stated not all narcotics were counted by the oncoming and offgoing nurses. She stated only the narcotics opened and in use were counted and that the number of cards in the narcotic boxes were not always counted. She stated this resulted in a nurse being able to steal narcotics from residents and no one monitored the procedure. Interview with RN #4, on 11/13/14 at 5:38 PM, revealed she had been trained by the facility regarding prevention of abuse. She stated the nurses were responsible for counting narcotics every shift; however, nurses were not following the procedure and doing a thorough count. She stated nurses were counting narcotics in use and not counting narcotics in overflow waiting to be used. 2. Review of five personnel files, revealed the facility hired Employee #3 on 10/14/14. There was no documentation provided to verify the facility checked the Nurse Aide Registries in two (2) other states where the employee lived/worked. The employee provided direct care to residents for thirty-one (31) days. Interview with Administrator, on 11/14/14 at 4:22 PM, revealed he was unaware that Employee #3 had lived/worked in other states. He stated the nurse aide registries in other states were not checked prior to employment. He stated these checks should have been completed prior to hiring to ensure residents were not exposed to abuse from known perpetrators.	F 224	residents' were found to be affected. 3. On 10/03/14, education was initiated with all licensed nurses regarding controlled substances, including storage, counting and administration and was ongoing. On 11/13/14, the controlled substance accountability count sheet, was updated to include a third licensed nurse to oversee controlled substance count. This was to ensure the controlled substance count was completed accurately and no discrepancies were noted during the count. In addition on 11/13/14, licensed nurses were no longer able to dispose of any depleted controlled substance cards, or controlled substance count sheets until the next controlled substance count was completed with the oncoming licensed nurse and third licensed nurse as a witness.	

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F 224		F 224	4. The Director of Nursing, Unit Manager or Weekend Supervisor review pharmacy delivery manifests daily, to ensure the controlled substances have been logged on the controlled substance accountability count sheet. In addition, the Director of Nursing, Unit Manager, or Weekend Supervisor audit the controlled substance accountability count sheet, to ensure the controlled substance counts have been completed, witnessed by the third licensed nurse and no discrepancies were noted. This process will be on going to ensure all controlled substances are accurately accounted for. Results will be reviewed by the Quality Assurance Committee or Sub Committee, consisting of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services Director, Activities Director, MDS Coordinator and Unit Manager on a monthly basis until the team concludes the	

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F 224		F 224	issue is resolved. If at any time concerns are identified, changes can occur to the process through the quality assurance committee.	

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F 246 F 246 SS=D	Continued From page 4 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure call lights were answered in a timely manner for one (1) of twenty-four (24) sampled residents, Resident #18, and one (1) of three (3) unsampled residents, Unsampled Resident B. The findings include: Review of the facility's policy regarding Answering the Call Light, dated October 2010, revealed the resident's call light was to be answered as soon as possible. 1. Review of the clinical record for Resident #18 revealed the facility admitted the resident on 09/24/13 with diagnoses of Peripheral Vascular Disease, Dementia, Atrial Fibrillation, Cerebral Degeneration, Generalized Pain, Gastroesophageal Reflux, Urine Retention, and Hypertension. The facility completed a quarterly Minimum Data Set (MDS) assessment on 07/04/14, that indicated the resident was cognitively intact.	F 246 F 246	F246 1. On 12/05/14, a visual aide was placed on the inside of both bathroom doors to request the occupant to please leave the door unlocked when exiting the bathroom. All residents currently using this bathroom unassisted are visual aide appropriate. Call light audits will begin on 12/11/14 for Resident #18 during the evening hours to ensure timeliness in the answering of his/her call light Call light audits will be reviewed at least weekly by the Administrator, DON, Unit Managers or Social Services. After a period of 4 weeks, if no further concerns are identified, then the call light will be monitored on a random basis. Staff education regarding the call light policy was started on 12/11/2014 by the Staff Development Coordinator, Weekend House Supervisor, and Charge nurses and is ongoing until each staff member has received the	12/23/2014

