

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

PRINTED: 11/25/2015
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R 12/02/2015 |
| NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| {F 000} | INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 12/02/15, as alleged. | {F 000} | | | |

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

TITLE

(X8) 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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26884, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

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| (Y1) Provider / Supplier / CLIA / Identification Number 185047 | (Y2) Multiple Construction A. Building B. Wing | (Y3) Date of Revisit 12/2/2015 |
| Name of Facility HAWS MEMORIAL NURSING & REHAB CENTER | | Street Address, City, State, Zip Code 1004 HOLIDAY LANE FULTON, KY 42041 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|--|---|--|---|---|---|
| ID Prefix <u>F0241</u> Reg. # <u>483.15(a)</u> LSC _____ | Correction Completed <u>12/02/2015</u> | ID Prefix <u>F0278</u> Reg. # <u>483.20(a) - (l)</u> LSC _____ | Correction Completed <u>11/24/2015</u> | ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____ | Correction Completed <u>11/24/2015</u> |
| ID Prefix <u>F0315</u> Reg. # <u>483.25(d)</u> LSC _____ | Correction Completed <u>12/02/2015</u> | ID Prefix <u>F0371</u> Reg. # <u>483.35(l)</u> LSC _____ | Correction Completed <u>10/30/2015</u> | ID Prefix <u>F0411</u> Reg. # <u>483.55(a)</u> LSC _____ | Correction Completed <u>12/02/2015</u> |
| ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____ | Correction Completed <u>12/02/2015</u> | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
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|-----------------------------------|------------------------|-----------------------|--|-----------------------|
| Reviewed By _____ State Agency | Reviewed By <u>JOH</u> | Date: <u>01/05/16</u> | Signature of Surveyor: <u>Deborah A. [Signature]</u> | Date: <u>01/05/16</u> |
| Reviewed By _____ CMS RO | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |

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| Followup to Survey Completed on: <u>10/23/2015</u> | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |
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| NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041 |
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|---------------|---|-------|--|---------|
| F 000 | INITIAL COMMENTS | F 000 | Corrective Action for the resident affected: Resident A was interviewed by the Dietary Manager (DM) on 11/9/15 and all food preferences were re-established. Other residents potentially affected: All other residents served food from the kitchen have the potential to be affected. All these residents will be interviewed to ensure their food preferences are displayed accurately on the tray card. The interviews were conducted by the DM or the Registered Dietician (RD) and completed by 11/9/15. Measures and Systemic Changes: On 10/22/15 the dietary employees were educated by the DM to read all dietary cards during plate preparation in order to honor food preferences likes and dislikes. In order to establish a second check for honoring food preferences, the Assistant Director of Nursing Service (ADNS) began educating the nurse aides on 11/9/15 regarding how to check the tray card for likes and dislikes during meal delivery. This education will be completed by licensed nurses by 12/1/15. The DM or a licensed nurse will monitor meal delivery during at least one meal a day (randomly alternating between all three meals) to assess for the honoring of food preferences. Monitoring: Compliance with food preferences and honoring resident likes and dislikes will be reviewed with the residents during resident council meetings by the DM or RD. The DM, RD or Registered Nurse (RN) will interview residents with their scheduled care plan meeting to update food preferences. Resident satisfaction and compliance with honoring food preferences at meal delivery will be reviewed in monthly Quality Assurance Performance Improvement (QAPI) committee | 12/2/15 |
| F 241 SS=D | <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined the facility failed to ensure food likes and dislikes were honored for one (1) Unsampled resident (Residents A).</p> <p>The findings include:</p> <p>Interview with the Interim Dietary Manager, on 10/22/15 at 12:05 PM, revealed she was not aware of any policy regarding likes and dislikes, but did expect the residents preferences to be honored.</p> <p>Record review revealed the facility admitted Unsampled Resident #A on 11/15/07 with diagnoses which included Arthritis, Anemia, Macular Degeneration, Atrial Fibrillation and Heart Failure. Review of quarterly Minimum Data Set (MDS), dated 07/21/15, revealed the facility assessed Unsampled Resident A's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6), which indicated the resident was not interviewable.</p> | F 241 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robin Chappell</i> | TITLE Administrator | (X6) DATE 11/24/15 |
|--|------------------------|-----------------------|

