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PRINTED: 09/30/2010
FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE

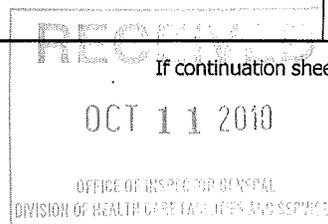
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185422	<input checked="" type="checkbox"/> CONSTRUCTION <input type="checkbox"/> ADDITION <input type="checkbox"/> B.WING	OFFICE OF INSPECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES (X3) DATE SURVEY COMPLETED 09/16/2010
NAME OF PROVIDER OR SUPPLIER FLAGET MEMORIAL HOSPITAL NF			STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004	
F 000	INITIAL COMMENTS	F 000		
F 156 SS=D	<p>A Standard Survey was conducted 09/14/10 through 09/16/10. Deficiencies were cited during the Standard Survey with the highest scope and severity of a "D". Life Safety Code survey was conducted on 09/14/10. There were no deficiencies cited related to the Life Safety Code Survey.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or</p>	F 156	<p>PLAN OF CORRECTION</p> <p>We ask that the plan of correction be accepted as our written credible allegation of compliance.</p> <p>Prefix Tag: F 156(SS=D) 483.10(b)(5) -10.483.10(b)(1) Notice of Rights, Rules, Charges.</p> <p>1. How the corrective action will be accomplished for those residents found to have been affected by the same deficient practice. Resident was discharged home. A call was made to the resident informing her of this right to Medicare Liability and appeal notice.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All records reviewed showed residents received notices for Medicare Liability and appeal notice.</p> <p>3. What measures are put into place or systemic changes made to ensure that the deficient practice will not recur? Director of Nursing will audit records monthly to ensure notices are signed and given upon admission. Nursing and Social Services to be educated.</p>	10/17/2010
(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

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE: See Down, RN, MSN TITLE: Nursing Home Administrator (X6) DATE: 10/11/2010

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185422	<input type="checkbox"/> HOME CONSTRUCTION <input type="checkbox"/> ADDL <input type="checkbox"/> B.WING	(X3) DATE SURVEY COMPLETED 09/16/2010
NAME OF PROVIDER OR SUPPLIER FLAGET MEMORIAL HOSPITAL NF			STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004	
(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 156	<p>Continued From page 1</p> <p>at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter</p>	F 156	4. Indicate how facility plans to monitor its performance to ensure that the solutions are sustained, and include dates when corrective action will be completed. Director of Nursing will report audits in the PI Meeting on a quarterly basis.	10/17/2010