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F 246	Continued From page 5 Interview with Resident #18, on 11/14/14 at 9:10 AM, revealed the nursing staff sometimes took a long time to answer the call light. Resident #18 stated he/she had noticed it usually took longer to get the call light answered on the evening shift. The resident stated he/she sometimes used the call light when something had spilled on the floor or the door to the shared bathroom was locked. Resident #18 further stated because of the delay in staff answering the call light, he/she would go to the adjoining resident room to unlock the bathroom door on his own. The resident stated the staff had to unlock the bathroom door for him/her on a regular basis. Resident #18 denied having a fall or incontinent episode due to staff delays in answering the call light. Review of the Physical Therapy (PT) Plan of Treatment for the certification period 10/14/14 - 11/11/14 revealed Resident #18 was receiving gait training to decrease his/her risk for falls. Observation of Resident #18, on 11/14/14 at 11:30 AM, revealed the resident sitting on the couch and watching television in the Atrium common area. The resident was neatly dressed, groomed, and wearing glasses and non-skid shoes. Interview with CNA #6, on 11/14/14 at 3:10 PM, revealed Resident #18 sometimes used the call light in his/her room or bathroom for assistance with toileting. The CNA stated the resident occasionally required assistance with incontinent care or getting a new brief. The CNA stated the resident had not reported having a problem with his/her bathroom door being locked. CNA #6 related nursing staff should answer call lights within three (3) minutes. The CNA further stated	F 246	education. 2. On 12/11/14 All Alert and Oriented residents were interviewed by Social Services, to determine if they had issues with their bathroom door being locked when unoccupied. During the interviews 3 other residents were identified as having concerns with the bathroom door. On 12/11/14 a sign was placed on both bathroom doors of each of the residents identified, to request the occupant to please leave the door unlocked when exiting the bathroom. Each resident will have the bathroom door checked by the nurse at least every 2 hours to ensure the door is unlocked. These every 2 hour checks will be completed for a period of 2 weeks. 3. Staff education began on 12/11/14 by the Staff Development Coordinator, Weekend Supervisor and Charge Nurses, to check resident bathroom doors during routine care rounds to	

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F 246	Continued From page 6 a resident could potentially be incontinent or fall if there were a delay in answering a call light. 2. Review of the clinical record for Unsampled Resident B revealed the facility admitted the resident on 08/30/14 with diagnoses of Recurrent Urinary Tract Infections, Hypertension, Recurrent Falls, Cerebrovascular Accident, Atrial Fibrillation, Glaucoma, and Symbolic Dysfunction. The facility completed a quarterly MDS assessment on 09/06/14, which revealed the resident's cognitive status was moderately impaired. Further review of the clinical record revealed the resident was evaluated by the Advanced Practice Registered Nurse (APRN) on 09/05/14 for complaints of urinary frequency. Interview with Unsampled Resident B, on 11/14/14 at 10:20 AM, revealed the resident had concerns with the staff answering the call light. Unsampled Resident B stated he/she sometimes went to the bathroom unassisted because of staff delays in answering the call light. The resident further stated he/she had experienced incontinent episodes after waiting extended periods of time for staff to answer his/her light. Review of the CNA Care Plan revealed Unsampled Resident B required stand-by-assist of one person for transfers. In addition, the Care Plan indicated the resident was continent of bladder and bowel and required one-person assist for his/her toileting needs. Interview with CNA #5, on 11/14/14 at 2:30 PM, revealed call lights should be answered within three (3) minutes. The CNA further stated a delay in answering call lights could result in a	F 246	ensure they are unlocked when unoccupied. These checks will be ongoing. In order to evaluate the effectiveness of the visual aide, the nursing department will complete every 2 hour checks beginning 12/5/14 and continue for two weeks to ensure it is unlocked when unoccupied. 4. The every 2 hour checks will be evaluated by the Director of Nursing, Unit Manager or Weekend House Supervisor daily for effectiveness and to identify any potential trends if the door is found to be locked. Follow up interviews will be conducted with 10 random, alert and oriented residents each month for any concerns with the bathroom door being locked when unoccupied. These random interviews will be ongoing. Results will be reviewed by the Quality Assurance Committee or Sub Committee, consisting of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services	

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F 246		F 246	Director, Activities Director, MDS Coordinator and Unit Manager on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified, changes can occur to the process through the quality assurance committee. F246 (continued) 1. On 11/14/2014 a toileting program was initiated for un sampled resident B to ensure resident had assistance to the bathroom and potentially decrease incontinent episodes. Individual call light audits were initiated 11/14/14 by the Unit Manager to evaluate timeliness of call light response. 2. Interviews will be conducted with all alert and oriented residents to determine any other concerns with timeliness of their call lights being answered. Interviews will be completed no later than 12/10/14. Based on the interviews individual call light audits will be developed where needed.	