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| F 241 | Continued From page 1 Observation during the lunch meal on 10/21/15 at 12:10 PM, revealed Unsampled Resident A had rice on his/her plate; however, review of resident's dietary card revealed he/she did not like rice. In addition, observation during the lunch meal on 10/22/15 at 12:00 PM, revealed Unsampled Resident A had potatoes on his/her plate and review of the dietary card revealed he/she disliked potatoes. Interview with Certified Nurse Aide (CNA) #3, on 10/23/15 at 10:05 AM, revealed she should always check the dietary card before delivering the tray to the resident to make sure what is on the meal tray is correct. Further interview, on 10/22/15 at 12:05 PM with the Interim Dietary Manager, revealed she would expect the cook, dietary aides and the staff who delivered the tray to Unsampled Resident A to check the dietary card before it reached the resident. Interview with the Administrator, on 10/23/15 at 11:45 AM, revealed she would expect the Dietary Manager and all dietary staff to honor all resident food choices, by reviewing all dietary cards; and would also expect the staff who delivers food trays to review the dietary card before leaving the tray with the resident. | F 241 | meetings attended by the Administrator, Director of Nursing Services (DNS), the Medical Director, and the department managers. The frequency of monitor will continue as stated until 100% compliance is achieved for three consecutive months. At that time, the QAPI committee, members indicated above, will determine the future monitoring frequency. | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate | F 278 | Resident's affected: The individual Minimum Data Set (MDS) for Resident #3 and Resident #12 were modified on 11/11/15 by the MDS Coordinator to reflect accurate information regarding urinary continence, use of catheters, and all other areas identified as inaccurate. | 11/24/15 | |

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| F 278 | <p>Continued From page 2</p> <p>each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure accuracy of Minimum Data Set (MDS) assessments for two (2) of twelve (12) sampled residents (Residents #3 and #12).</p> <p>Resident #12's Interim MDS assessment, dated 09/15/15, revealed the resident was coded as having an indwelling catheter; however, the MDS was also coded as always incontinent of urine and there was no evidence the catheter was</p> | F 278 | <p>Other potentially affected residents: All other residents most recently submitted MDS were reviewed by the MDS Coordinator by 11/23/15 for accuracy of coding regarding urinary continence and bowel continence. Measures and systemic changes: The MDS Coordinator was educated by the Clinical Reimbursement Specialist Consultant regarding coding resident assessments accurately and updating care plans on 11/3/15. Monitoring performance: Every MDS will be checked electronically for inaccuracies after completion prior to transmission through Team System Intelligigics (TSI) MDS accuracy software. The MDS coordinator will be responsible for checking the TSI report and following up on inconsistencies/ inaccuracies. After correction the reports and corrections will be reviewed by the DNS. The Clinical Reimbursement Specialist Consultant will audit any corrections required for the bowel and bladder inconsistencies. These reviews will be ongoing until 100% compliance is met for three consecutive months. The reviews and necessary corrections will be reported to the QAPI committee (members listed above) on a monthly basis until 100% compliance is achieved for three months. After three months compliance, the QAPI committee will determine the future frequency for reporting.</p> | | |

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| F 278 | <p>Continued From page 3 leaking.</p> <p>In addition, Resident #3's Annual MDS assessment, dated 02/27/15, revealed the resident was coded as having an indwelling catheter; however, was also coded as occasionally incontinent of urine and there was no evidence the catheter was leaking. Further review revealed the resident was coded as (9) not rated, for bowel, however, there was no evidence to indicate Resident #3 had a colostomy.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "CMS's RAI Version 3.0 Manual", dated 09/2010, revealed Section H 0100: Appliances, revealed the steps for assessment were as follows: Examine the resident to note the presence of any urinary and bowel appliances. Review the medical record, including bowel and bladder records, for documentation of current or past use of urinary or bowel appliances. Coding instructions for Section H 0300: Urinary Incontinence include: Code 0 for always continent Code 1 for occasionally incontinent Code 2 for frequently incontinent Code 3 for always incontinent Code 9 for not rated related to the use of catheter</p> <p>1. Record review revealed the facility admitted Resident #12 on 09/10/15 with diagnoses which included Encounter for Palliative Care, Breast Cancer, Hypertension, Pneumonia, Atrial Fibrillation, Pleural Effusion, Anemia, Leukocytosis, and Coronary Atherosclerosis.</p> <p>Review of the Initial MDS assessment, dated</p> | F 278 | | |

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| F 278 | <p>Continued From page 4</p> <p>09/15/15, revealed under Section H 0100-A, Resident #12 was coded as having an indwelling catheter, however, under Section H 0300-3, the MDS was coded as always incontinent of urine. There was no documentation provided to dispute the inaccurate coding.</p> <p>Review of the Interim Care Plan, dated 09/10/15, revealed "I have indwelling catheter related to terminal condition".</p> <p>Review of a Urinary Incontinence Assessment, dated 09/14/15, revealed Resident #12 had a indwelling catheter related to a terminal illness. Review of the elimination pattern assessments, dated 09/11/15 through 09/13/15, revealed the resident was completely dry of urine during the three (3) day assessment period.</p> <p>Interview with the MDS Coordinator, on 10/23/15 at 9:13 AM, revealed the only thing she could reference to the MDS coding of the resident having an indwelling catheter and being coded as always incontinent of urine would be if the catheter had leaked. She revealed there was no Nursing documentation to indicate the catheter had leaked; therefore, the coding was incorrect.</p> <p>2. Record review revealed the facility admitted Resident # 3 on 03/31/14 with diagnoses which included Pressure Ulcer of the lower back, Hypertension, Insomnia, Muscle Weakness, Constipation, Hereditary and Idiopathic Neuropathy, Fitting and Adjustment of Urinary Device, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the Annual MDS assessment, dated 02/27/15, revealed under Section H 0100-A,</p> | F 278 | | | |

