

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

JAN 30 2015

OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES  
PRINTED: 01/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>		
(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	F 000			
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy for enteral feeding it was determined the facility failed check placement of a Gastrostomy tube prior to administration of a bolus tube feeding for one resident (Resident #1) with a Gastrostomy tube out of a total sample of</p>	F 322	<p>F322</p> <p>On 1/13/15, the Licensed Practical Nurse (LPN) caring for Resident #1 administered an intermittent tube feeding by Gastrostomy tube (G-tube) according to Patient Care Policy 0204-0003 ENTERAL FEEDING, which states, "prior to each feeding aspirate stomach contents using syringe, measure residual and re-instill." When the LPN was asked about verifying placement with air auscultation prior to feeding, the LPN did not know the Enteral Feeding Policy, which states regarding tube placement, "Key Point: Never give feeding until placement has been checked. Exception: G-tube, J-tube, or Dobhoff." With this exception for G-tubes, the policy was followed appropriately for the resident to receive the feeding into a Gastrostomy tube without verification of placement with air auscultation. On 1/13/15, the Manager of the Skilled Nursing Facility confirmed that no other residents had a Gastrostomy tube or feeding tube of any kind in place. On 1/22/15, the Director of Medical Inpatient Services, the Manager of the Skilled Nursing Facility, the SNF Unit-based Educator, and the Manager of Clinical Outcomes met to review Patient Care Policy 0204-0003 ENTERAL FEEDING to address any policy and/or systemic changes required to ensure any resident with an enteral feeding tube receives the appropriate treatment and services. Upon review of the policy, it was noted the policy requires aspiration of gastric contents and/or</p> <p>(continue)</p>	2/27/15	

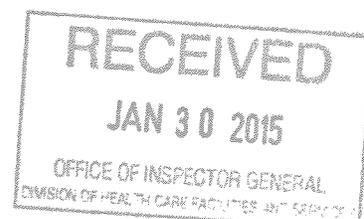
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*X* Karolyn Griswell TITLE  
Manager of Clinical Outcomes  
X  
(X6) DATE  
1/30/15

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.

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

PRINTED: 01/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

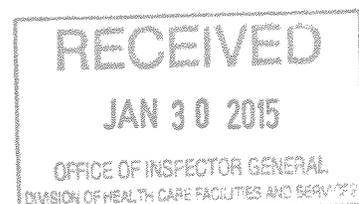
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>		
(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 322	Continued From page 1 eight (8).  The findings include:  Review of the facility's Enteral Feeding Policy, revised July 2012, revealed to prevent aspiration confirm tube placement by aspiration of gastric contents and use a syringe with 10-30 ml of air pushed through the tube while auscultating the patient's stomach to confirm tube placement. The policy further stated never give feeding until placement has been checked.  Observation, on 01/13/15 at 11:38 AM, of a bolus tube feeding for Resident #1 revealed the License Practical Nurse (LPN) #1 checked residual of the resident's stomach contents. There was no residual. The nurse then flushed the Gastrostomy tube with sixty (60) ml of water. She then administered the bolus tube feeding and flushed the tube with water after all the tube feeding had been administered. She did not auscultate with air to confirm tube placement. The nurse did not have a stethoscope.  Interview with LPN #1, on 01/13/15 at 11:42 AM, revealed she had checked the tube for placement earlier that morning when given medications and did not think to check again prior to giving the bolus tube feeding. She stated she should check placement of the Gastrostomy tube each time a medication or feeding was given via the tube.  Interview with the Skilled Unit Director, on 01/14/105 at 2:40 PM, revealed Gastrostomy tube placement are to be checked prior to administering a medication or feeding. She said all nurses are supposed to check placement with air auscultation and stomach residual. She stated	F 322	F 322 (continued) auscultation of air to confirm tube placement with the exception of G-tubes, J-tubes or Dobbhoffs. The decision was made to proceed with the policy review and staff education since this exception was not known or identified by the LPN on 1/13/15. On 1/23/15, the Director of Medical Inpatient Services reviewed the enteral feeding policy and the listed supporting references. The Director of Medical Inpatient Services sent the enteral feeding policy to the policy owner, the Manager of the Medical Care Unit, on 1/29/15. The policy owner is responsible to ensure a thorough clinical review of evidence and best practice occurs and that the policy is updated to reflect the most appropriate treatment and services. Examples may include visual inspection of G-tube placement prior to any tube feeding and/or what to do in the absence of gastric contents to confirm proper placement. The policy will then be reviewed by the Patient Care Directors, Patient Care Managers, and the Chief Nursing Officer for approval. The Director of Medical Inpatient Services will ensure the final approval for the policy will be completed by 2/27/15. On 1/29/15, the SNF Unit-based Educator created a hand out to educate the Nursing staff about types of feeding tubes and proper maintenance. The current Patient Care Policy 0204-0003 ENTERAL FEEDING and the handout will be reviewed with each RN and LPN face to face by the Manager of the Skilled Nursing Facility. Each nurse will sign a roster indicating the education was received and understood. The education will occur on 2/2/15 through 2/13/15 to cover multiple shifts. If any updates are applied to the policy through the review process, they will be reviewed with staff likewise. To monitor the effectiveness of the (continue)		