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F 246		F 246	3. Routine call light audits will begin 12/12/14 consisting of two random rooms per shift 7 days per week for 4 weeks. After the period of 4 weeks, random call light audits will be completed consisting of 10 rooms per month to identify further potential concerns for timeliness. 4. Routine call light audits will be reviewed weekly for the first 4 weeks and then monthly, by either the Administrator, Director of Nursing, Unit Manager or Social Services. Results will be reviewed by the Quality Assurance Committee or Sub Committee, consisting of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services Director, Activities Director, MDS Coordinator and Unit Manager on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified, changes can occur to the process through the quality assurance committee.	

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F 246	Continued From page 7 resident being incontinent or falling. Interview, on 11/14/14 at 2:45 PM, with the Unit Manager (UM) for Unit 2 revealed she conducted call light audits when there was a Resident Council concern or when she noticed an issue. The UM stated she had not noticed a problem with call lights in a while. The UM further stated the facility did not conduct routine call light audits and she was not aware of Resident #18's concern regarding the locked bathroom door. The UM stated there was the potential for a resident to fall or be incontinent because of a delay in answering call lights. Interview, on 11/14/14 at 3:30 PM, with the Director of Nursing (DON) revealed nursing staff should respond to a resident's call light within five (5) minutes. The DON stated the facility did not perform routine call light audits. She further stated she was not aware of any issues regarding staff delays in answering call lights. She indicated the facility had not conducted call light audits recently because there had not been any resident complaints. The DON stated a resident could potentially have an incontinent episode or fall as a result of a delay in answering the call light. The DON stated she was not aware of Resident #18's concern with the locked bathroom door.	F 246		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272	F272 1. A revised MDS assessment will be completed for both residents #1 and #7 by 12/12/14. Once completed,	12/23/2014

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F 272	Continued From page 8 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to complete additional assessments on triggered areas from	F 272	CAA's will be completed for both residents' #1, and #7 to include further assessments of care area triggers, documented risk factors and will include documentation of supporting diagnoses. No supporting diagnoses will be added to resident #1's indwelling catheter as it was discontinued, as of 10/21/14. 2. The MDS Coordinators, Social Services, Activities and Registered Dietician staff will be reeducated by the Regional clinical consultant by 12/12/14, this will include further assessment of triggered care areas, documenting risk factors and including supporting diagnoses. A 100% audit will begin on 12/11/14 of all most recent comprehensive assessments for all active residents' will be reviewed for completion and accuracy of assessments, CAA's and further assessment of care area triggers by 12/19/2014.	

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F 272	Continued From page 9 the Minimum Data Set (MDS) for two (2) of six (6) Hospice of the twenty-four (24) sampled residents. (Resident #1 and #7). In addition, the facility failed to complete Section C, Cognitive Patterns on the MDS for Resident #1. The findings include: Review of the facility's policy for Care Planning-Comprehensive Implementation, dated October 2010, revealed areas of concern that were triggered during the assessment were evaluated using specific tools (including the Care Area Assessment) before interventions were added to the care plan. 1. Review of the clinical record for Resident #1, revealed the facility admitted the resident with diagnoses of Anemia, Heart Failure, Hypertension and Dysphagia. The facility completed an annual MDS assessment on the resident on 07/21/14 which revealed the resident required total care for dressing and extensive assistance for eating, bed mobility and hygiene, The resident was incontinent of bowel, had an indwelling catheter and received nutrition via a gastric tube from 6:00 PM until 9:00 AM daily. Review of the MDS Section B, Hearing, Speech and Vision, dated 07/21/14, revealed Resident #1 had clear speech, was able to express ideas and wants and was able to understand with clear comprehension. In addition, the facility filled out Section C Cognitive Patterns with dashes and no information was located on the MDS regarding the resident's cognitive evaluation score. Review of the MDS Care Area Assessment (CAA), dated 07/21/14, revealed the facility	F 272	3. When completing comprehensive assessments, the MDS coordinators, Social Services, Activities, and Registered Dietician will further assess all triggered care areas, document risk factors and include supporting diagnoses. MDS coordinators will review the CAA's of the triggered care areas to ensure they were further assessed, and there is documentation of risk factors and supporting diagnoses prior to submission. If there are any issues identified, they will be corrected by either the MDS coordinator or Activities, Social Services, or the Registered Dietician to ensure they are complete and accurate. 4. 100% of comprehensive assessments completed each week, will be reviewed by clinical consultant or Administrator to ensure CAA's have further assessed	