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| F 278 | Continued From page 5 Resident # 3 was coded as having a urinary catheter and coded under Section H0300 as being occasionally incontinent of urine. Further review revealed the resident was coded Under Section H0400, as a 9 (unrated) for Bowel Continence and there was no documentation of the resident having a colostomy. Observation of Resident #3, on 10/21/15 at 9:28 AM, revealed the resident was laying in bed with an indwelling catheter observed connected to the bedside and Certified Nurse Aide (CNA) #1 and CNA #3 provided pericare and catheter care. No colostomy was noted. Review of Comprehensive Care Plan for Resident #3 revealed "I have an indwelling catheter related to unhealing stage three wound to my coccyx". Further review of the care plan revealed "I have the tendency toward constipation", with goal of having a soft formed bowel movement every one (1) to three (3) days and interventions of administering laxative/stool softener per Medical Doctor order and assessing abdomen for distention, bowel sounds, and /or pain as needed. Interview with MDS Coordinator, on 10/22/15 at 9:50 AM and on 10/23/15 at 9:15 AM, revealed the coding on bowel and bladder for Resident #3 was an error on her part and the resident did not have a colostomy and she had never known of the resident's urinary catheter leaking. | F 278 | | | |
| 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 | F 280 | Resident affected: The care plan for resident #4 was revised by the MDS Coordinator on 10/24/15 to accurately reflect the prompted toileting schedule. Other potentially affected residents: All care plans for current residents were reviewed for accuracy of the | 11/24/15 | |

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| F 280 | <p>Continued From page 6</p> <p>participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to ensure the Comprehensive and Certified Nurse Aide (CNA) Care Plans were revised for one (1) of twelve (12) residents (Resident #4) related to a Prompted Toileting Schedule.</p> <p>The findings include: Review of facility's policy 'Comprehensive Care Plan Policy and Procedure', not dated, revealed the care plan must describe any services that are to be furnished to attain or maintain the patient's highest practicable physical, mental and psychosocial well-being.</p> <p>Record review revealed the facility admitted</p> | F 280 | <p>prompted toileting program by the MDS Coordinator by 11/23/15. Systemic Changes: The MDS Coordinator/Care Plan Nurse was educated to the process for revising care plans to individualized resident needs on 11/3/15 by the Clinical Reimbursement Specialist Consultant. Monitoring performance: 100% of the toileting care plans will be audited by the DNS or RN designee until 100% compliance for accuracy is achieved for three months. Audit reports will be presented to the QAPI committee monthly (members listed above) by the DNS. After compliance for three months is achieved the QAPI will determine future frequency of audits.</p> | | |

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| F 280 | <p>Continued From page 7</p> <p>Resident #4 on 07/24/15 with diagnoses which included Hypertension, Non Insulin Dependent Diabetes Mellitus, Constipation, Pancreatic Mass, Weakness, Gout and Asthma. Review of the Admission Minimum Data Set (MDS) assessment, dated 08/17/15, revealed the facility assessed Resident #4 as cognitively intact with a Brief Interview for Mental Status Score (BIMS) of fifteen (15) which indicated this resident was interviewable. Further review of the MDS assessment, revealed Resident #4 was coded as having frequent urinary incontinence.</p> <p>Review of Resident #4's Comprehensive Care Plan for bladder and bowel incontinence, and the CNA Care Plan, dated 08/10/15, revealed an intervention of "assist me to the toilet after every meal, before bedtime and as needed when awake during the night".</p> <p>Review of an Elimination Pattern Assessment, dated 08/25/15 through 08/27/15, revealed the resident was assessed to need a toilet prompting schedule of before and after breakfast, lunch, supper and bedtime; however, further review of the Care Plans revealed the Care Plans were not revised to include the need for the toilet prompting schedule.</p> <p>Interview with Unit Manager, Registered Nurse (RN) #1, on 10/22/15 at 03:25 PM, revealed she expected the Certified Nurse Aide (CNA) and Comprehensive Care Plans to both match and be updated with the most current toileting program which was established with the Elimination Pattern Assessment, dated 08/25/15 through 08/27/15.</p> <p>Interview with Director of Nursing (DON), on</p> | F 280 | | | |

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| F 280 | Continued From page 8 10/22/15 at 03:30 PM, revealed she expected the CNA and interdisciplinary care plans to both match and be updated with the most current toileting program which was established with the Elimination Pattern Assessment dated 08/25/15 through 08/27/15, so all staff would be attempting the same toileting program for Resident #4 with the most updated information from the most recent assessment. | F 280 | | |
| 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 observation, interview, record review and review of facility policy, it was determined the facility failed to ensure each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible and a resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible for two (2) of twelve (12) sampled residents (Residents #4 and #7). | F 315 | 1) Resident affected: a new urinary incontinence assessment was completed for resident #4 on 10/26/15 by the DNS. Based on the assessment, the type of incontinence was identified and a toileting program was not required. Other potentially affected residents: All incontinent residents will be re-assessed by a RN and placed on an appropriate toileting program by 12/1/15. Systemic Changes: All nursing staff will be educated on the toileting assessment and implementation of the toileting program by the DNS or RN designee by 12/1/15. Monitoring for performance: The DNS or RN designee will be performing 100% bowel and bladder assessment audits until 100% compliance is achieved for three months. The DNS will report the audit findings to the QAPI committee (members listed above) monthly. The QAPI committee will determine future audit frequency after compliance is achieved for three consecutive months. | 12/2/15 |