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

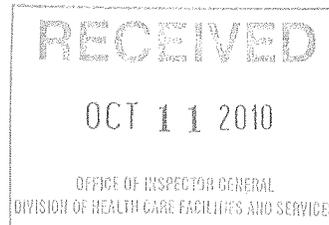
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185422	CONSTRUCTION NUMBER BUDGET BWNNG	(X3) DATE SURVEY COMPLETED 09/16/2010
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NAME OF PROVIDER OR SUPPLIER FLAGET MEMORIAL HOSPITAL NF	STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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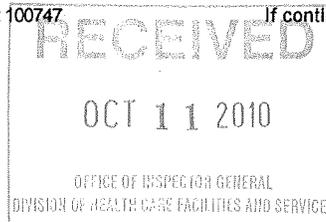
F 156	Continued From page 2 related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide written information to one (1) of eight (8) sampled residents. Resident #8 did not receive a Medicare liability and appeal notice. The findings include: Record review of Resident #8 revealed the resident was admitted on 08/31/10 with the diagnoses of a right femur fracture, diabetes mellitus, morbid obesity, gastroesophageal reflux, sleep apnea, asthma, hypertension and tobacco use. Resident #8 was discharged home on	F 156		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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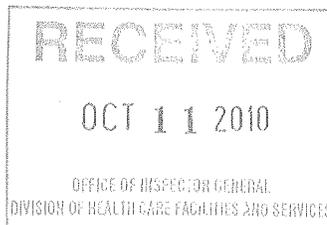
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185422	STATE CONSTRUCTION A _____ B/WING BUDG _____		(X3) DATE SURVEY COMPLETED 09/16/2010
NAME OF PROVIDER OR SUPPLIER FLAGET MEMORIAL HOSPITAL NF			STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004		
(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 156	Continued From page 3 08/11/10. Record review of Resident #8's closed record did not include the Medicare liability and appeal notice. Interview and record review on 09/16/10 at 2:29pm with the Director of Nurses revealed she was unable to produce the Medicare liability and appeal notice from the closed record for Resident #8. She reported the Medicare liability and appeal notice should have been obtained at time of the admission or during the hospital stay. She reported she was unable to produce this form completed by the resident. She reported the social services director is normally who gets the resident to complete the form, and does not know why the Medicare liability and appeal notice is not in this closed record. Interview with the Minimal Data Set (MDS) Coordinator/Social Services Director on 09/16/10 at 2:55pm revealed she was unable to produce the Medicare liability and appeal notice from the closed record for Resident #8. She reported the Medicare liability and appeal notice should have been obtained at time of the admission or during the hospital stay. She reported she was unable to produce this form completed by the resident.	F 156			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain a sanitary	F 253	Prefix Tag:F 253 SS-D 483.15 (b) (2) Housekeeping and Maintenance Services PLAN OF CORRECTION We ask that the plan of correction be accepted as our written credible allegation of compliance. 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Handle was replaced.	10/17/2010	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185422	<input checked="" type="checkbox"/> CONSTRUCTION NURSE BUDG BVWG	(X3) DATE SURVEY COMPLETED 09/16/2010
NAME OF PROVIDER OR SUPPLIER FLAGET MEMORIAL HOSPITAL NF			STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004	
(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 253	<p>Continued From page 4</p> <p>assistive device for one (1) of eight (8) sampled residents. Resident #3's foam padding on the cane gripe handle was ripped, frayed and torn.</p> <p>Observations on 09/15/10 at 8:15am revealed the grip handle of Resident #3's walking cane was ripped, torn and frayed.</p> <p>Interview with the rehabilitation Physical Therapy Assistant (PTA) on 09/15/10 at 3:10pm revealed the rehabilitation department was aware of the torn and frayed grip handle on the cane and confirmed it should have been repaired to prevent a possible transmission of micro-organisms and ensure the cane was sanitized before giving to another resident for use.</p> <p>Interview with Registered Nurse (RN) #1 on 09/15/10 at 3:20pm revealed RN #1 was aware the handle was frayed and torn. RN #1 reported the handle could not be adequately cleaned or sanitized with frayed and torn foam. RN #1 confirmed the foam should have been replaced.</p>	F 253	<p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Checked all equipment other residents were using. None found to need repair.</p> <p>3. What measures are put into place or systemic changes made to ensure that the same deficient practice will not recur? Director of Nursing will re-educate staff, to include Nursing, and Therapy staff. Employees will follow policy and procedures for safe medical devices as follows:</p> <ol style="list-style-type: none"> 1. Tag the equipment 2. Remove it from service. 3. Remove it from service to the dirty utility room, if feasible. If equipment is too large or heavy maintenance will be notified. 4. A work order will be filled out and Maintenance notified. 5. Maintenance will remove equipment from the unit or dirty utility room the next working day and repair if possible. 6. The equipment will be repaired or replaced as soon as possible. 7. Management will be notified for approval for replacement of equipment. <p>4. Indicate how facility plans to monitor its performance to ensure that the solutions are sustained, and include dates when corrective action will be completed. Rehabilitation manager will audit equipment and keep log. Audits will be reported in the PI Meeting quarterly.</p>	10/17/2010



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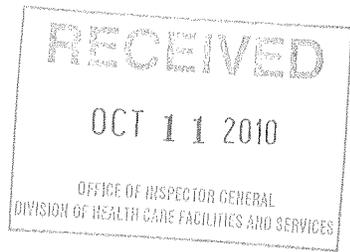
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185422	(X2) MULTIPLE A. BUILDING CONSTRUCTION 02 .3RD FLOOR SNF UNIT B.WING	(X3) DATE SURVEY COMPLETED 09/14/2010
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NAME OF PROVIDER OR SUPPLIER FLAGET MEMORIAL HOSPITAL NF	STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004
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(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS A standard Life Safety Code survey was conducted on September 14, 2010. The facility was found to be in substantial compliance with Title 42, Code of Federal Regulations, 483.70 (a) relating to NFPA 101 Life Safety Code 2000 Edition, with no regulatory violations identified on the date of the survey.	K 000		
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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shirley Deane, RN, MSN* TITLE *Nursing Home Administrator* (X6) DATE *10/11/2010*

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