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F 272	Continued From page 10 triggered Resident #1 for Psychosocial Well-being. There was no evidence located to show the facility further assessed the triggered area. Documented risk factors did not include the resident's terminal condition or progressive decline. 2. Review of the clinical record for Resident #7, revealed the facility admitted the resident with diagnoses of Alzheimer's Disease, Dementia with Behaviors, Aphasia, and Huntington's Disease. The facility completed an annual MDS assessment on 08/05/14 which revealed the resident required total care with dressing and eating, extensive assistance with bed mobility and was incontinent of bowel and bladder. The resident had severe cognitive impairmants. Review of the MDS Communication CAA, dated 08/05/14, revealed no evidence was located to show a further assessment of this trigger. Review of the MDS Urinary CAA, dated 07/21/14, revealed there was no documentation on the CAA to show the facility completed further assessment of the resident's urinary status. Review of the MDS Psychosocial Well-being CAA, dated 07/21/14, revealed Resident #7 had Failure to Thrive, Schizophrenia, Behaviors and Hospice/Palliative Care. These risk factors were not identified on the CAA. The CAA referred to a BIMS score; however, the BIMS score box on the MDS, dated 07/21/14, was blank. Review of the MDS Section B, Hearing, Speech and Vision, dated 07/21/14, revealed Resident #7 was nonverbal.	F 272	triggered care areas, documented risk factors and include supporting diagnoses. These reviews will include 100% of the comprehensive assessments weekly for 4 weeks. Then 50% of all comprehensive assessments weekly for 4 weeks. Then 25% of comprehensive assessments weekly for 4 weeks. After the period of 12 weeks, the Clinical Consultant, will review at least two CAA's each quarter to ensure no further potential issues are identified. Results will be reviewed by the Quality Assurance Committee or Sub Committee, consisting of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services Director, Activities Director, MDS Coordinator and Unit Manager on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified, changes can occur to the	

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F 272	Continued From page 11 Review of the MDS Nutrition CAA, dated 07/21/14, revealed the facility did not address Resident #7's risk factors. The clinical record revealed the resident had diagnoses of Failure to Thrive, Dysphagia, and a History of Aspiration Puemonia and a new diagnosis of Pulmonary Tuberculosis, with a fourteen (14) pound weight loss. These risk factors were not identified or explored in the CAA. Interview with the MDS Nurse, on 11/14/14 at 2:10 PM, revealed she was responsible for completion of the MDS process on assigned residents. She stated a CAA Summary was never completed for residents. She stated she was not aware triggered care areas required further assessment. She stated the CAAs lead to the care plan and were important to developing the care plan. She stated Resident #1 was disoriented. Interview with the MDS Nurse Coordinator, on 11/14/14 at 2:30 PM, revealed the MDS nurses were responsible for ensuring the MDS and CAAs were completed. She stated the CAAs contained the resident's risk factors and other information. She stated she did not review the Hospice care plan or the assessments and did not identify or include Hospice specific interventions in the CAAs for Resident #1 or #7. She stated she simply wrote Hospice on the care plan and nothing more. She stated missing risk factors could result in an inadequate care plan. She indicated that she was not aware further assessments were completed on triggered care areas. She stated she used the items from the MDS as the assessment. Interview with the Director of Nursing, on 11/14/14	F 272	process through the quality assurance committee.	

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F 272	Continued From page 12 at 2:50 PM, revealed the CAAs were a summary of the resident from beginning to current time. She stated her expectation was that the CAAs would contain the information needed to develop an accurate care plan. She stated she was not aware the triggered care areas required further assessment.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to develop comprehensive care plans to address the	F 279	F279 1. A revised MDS assessment for resident #1 and #7 was completed on 12/9/14.The comprehensive care plans for each resident was updated on 12/9/14 and 12/10/14 by the MDS coordinator. Resident #7 had updates to the following care plans; assess and report discomfort related to foley catheter, assess and report for signs and symptoms of infection related to foley catheter, assess for nonverbal cues of pain (sweating, grimacing, restlessness), educated family on nonverbal cues of pain, contact Hospice for 1:1 visits, Hospice CNA to visit two times per week for ADL care, coordinate with Hospice for goals of care related to end of life at least quarterly and as needed,	12/23/2014