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| F 315 | <p>Continued From page 9</p> <p>The facility failed to complete the Urinary Continence Assessment on 08/23/15 for Resident #4 to determine the type of incontinence and if a toileting schedule was needed to restore as much bladder function as possible. In addition, the facility failed to complete a new Voiding Pattern on 10/21/15 when they completed another Urinary Continence Assessment but determined the resident required a Prompted Toileting Schedule. The facility also failed to revise the care plan to ensure staff were aware of the needed toileting schedule.</p> <p>Staff failed to provide catheter care according to facility policy for Resident #7 to prevent urinary tract infections.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of facility policy titled, "Bowel and Bladder Program Policy and Procedures", dated 01/12/06, revealed the purpose of this policy was to restore as much normal bladder and bowel function as possible. The policy further revealed, under procedure, a licensed nurse will perform a Urinary Incontinence Assessment with every resident upon admission and prn (as needed). <p>Record review revealed the facility admitted Resident #4 on 07/24/15 with diagnoses which included Hypertension, Non Insulin Dependent Diabetes Mellitus, Constipation, Pancreatic Mass, Weakness, Gout and Asthma. Review of the Admission Minimum Data Set (MDS) assessment, dated 08/17/15, revealed the facility assessed Resident #4 as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated this resident was interviewable. Further review of the same MDS</p> | F 315 | <p>2) Resident affected: the correct procedure was used to perform catheter care on resident #4 on 10/22/15 by the LPN. Other potentially affected residents: Two other residents have catheters and may potentially be affected. Systemic Changes: The ADNS began education with the LPN on duty on 10/22/15 and will be completed for all nursing staff by 12/1/15 by the DNS or RN designee. Monitoring performance: Observation audits of catheter care will be performed by the DNS or RN designee weekly for four weeks and then monthly until 100% compliance is achieved for three months. Audit reports will be presented to the monthly QAPI committee (members listed above) by the DNS until 100% compliance for three months is achieved. Future audit frequency will be determined by the QAPI after compliance is achieved for four months.</p> | | |

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| F 315 | <p>Continued From page 10</p> <p>assessment, revealed Resident #4 was coded as having frequent urinary incontinence.</p> <p>Review of a Urinary Incontinence Assessment, not dated, revealed it was blank and it was attached to an "Elimination Pattern Assessment", dated 08/21/15 through 08/23/15 which was also incomplete with no nursing signature or toileting plan established related to the results of the patterning.</p> <p>Further review of the clinical record, revealed another "Urinary Incontinence Assessment", dated 10/21/15, which was incomplete and did not identify the type of incontinence or a nurse's signature. The 10/21/15 Assessment was attached to a 'Elimination Pattern Assessment", dated 08/25/15 through 08/27/15, which indicated the resident should be on a Prompted Toileting Schedule of before and after; breakfast, lunch, dinner, and bedtime; however, review of the Comprehensive Care Plan and CNA Care Plan, dated 08/10/15, revealed the care plan was not updated to include the Prompted Toileting Schedule the resident was assessed as needing on 08/27/15.</p> <p>Interview with Unit Manager, Registered Nurse (RN) #1, on 10/22/15 at 3:25 PM, revealed she expected the Urinary Incontinence Assessments to be complete because the assessment determines the cause of incontinence and helps to establish the appropriate individualized plan for the resident.</p> <p>Interview with Director of Nursing, on 10/22/15 at 3:30 PM, revealed she expected licensed nurses to complete the Urinary Incontinent Assessments as this is a part of the overall process to</p> | F 315 | | | |

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| F 315 | <p>Continued From page 11</p> <p>determine the root cause of the resident's incontinence and guide the facility to establish a toileting program to help the resident gain more continence. The DON stated the Urinary Incontinence Assessment, dated 10/21/15, should have had data from the same time period and not from August 2015 attached to it, as data from two (2) months prior would not allow for an accurate up to date assessment.</p> <p>2) Review of facility's policy titled, "Catheter Care", not dated, revealed staff should gently wash around the opening of the urethra with soap and water and holding the catheter near the meatus, clean the catheter from the meatus down the catheter about four (4) inches, using soap, water and a clean washcloth; clean downward away from the meatus with one stroke; repeat as needed with a clean area on the washcloth each time; pat and dry.</p> <p>Record review revealed the facility admitted Resident #7 on 04/08/11 with diagnoses which included Alzheimer's Disease and Hypertrophy of Prostate with Urinary Obstruction. Review of the Annual Minimum Data Set (MDS) assessment, dated 09/25/15, revealed the facility assessed Resident #7's cognition as severely impaired with a BIMS score of seven (7) which indicated this resident was not interviewable. Further review of the same MDS assessment, revealed Resident #4 was coded as having had an indwelling urinary catheter.</p> <p>Observation of Licensed Practical Nurse (LPN) #3 performing indwelling urinary catheter care on Resident #7, on 10/22/15 at 03:53 PM, revealed LPN #3 gathered supplies, washed around Resident #7's supra-pubic urinary opening with</p> | F 315 | | | |