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

PRINTED: 01/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>		
(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 322	Continued From page 2 if a resident was on a continuous feeding via pump, placement should be checked prior to medication administration. She revealed all nurses are trained during skills check-off and competency tested. Nurses do actual demonstration of the skills, including tube feeding. She stated the competency of the nurses are monitored by the Unit Based Educators and they document problems and conduct on the spot training to correct the problem. She stated she had not had any reports of any nurse who did not perform placement of a Gastrostomy tube prior to administering medication or tube feeding. She again stated all nurses must pass competency test that included checking for placement of a Gastrostomy tube. She continued to state that day to day monitoring is conducted by the Charge Nurse and the Unit Based Educators. Oversight was provided by the Unit Manager.	F 322	F 322 (continued) education, and to ensure sustained compliance, the Unit-based Educator will create a competency assessment tool with which she will assess knowledge of the enteral feeding policy and procedure. The tool will include a written exam and a checklist for verbalizing correct elements of the procedure. The Unit-based Educator will administer a competency assessment to each Registered Nurse and Licensed Practical Nurse of the Skilled Nursing Facility during the months of April (3 months), July (6 months) and January, 2016 (1 year). Each nurse must pass the competency assessment with a score of 90% or better, or be placed on a remediation action plan according to Education & Development Policy EDUC-0002 ORGANIZATION-WIDE COMPETENCY ASSESSMENT. The Unit-based Educator and Manager of the Skilled Nursing Facility will report the competency assessment results to the QAPI Committee of the Skilled Nursing Facility. The QAPI Committee will determine any further requirements for monitoring.		



JAN 30 2015

OFFICE OF INSPECTOR GENERAL

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1954, 1967, 1979, 1983, 1989, 1993, 2005</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Six stories, Type I (332)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type I, 510KW generator installed in 2005. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 01/13/15. The facility was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifteen (15) beds with a census of eleven (11) 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> <p>Deficiencies were cited with the highest</p>	K 000		
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Karolyn Griswell</i>	TITLE Manager of Clinical Outcomes	(X6) DATE <i>X</i> 1/30/15
--	---------------------------------------	-------------------------------

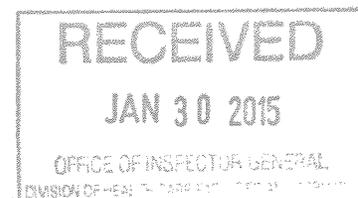
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RW

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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