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F 279	Continued From page 13 terminal status of two (2) of six (6) Hospice residents of the twenty-four (24) sampled residents. Residents #1 and #7. The findings include: Review of the facility's policy regarding Hospice, dated December 2010, revealed the interdisciplinary team (IDT) identified the care and services needed by the resident and the facility and Hospice provided those services. The facility and Hospice performed their respective functions agreed upon and included in the plan of care for which they were responsible. Review of the facility's policies regarding Care Planning and Comprehensive Implementation, dated October 2010, revealed the IDT was responsible for the development of an individualized comprehensive care plan for each resident that included measurable objectives and timetables to meet the residents' medical, nursing, mental and psychsocial needs. The care plan was based on the Minimum Data Set (MDS) assessment. Areas of concern that were triggered during the assessment were evaluated using specific tools (including the Care Area Assessment) before interventions were added to the care plan. 1. Observation of Resident #1, on 11/12/14 at 11:32 AM, revealed the resident was sitting in a wheelchair in the dining room, clean, dressed, neat, no odors. The resident was alert and pleasantly confused to time and place. Review of the clinical record for Resident #1, revealed the facility admitted the resident with diagnoses of Anemia, Heart Failure,	F 279	review Hospice care plans routinely for changes/updates. Resident #1 had changes to the following care plans; assess for signs and symptoms of urinary retention, collaborate with Hospice for adaptive equipment and or safety devices related to mobility, report respiratory status changes to Hospice nurse, report changes in pain status to Hospice nurse, collaborate with Hospice/family with goals of care related to end of life at least quarterly and as needed. Assessment for resident #1 also included section C. 2. 100% of all Hospice residents will have a care plan review by 12/12/14 by the MDS Coordinator to ensure each of them include a plan of care to reflect performed functions from both the facility and Hospice. 3. All care plans for Hospice residents' will be reviewed by the MDS coordinator and	

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F 279	Continued From page 14 Hypertension, Aphasia, and Dysphagia. The facility completed an annual MDS assessment, on 07/21/14, which revealed the resident required total care for dressing and extensive assistance for eating, bed mobility and hygiene, The resident was incontinent of bowel and had an indwelling catheter. Review of the MDS Section B, Hearing, Speech and Vision, dated 07/21/14, revealed Resident #1 had clear speech, was able to express ideas and wants and was able to understand with clear comprehension. Section C of the MDS was incomplete and a cognitive score was not documented. Review of the MDS CAA, dated 08/05/14, revealed the facility triggered Resident #1 for Psychosocial Well-being. There was no evidence located to show the facility further assessed the triggered area. Risk factors documented for the resident did not include the resident's terminal condition and progressive decline, pain, anxiety, and support services. Review of the comprehensive care plan for Resident #1, revealed hospice services of nurse aide visits, education regarding the dying process, and the use of volunteers for the resident's emotional support were not developed and integrated into the facility's care plan for the resident. 2. Observation of Resident #7, on 11/12/14 at 11:45 AM, revealed the resident was laying on the bed awake with the call light in reach. The resident had visitors. Review of the clinical record for Resident #7, revealed the facility admitted the resident with diagnoses of Alzheimer's Disease, Dementia with	F 279	Hospice nurse two times a month, with each Hospice Care IDT Report, to ensure both Facility and Hospice have measurable goals and timelines to meet both the medical and psychosocial needs of the resident. These reviews will begin by 12/19/14 and will be ongoing. 4. Each month the MDS Coordinator will review the care plans of each hospice resident during the first care plan conference date of the month which will begin 12/18/14. The review will be conducted with the presence of the IDT, which includes at least, Social Services, Activities, Dietary and Nursing. These reviews will be conducted for a period of no less than 3 months and then reviews will be completed quarterly with the MDS Assessment and will be ongoing. Results will be reviewed by the Quality Assurance Committee or Sub Committee, consisting	

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F 279	Continued From page 15 Behaviors and Failure to Thrive. The resident was hospitalized and diagnosed with Active Pulmonary Tuberculosis on June 22, 2014. The facility completed an annual MDS assessment when the resident was readmitted, on 08/05/14, which indicated the resident required total care with eating and dressing, extensive assistance with bed mobility, and was incontinent of bowel and bladder. The resident received Hospice Services. Review of the Hospice progress note, dated 11/14/14, revealed Resident #7 required social and emotional support, validation of feelings, family education regarding the signs and symptoms of the dying process. Review of the comprehensive care plan, dated 07/25/14, revealed Resident #7 required extensive to total assistance with Activities of Daily Living (ADLs). There were no interventions to address what the Hospice staff contributed or the frequency of the visits. Review of the Hospice notes, 11/11/14, revealed Resident #7 had a nutritional decline and lost weight. Review of the weight record for the resident dated10/30/14, revealed the resident actually lost fourteen (14) pounds since the diagnosis was made of Pulmonary Tuberculosis in June 2014. The resident would receive a nurse aide visit twice weekly, chaplin visits and nurse visits. The care plan, dated 10/14/14, was reviewed and the problem was documented as nutritional risk related to having a gastric tube and requiring assistance with eating. The resident was weighed monthly per physician orders related to a terminal condition. There was no evidence to indicate interventions were developed to stop weight loss. In addition, the care plan did not	F 279	of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services Director, Activities Director, MDS Coordinator and Unit Manager on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified, changes can occur to the process through the quality assurance committee.	