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| F 315 | <p>Continued From page 12</p> <p>soap and water, dried the area and placed a drainage sponge over the area. LPN #3 did not cleanse the catheter per the facility policy and at the time stated she had completed catheter care.</p> <p>Interview with LPN #3, on 10/22/15 at 4:00 PM, revealed she knew she was supposed to clean the catheter but because the catheter was newly placed that day she did not. After this interview, LPN #3 proceeded to get supplies and cleansed the catheter.</p> <p>In addition, observation of Resident #7 on 10/21/15 at 1:30 PM and 3:23 PM, on 10/22/15 at 8:15 AM and on 10/23/15 at 8:30 AM, revealed Resident #7 was sitting up in a wheelchair in the hallway with the urinary drainage bag resting on the floor.</p> <p>Interview with Certified Nursing Assistants (CNA) #1 and #2, on 10/23/15 at 8:30 AM, revealed they were unsure if it was acceptable for urinary drainage bags to be on the floor. Both CNA #1 and #2 stated they do not remember having any training in regards to the proper care and storage of urinary drainage bags.</p> <p>Interview with LPN #1, on 10/23/15 at 8:35 AM, revealed she expected all urinary drainage bags to be off the floor because this was an infection control issue that could lead to residents getting infections.</p> <p>Interview with LPN #2, on 10/23/15 at 09:10 AM, revealed she expected urinary drainage bags to be off the floor at all times and this was a potential cause for infection. She further stated that all CNA's should know this information as they have been certified and that is something</p> | F 315 | | | |

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| F 315 | Continued From page 13 they would have been taught. Interview with Director of Nursing (DON), on 10/23/15 at 09:05 AM and 11:50 AM, revealed revealed she expected nursing staff to perform catheter care as per policy and it was important to perform that step of the care to prevent infection. The DON stated she expected nursing staff to be sure all urinary drainage bags were off the floor as this was an infection control issue that could lead to the development of infections. She further stated that the CNA's learn this during their training and certification. | F 315 | | | |
| F 371 SS=E | 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 review of the facility policy and procedure, it was determined the facility failed to ensure foods and liquids were dated with the date opened and with the use by date for four (4) liquid containers. Review of the facility Census and Condition, | F 371 | Residents affected: the four undated liquid containers were discarded immediately on 10/21/15 by the Dietary Manager (DM). The DM surveyed the food storage on 10/21/15 and no other undated containers were identified. Other residents potentially affected: All residents and others served food from the kitchen have the potential to be affected. Systemic Changes: The DM educated all kitchen staff regarding the process for dating all opened containers on 10/21/15. Monitoring performance: the DM or RD will audit the kitchen for dated opened food item compliance weekly until 100% compliance is achieved for three months. The DM will report the results to the QAPI committee (members listed above) monthly until 100% compliance is achieved for three months. The QAPI committee will determine the future frequency of reporting after three months of compliance. | 10/22/15 10/30/15 per Adam DH | |

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| F 371 | Continued From page 14 dated 10/20/15, revealed forty-three (43) of forty-six (46) residents in the facility received there food from the kitchen as three (3) residents received tube feeding only. The findings include: Review of the facility policy titled, "Dating of Food Items", not dated, revealed, "All items will be dated the date received. Once an item has been opened, it will be labeled with an open and use by date". Observation during the initial kitchen tour, on 10/21/15 at 9:15 AM, revealed a half gallon of buttermilk, a gallon of milk, a pitcher of unsweet tea, and a carton of prune juice opened with no date of opening or use by date. Interview with the Dietary Manager, on 10/21/15 at 9:45 AM, revealed she expected food and liquids to be labeled with an opened date and a use by date. She stated she was unsure as to why the four (4) items were not labeled, but would ensure staff were re-educated on the dietary policy. | F 371 | | | |
| F 411 SS=F | 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if | F 411 | Residents affected: Residents #1 and #3 along with all other residents willing to participate will be seen by Dentist in the facility on 12/1/15. Other residents potentially affected: All other residents willing to be assessed by a Dentist have the potential to be affected. Systemic Changes: The company Special Care has contracted with the center in order to offer/ provide at a least annual dental screenings and necessary treatment for all residents willing to participate. As arranged prior to 10/23/15, Special Care will be providing services at the center beginning 1/6/16. | 12/2/15 | |

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| F 411 | <p>Continued From page 15</p> <p>necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of a document received from Social Services, it was determined the facility failed to ensure routine dental services to meet the needs of each resident was provided for forty three (43) residents out of a current facility census of forty-six (46) residents, including three (3) of twelve (12) sampled residents (Residents #1, #3 and #6).</p> <p>Review of a list provided by the Social Services Director, dated 10/22/15, revealed three (3) resident's had a private dentist and forty-three (43) had no private dentist.</p> <p>The findings include:</p> <p>Interview with the facility Administrator, on 10/22/15 at 10:55 AM, revealed the facility did not have a policy related to annual dental screenings.</p> <p>Review of publication Annals of Long Term Care (LTC) entitled, "Meeting Oral Health Challenges in Long-Term Care Facilities, Volume 20, Issue 9, September 2012, revealed there are strong correlations between poor oral health and life-threatening systemic diseases and conditions. Further review revealed many studies indicate a positive relationship between the provision of oral care and a reduction in aspiration pneumonia.</p> | F 411 | <p>Oral hygiene assessments will be performed by the charge nurse within 24 hours of a new resident admission. Oral hygiene assessments will be performed by the charge nurse at least quarterly on every resident. Oral hygiene needs will be reported to the Special Care Dentist. The licensed nurses will be educated by 12/1/15 by the DNS regarding the oral hygiene assessment requirements. The DNS or RN designee will educate the unlicensed nursing employees regarding indications of oral hygiene needs such as pain, decreased appetite, etc. by 12/1/15. Monitoring performance: Oral hygiene assessment audits will be performed by the DNS or RN designee for completion and follow up care provision for every newly admitted resident and a random 10% sample of quarterly assessments until 100% compliance is achieved for three months. Results of the audits will be presented to the QAPI committee (members listed above) monthly until compliance is achieved. The QAPI committee will determine future audit frequency after 100% compliance is achieved.</p> | | |

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| F 411 | <p>Continued From page 16</p> <p>This article concludes by stating that" There is an increasing amount of evidence supporting the adverse relationship between poor oral health and systemic illness in residents in LTC settings".</p> <p>1. Record review revealed the facility admitted Resident #1 on 04/13/11 with diagnoses which included Multiple Sclerosis, Disorder of Bone and Cartilage, Attention to Gastrostomy, Dysphagia, Contracture of Joint of Multiple Sites, Chronic Obstructive Pulmonary Disease, Allergic Rhinitis, and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/22/15, revealed the facility assessed Resident #1's cognition as intact with a Brief Interview of Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.</p> <p>Observation of Resident #1, on 10/22/15 at 2:52 PM revealed the resident had his/her own natural teeth and received tube feedings.</p> <p>Interview with Resident #1, on 10/22/15 at 9:10 AM, revealed staff brushed his/her teeth. Further interview with Resident #1, on 10/23/15 at 10:45 AM, revealed he/she had not seen a dentist since he/she was admitted to the facility.</p> <p>2. Record review revealed the facility admitted Resident #3 on 03/31/14 with diagnoses which included Hypertension, Muscle Weakness, Pressure Ulcer of Lower Back, Insomnia, Chronic Obstructive Pulmonary Disease, Hypertension, and Hereditary and Idiopathic Neuropathy. Review of Significant Change MDS assessment, dated 09/11/15, revealed the facility assessed Resident #3's cognition as intact with a BIMS score of fourteen (14) indicating the resident was</p> | F 411 | | | |

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| F 411 | <p>Continued From page 17 interviewable.</p> <p>Observation of Resident #3, on 10/23/15 at 10:45 AM, revealed the resident had his/her own natural teeth and there was a white substance between his/her teeth. Interview with Resident #3 at this time revealed staff brushed his/her teeth once a day but have not done so yet this morning. The resident stated he/she had not been seen by a dentist since he/she was admitted to the facility.</p> <p>3. Record review revealed the facility admitted Resident #6 on 02/26/10 with diagnoses which included Dysphagia, Chronic Respiratory Failure, Chronic Kidney Disease and Anemia. Review of the quarterly MDS assessment, dated 09/10/15, revealed the facility assessed Resident #6's cognition as intact with a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was interviewable.</p> <p>Interview with Resident #6, on 10/22/15 at 11:15 AM, revealed he/she has lived here in this facility for going on five (5) years and no dentist ever came in to look at his/her mouth.</p> <p>Interview with the facility Social Services Director, on 10/23/15 at 12:15 PM, revealed she was the person who kept up with dental services needed for the residents in the facility and the facility had a contracted dentist in case of dental emergencies. She stated she had no knowledge of a dentist providing routine annual dental exams, and she had no system in place to ensure residents without a private dentist were receiving routine dental exams. She further revealed out of the total current census of forty six (46) that only three (3) residents had access to a routine dental exam by a private dentist.</p> | F 411 | | | |

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| F 411 | Continued From page 18 | F 411 | | | |
| F 441 SS=D | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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</p> | F 441 | <p>Residents affected: On 10/23/15 resident C's room was set up with biohazard bags for linen and trash and the proper signage was placed on the door by the ADNS. The DNS and ADNS educated the staff on duty regarding proper procedure for contact isolation. Other potentially affected residents: any other resident with contact isolation precautions—none identified. Systemic changes: The DNS and RN designee will educate all nursing employees regarding correct isolation precaution procedures by 12/1/15. Monitoring of performance: The DNS or RN designee will observe isolation set-up for compliance five times daily for one week then weekly until isolation is discontinued for all</p> | 12/2/15 | |