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F 279	Continued From page 16 include any interventions for Hospice Services. Interview with Certified Nurse Aide (CNA) #5, on 11/13/14 at 9:00 AM, revealed she was not aware of what Hospice offered Resident #1 or #7 inregards to visits. She stated someone gave the resident a bath once, but she thought it was a family member. She stated she had not received information on how to provide emotional support to Residents #1 or Resident #7. Interview with the MDS Nurse, on 11/14/14 at 2:10 PM, revealed she was responsible for the completion of the comprehensive care plan on assigned residents. She stated a care plan was based on the MDS and interviews and chart review. She stated she was not aware the Hospice care plan and the comprehensive care plan were integrated. She stated she did not see the Hospice care plan. Interview with the MDS Nurse Coordinator, on 11/14/14 at 2:30 PM, revealed the MDS nurses were responsible for ensuring the comprehensive care plan was complete and accurate. She stated she never reviewed the Hospice care plan or the assessments and did not identify or include Hospice specific interventions in the care plans for Resident #1 or #7. She stated that she simply wrote Hospice on the care plan and nothing more. She stated missing risk factors could result in an inadequate care plan. Interview with the Director of Nursing, on 11/14/14 at 2:50 PM, revealed the comprehensive care plans were accurate and complete. She stated her expectation was that the CAAs would contain the information needed to develop an accurate care plan. She stated she was not aware the	F 279		

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F 279	Continued From page 17 triggered care areas required further assessment. In addition, she was not aware the Hospice care plan and the facility care plan were integrated.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to assess and provide necessary services for bowel and bladder management in maintaining urinary continence for one (1) of three (3) unsampled residents, and twenty-four (24) sampled residents. (Unsampled Resident B) The findings include: Interview with the Director of Nursing, on 11/14/14 at 4:55 PM, revealed the facility had no policy for assessing residents' bowel and bladder function or developing a toileting program for any specific resident. Review of the clinical record for Unsampled Resident B revealed the facility admitted the	F 315	F315 1. On 11/14/2014 a toileting program was initiated for un sampled resident B to ensure resident had assistance to the bathroom and potentially decrease incontinent episodes. Individual call light audits were initiated 11/14/14 by the Unit Manager to evaluate timeliness of call light response. 2. 100% of residents will have a bowel and bladder assessment completed by Director of Nursing, Unit Mangers, Staff Development Coordinator, Weekend Supervisor or MDS Coordinator no later than 12/19/14. All residents identified as potentially benefitting from an individualized toileting plan will have a plan initiated and their care plans updated to reflect need.	12/23/2014

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F 315	Continued From page 18 resident on 08/30/14 with diagnoses of Recurrent Urinary Tract Infections, Hypertension, Recurrent Falls, Cerebrovascular Accident, Atrial Fibrillation, Glaucoma, and Symbolic Dysfunction. The facility completed a quarterly Minimum Data Set (MDS) assessment on 09/06/14, which revealed the resident's cognitive status was moderately impaired. Review of the Daily Skilled Nurse's Note, dated 11/14/14, revealed Unsampled Resident B was incontinent of bladder and bowel. Review of Unsampled Resident B's Bladder and/or Bowel Retraining Assessment Form, dated 08/30/14, revealed a total score of six (6) indicating the resident was likely to benefit with a bladder/bowel retraining program. Further review of the clinical record revealed the Advanced Practice Registered Nurse (APRN) had evaluated the resident on 09/05/14 for complaints of urinary frequency, urgency, and back pain. Review of the Admission Minimum Data Set (MDS) 3.0, dated 09/06/14, revealed a trial toileting program had not been attempted for Unsampled Resident B. Interview with Unsampled Resident B, on 11/14/14 at 10:20 AM, revealed the resident was concerned about the nursing staff answering the call light. Unsampled Resident B stated he/she would sometimes have to go into the shared bathroom unassisted because of staff delays in answering the call light. The resident further stated he/she had experienced incontinent episodes after waiting extended periods of time for nursing staff to come and answer the call light. Review of the Certified Nurse Aide Care Plan revealed Unsampled Resident B required	F 315	3. Bowel and Bladder assessments will then be completed on a quarterly basis by the MDS Coordinator to determine effectiveness of toileting plan. 4. The Director of Nursing or Assistant Director of Nursing will monitor on a weekly basis all quarterly Bowel and Bladder Assessments conducted each week for 3 months and then monthly thereafter to ensure updates are completed to toileting plans. Results will be reviewed by the Quality Assurance Committee or Sub Committee, consisting of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services Director, Activities Director, MDS Coordinator and Unit Manager on a monthly basis ongoing until the team concludes the issue is resolved. If at any time concerns are identified, changes can occur to the process through the quality assurance committee.	