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| F 441 | <p>Continued From page 19</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to 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 for one (1) Unsampled resident (Resident C).</p> <p>The findings include:</p> | F 441 | <p>residents placed in isolation. The results of the observations will be reported to the QAPI committee for compliance and any recommendations for additional audits as needed.</p> | | |

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| F 441 | <p>Continued From page 20</p> <p>Review of facility's policy titled "Contact Precautions", dated 2007, revealed gloves should be worn when entering the room and while providing care for a resident on contact precautions and dedicated resident care equipment should be considered for the resident and if use of common equipment or items is unavoidable, the items should be adequately cleaned and or disinfected before use for another resident.</p> <p>Record review revealed the facility admitted Unsampld Resident C on 05/24/10 with diagnoses to include Congestive Heart Failure, Chronic Respiratory Failure, Chronic Kidney Disease stage three (3), Diabetes Mellitus type two (2), and Methicillin-Resistant Staphylococcus Aureus to right knee wound. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 09/24/15, revealed Unsampld Resident C's was cognitively intact with a Brief Interview of Mental Status (BIMS) score of thirteen (13) which indicated the resident was interviewable.</p> <p>Observation, on 10/21/15 at 9:18 AM revealed Certified Nurse Aide (CNA) #3 entered into Unsampld Resident C's room and did not place gloves on. CNA #3 looked around Unsampld Resident C's room then came out of the room. When the surveyor asked CNA #3 about a hanging apparatus on the resident's door which contained gowns, gloves and masks in it, CNA #3 replied Unsampld Resident C was on contact precautions. CNA #3 stated anyone having any contact with Unsampld Resident C had to have gloves on. Further observation revealed there was no visible sign present to inform staff or visitors to contact nursing for guidance on entering Unsampld Resident C's room in relation</p> | F 441 | | | |

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| F 441 | <p>Continued From page 21 to contact precautions.</p> <p>Observation on 10/22/15 at 3:10 PM, revealed Licensed Practical Nurse (LPN) #3 went into Unsampled Resident C's room to check the resident's peripheral capillary oxygen saturation with a wireless pulse oximeter. She proceeded to take the reading and then placed the oximeter in her pocket and came out of the room without cleaning the equipment or washing her hands. LPN #3 stated that Unsampled Resident C had a Methicillin-Resistant Staphylococcus Aureus infection to her right knee wound and was unsure if the only time anyone would have to have protective equipment on was if they were going to be in contact with the resident's wound. She then stated gloves would need to be on at least anytime contact was provided regardless if it was for care to the wound or just contact with the resident. Further observation at that time, revealed a clothes hamper in Unsampled Resident C's room with no bag in the hamper but soiled linen in the hamper. LPN #3 stated there should be a bag in the hamper so that soiled linen could be transferred out of the room and to laundry safely due to Unsampled Resident #C's infection.</p> <p>Interview with Unit Manager, Registered Nurse (RN) #1, on 10/22/15 at 3:20 PM, revealed the facility was supposed to have a sign up at Unsampled Resident C's door informing staff and visitors to contact nursing staff prior to entering the resident's room due to the resident being on contact precautions. She stated she expected a red biohazard bag to be in the hamper and the soiled clothes from the resident to be placed in the red biohazard bag and it was not appropriate for the clothes to be just placed in the hamper</p> | F 441 | | | |

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| F 441 | <p>Continued From page 22 without a red biohazard bag.</p> <p>Interview with Assistant Director of Nursing (ADON), on 10/22/15 at 3:45 PM, revealed a sign should be up and visible at Unsamped Resident C's door informing staff and visitors to contact nursing staff prior to entering the resident's room due to the resident being on contact precautions. She stated gown and gloves needed to be worn by any staff participating with dressing changes and gloves without a gown for any other contact in relation to the care for the resident. She also stated a red biohazard bag must be used in the hamper at all times for the collection of soiled linen. The ADON was unable to provide any education or training which had been provided to staff in regards to Unsamped Resident C's contact precautions.</p> <p>Interview with Director of Nursing (DON), on 10/23/15 at 11:55 AM, revealed she expected staff to adhere to contact precautions and to use protective equipment when providing hands on care. The DON stated biohazard bags had to be used in the resident's clothes hamper to help prevent the spread of infection. She further stated a sign must be up and visible to notify staff and visitors that they need to speak to nursing staff prior to entering the resident's room due to this resident having an infection and needing to be on contact precautions.</p> | F 441 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED R 12/02/2015 |
| NAME OF PROVIDER OR SUPPLIER HAWS MEMORIAL NURSING & REHAB CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041 | | |
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| {K 000} | INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance on 12/02/15, as alleged. | {K 000} | | | |

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

TITLE

(X6) DATE

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

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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: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with twenty-one (21) smoke detectors and twenty-one (21) heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/21/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty (60) beds with a census of forty-six (46) on the day of the survey.</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 | <p>The two holes in the ceiling of the boiler room were repaired with sheet rock, sheet rock tape and sheet rock mud by the Maintenance Supervisor on 11/6/15. All residents have the potential to be affected. All other ceilings will be checked by the Maintenance Supervisor by 11/30/15 with any identified penetrations repaired with sheet rock or fire rated caulking depending on the size and location. Systemic Changes: the Maintenance Supervisor was educated by the Regional Maintenance Director and the Administrator on 11/30/15 related to the repair future penetrations. Monitoring performance: The Maintenance Supervisor will audit all ceiling areas in the center monthly as a component of the Preventive Maintenance Program. The Maintenance Supervisor will report compliance of Life Safety Standards at the monthly QAPI meeting that is attended by those listed above.</p> | 12/1/15 |



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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

11/24/15

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

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| K 000 | Continued From page 1 | K 000 | | | |
| K 029 SS=D | <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain hazardous areas in accordance with the National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of the four (4) smoke compartments, residents, staff and other occupants of the building. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was forty-six (46).</p> <p>The findings include:</p> <p>Observation on 10/21/15 at 10:15 AM with the Environmental Services Director (ESD) revealed two (2) holes approximately three (3) inches in</p> | K 029 | | | |

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| K 029 | Continued From page 2 diameter in the ceiling of the Boiler Room in the North Wing of the facility. These holes must be filled with a suitable material to help prevent smoke and fire from spreading to other parts of the facility in a fire situation. Interview on 10/21/15 at 10:16 AM with the ESD revealed she was not aware of the holes in the ceiling area of the boiler room. The census of forty-six (46) was verified by the Administrator on 10/21/15. The findings were acknowledged by the Administrator and verified by the ESD at the exit interview on 10/21/15. | K 029 | | |
| K 069 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure kitchen areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of the four (4) smoke compartments, residents, staff and other occupants of the building. The facility has sixty (60) certified beds and the census was forty-six (46) on the day of the survey. The findings include: Observation on 10/21/15 at 10:04 AM with the Environmental Services Director (ESD) revealed a K-Type Fire Extinguisher in the Kitchen Area did not have a placard identifying the fire extinguisher as a secondary back up means to the automatic | K 069 | A placard identifying the fire extinguisher as a secondary back up means to the automatic fire suppression system was placed over the K-type fire extinguisher in the kitchen on 11/6/15. No other fire extinguishers are located in the kitchen. The Maintenance Supervisor will observe that the placard remains in place above the fire extinguisher in the kitchen during the weekly routine Preventive Maintenance rounds. Monitoring Performance: The Maintenance Supervisor will report the Preventive Maintenance rounds to the QAPI committee (members in attendance listed above) monthly. | 11/7/15 |

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| K 069 | Continued From page 3 fire suppression system. Interview on 10/21/15 at 10:05 AM with the ESD revealed the facility had not identified the placard as missing in the Kitchen Area. The census of forty-six (46) was verified by the Administrator on 10/21/15. The findings were acknowledged by the Administrator and verified by the ESD at the exit interview on 10/21/15. Reference: NFPA 96 (1999 Edition) 7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area. | K 069 | | |
| K 076 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 | K 076 | The Maintenance Supervisor has moved the medical gas, oxygen, storage into enclosed interior spaces of limited combustible construction, behind locked doors that are secure against unauthorized entry on 11/24/15. Systemic Changes: All nursing employees will be educated by the Director of Nursing Services (DNS) to the new oxygen storage areas and requirements for compliance to K 076 by 12/1/15. Monitoring for performance: Oxygen storage will be monitored by the Maintenance supervisor monthly. The Maintenance Supervisor will report compliance with oxygen storage to the QAPI Committee monthly. | 12/2/15 |

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| NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041 | | |
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| K 076 | <p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure outdoor oxygen storage areas were stored in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect residents, staff, and other occupants inside and outside of the building. The facility has sixty (60) certified beds and the census was forty-six (46) on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 10/21/15 at 10:33 AM with Environmental Services Director (ESD) revealed thirty-two (32) oxygen tanks stored on the outside of the west wing lobby exit. Oxygen tanks are required to be secured against unauthorized access.</p> <p>Interview on 10/21/15 at 10:34 AM with the ESD revealed that she had not been made aware of outside oxygen storage area requirements.</p> <p>The census of forty-six (46) was verified by the Administrator on 10/21/2015. The findings were acknowledged by the Administrator and verified by the ESD at the exit interview on 10/21/15.</p> <p>Reference: NFPA 99 (1999 Edition) 8-3.1.11.2 Storage for nonflammable gases less than 3000 ft³ (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable</p> | K 076 | | |

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

PRINTED: 11/05/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185047 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 10/21/2015 |
|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER HAWES MEMORIAL NURSING & REHAB CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041 | |
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| K 076 | Continued From page 5 gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2 (b) 4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2 (a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27 (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: | K 076 | | |

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| K 076 | Continued From page 6 CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING | K 076 | | | |