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185327		11/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 19 stand-by-assist of one person for transfers. In addition, the care plan indicated the resident was continent of bladder and bowel and required one-person assist for toileting needs. Interview with CNA #5, on 11/14/14 at 2:30 PM, revealed a delay in answering call lights could result in a resident being incontinent or falling. Interview, on 11/14/14 at 2:45 PM, with the Unit Manager (UM) for Unit 2 revealed there was the potential for a resident to fall or be incontinent because of a delay in answering call lights. The UM revealed nursing staff was responsible for completing an admission bowel and bladder assessment for each resident. In addition, CNA's were responsible for completing an initial three-day bowel and bladder tracking assessment. She stated after the three-day bowel and bladder monitoring was completed the resident's continence status was reassessed to best determine toileting needs. The UM stated she did not know who was responsible for reassessing residents for bowel and bladder management. The nurse revealed the three-day bowel and bladder assessments, and the CNA sign off sheets were filed in the UM office at the end of the month. The nurse stated she sometimes put a note in the CNA care plan book to remind the aide to perform scheduled toileting with specific residents. The UM stated there was no toileting schedule for Unsampled Resident B and she further stated the facility did not have a bowel and bladder toileting program. Interview, on 11/14/14 at 3:30 PM, with the Director of Nursing (DON) revealed she was not aware of any issues regarding staff delays in answering call lights. The DON stated a resident	F 315		

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SIGNATURE HEALTHCARE OF SPENCER COUNTY	625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071

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F 315	Continued From page 20 could potentially have an incontinent episode or fall as a result of a delay in answering the call light. The DON stated the facility did not have a bowel and bladder program.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide a hands-free trashcan for one (1) of one (1) handwashing sink in the kitchen. The findings include: Review of the facility's policy regarding Preventing Foodborne Illness - Employee Hygiene and Sanitary Practice, dated December 2008, revealed food service employees were to wash their hands after handling soiled equipment or utensils, when changing tasks, or after engaging in other activities that contaminated the hands in order to prevent cross contamination Observations during initial tour of the kitchen, on 11/12/14 at 9:40 AM, revealed the kitchen staff	F 371	F371 1. On 11/14/14 a hands free trash can was placed by the hand washing sink. 2. All residents' had the potential to be affected by the absence of the hands free trash can, but no residents were identified as being affected. 3. The Dietary Manager was re-educated by the Administrator on 12/5/2014 on Preventing Food-Bourne illness/ Employee Hygiene and Sanitary Practices. Education will completed for the dietary staff by 12/12/14 on Preventing Food Bourne illness/ Employee Hygiene and Sanitary Practices. 4. The Dietary Manager will make an observation 5 days per week for 4 weeks to ensure there is a hands free trash can available by the hand washing sink and that it is functioning properly. Results will be	12/23/2014

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	185327		11/14/2014

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F 371	Continued From page 21 had no trashcan located at the hand washing sink to dispose of paper towels after washing their hands in the kitchen. Interview with Dietary Manager, on 11/12/14 at 9:42 AM, revealed after washing their hands, staff disposed of the paper towels in a large garbage can located on the other side of the food preparation area. The garbage can had a closed snap top lid which had to be lifted off then replaced. Observation, on 11/12/14 at 9:47 AM, revealed staff used their freshly washed hands to take the lid off the garbage can in order to throw away the paper towels used to dry their hands, then replaced the lid Observation, on 11/13/14 at 11:10 AM, revealed staff had placed a trash can in the kitchen near the hand washing sink. This trash can was a blue cylindrical metal can. The trash can had a lid which staff could push open with their hands in order to drop items into the can. The lid on the trash can contained white and brown smeared substances. Interview with the Dietary Aide, on 11/13/14 at 11:10 AM, revealed the kitchen staff washed their hands and placed the paper towels into the blue cylindrical garbage can with the push door on the lid. Observations, on 11/13/14 between 11:10 AM and 12:10 AM, revealed dietary staff did touch the lid door on the trash can with their uncovered hands. Interview with Dietary Manager, on 11/14/14 at	F 371	reviewed by the Quality Assurance Committee or Sub Committee, consisting of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services Director, Activities Director, MDS Coordinator and Unit Manager on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified, changes can occur to the process through the quality assurance committee.	

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	185327		11/14/2014

NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
625 TAYLORSVILLE RD
TAYLORSVILLE, KY 40071

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F 371	Continued From page 22 2:00 PM, revealed dietary did not have a hands free trash can at the hand washing station. The Dietary Manager stated that a hands free trash can was located at the hand washing station until it broke and staff had removed it a couple of weeks ago. The Dietary Manager stated if staff touched the lid of the trash can and then prepared food, this could cause cross contamination and lead to food borne illnesses for the residents.	F 371		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure call lights were in working condition for five (5) of eight (8) call lights in two (2) of two (2) shower rooms. (Shower room A and B) The findings include: Observation, on 11/13/14 at 10:09 AM, revealed four (4) of four (4) call lights were not illuminating or sounding in the B Unit shower room. Observation, on 11/13/14 at 10:25 AM, revealed one (1) of four (4) call lights were not illuminating or sounding in the A Unit shower room. Interview with the Plant Operations Director, on	F 463	F463 1. On 11/13/14 the call light systems for both shower rooms A and B were repaired by maintenance. 2. All residents' had the potential to be affected by the absence of a properly functioning call light system in the shower rooms. A 100% audit of all call light systems which include resident rooms, bathrooms and shower rooms will be completed by 12/12/14 to identify any other issues. 3. Routine monitoring of call light systems for proper	12/23/2014

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F 463	Continued From page 23 11/13/14 at 2:05 PM, revealed he performed audits on the call lights monthly. At last audit all bathroom lights passed and no maintenance requests have been received. He stated he was unaware the call lights were not working in the two shower rooms. Review of the facilites Call Light Audits, dated 8/27/2014, 9/24/2014, and 10/22/2014, revealed call light audits were performed monthly and all call lights were in working condition. Interview with Certified Nursing Assistant (CNA) #1, on 11/13/14 at 10:55 AM, revealed she assisted two (2) to three (3) residents per day with showering in the shower rooms. She stated if she needed assistance with a resident emergency she would pull the call light in an effort to get help. Interview with CNA #2, on 11/13/14 at 11:05 AM, revealed she also assisted two (2) to three (3) residents per day with showering in the shower rooms. She stated if an emergency situation were to arise while assisting a resident one to one (1:1), she would pull the call light. If the call light did not work, she would yell. The call light system had helped her in the past to know when another CNA needed additional assistance with a resident. Interview with the Director of Nursing (DON), on 11/13/14 at 1:35 PM, revealed about fifty (50) residents received showers in the shower room daily. She stated residents were never alone in shower room; however, CNAs used the call light cords in case of needing help or for an emergency.	F 463	functioning will consist of 100% of resident rooms and bathrooms monthly, and shower rooms and community bathrooms weekly for 4 weeks. 4. The Administrator will review the call light system audits weekly to ensure completion and further recommendations. Results will be reviewed by the Quality Assurance Committee or Sub Committee, consisting of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator, Social Services Director, Activities Director, MDS Coordinator and Unit Manager on a monthly basis until the team concludes the issue is resolved. If at any time concerns are identified, changes can occur to the process through the quality assurance committee.	

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

PRINTED: 11/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	185327		**11/13/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF SPENCER COUNTY	**625 TAYLORSVILLE RD** **TAYLORSVILLE, KY 40071**

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K 000	INITIAL COMMENTS	K 000		
	CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1985, 1992 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (000) SMOKE COMPARTMENTS: Nine (9) smoke compartments. FIRE ALARM: Complete fire alarm system with smoke detectors. SPRINKLER SYSTEM: Complete, automatic dry sprinkler system. GENERATOR: Type II, 80 KW generator. Fuel source is propane. A Recertification Life Safety Code Survey was conducted on 11/13/14. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).			

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.