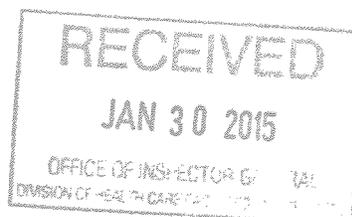
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 027 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire exit hardware was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, fifteen (15) residents, staff and visitors. The facility has the capacity for fifteen (15) beds and at the time of the survey, the census was eleven (11).</p> <p>The findings include:</p> <p>1.) Observation, on 01/13/15 at 12:00 PM, with the Supervisor of Plant Engineering revealed the cross corridor doors, identification number 3A4-015-S, located in a two (2) hour wall that was being used as a smoke barrier had fire exit hardware installed on the doors. The bottom</p>	K 027	<p>K 027</p> <p>On 1/14/15, the Supervisor of Plant Engineering placed a call to the supply vendor for construction hardware. On 1/22/15, the supply vendor arrived on the Skilled Nursing Facility to perform an evaluation of door number 3A4-015-S and door number 3A1-012-S. The supply vendor is searching for replacement hardware to restore the current doors with the bottom latch bolt missing from the original fire exit hardware. Should the vendor be unable to locate the appropriate replacement hardware, new doors will be purchased to replace both door number 3A4-015-S and door number 3A1-012-S. The Supervisor of Plant Engineering will ensure the complete hardware or doors will be replaced by the construction supply vendor no later than 2/27/15.</p>	2/27/15



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

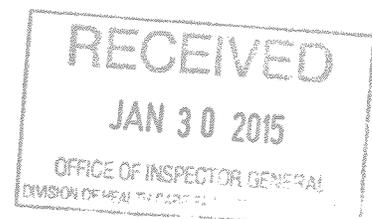
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 027	<p>Continued From page 2</p> <p>latch bolt, which extended from the push bar to the floor, had been removed from the fire exit hardware by staff.</p> <p>Interview, on 01/13/15 at 12:01 PM, with the Supervisor of Plant Engineering revealed he was aware the bottom latch bolt had been removed.</p> <p>2.) Observation, on 01/13/15 at 12:25 PM, with the Supervisor of Plant Engineering revealed the cross corridor doors, identification number 3A1-012-S, located in a two (2) hour wall that was being used as a smoke barrier had fire exit hardware installed on the doors. The bottom latch bolt, which extended from the push bar to the floor, had been removed from the fire exit hardware by staff.</p> <p>Interview, on 01/13/15 at 12:26 PM, with the Supervisor of Plant Engineering revealed he was aware the bottom latch bolt had been removed.</p> <p>The census of eleven (11) was verified by the Administrator on 01/13/15. The findings were acknowledged by the Administrator and verified by the Supervisor of Plant Engineering at the exit interview on 12/13/15.</p> <p>Actual NFPA Standard:</p> <p>8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following.</p>	K 027			



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

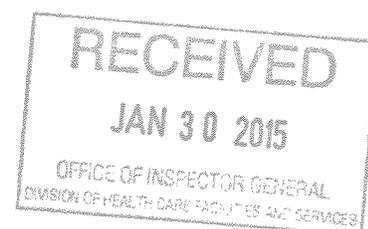
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	<p>Continued From page 3</p> <p>(a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1.</p> <p>(b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.</p> <p>8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (1) 2-hour fire barrier - 1 1/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42 Exception No. 1: Where the fire barrier specified in 8.2.3.2.3.1(2) is provided as a result of a requirement that corridor walls or smoke barriers be of 1-hour fire resistance-rated construction, the opening protectives shall be permitted to have not less than a 20-minute fire protection rating when tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test. Exception No. 2: The requirement of</p>	K 027		



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

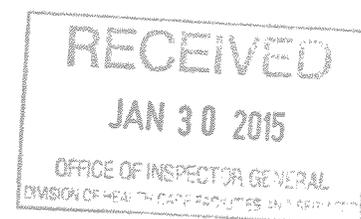
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 4 8.2.3.2.3.1(2) shall not apply where special requirements for doors in 1-hour fire resistance-rated corridor walls and 1-hour fire resistance-rated smoke barriers are specified in Chapters 18 through 21. Exception No. 3: Existing doors having a 3/4-hour fire protection rating shall be permitted to continue to be used in vertical openings and in exit enclosures in lieu of the 1-hour rating required by 8.2.3.2.3.1(2). (3) 1/2-hour fire barrier - 20-minute fire protection rating Exception: Twenty-minute fire protection-rated doors shall be exempt from the hose stream test of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.	K 027		
K 076 SS=D	4.6.1.1 The authority having jurisdiction shall determine whether the provisions of this Code are met. 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	K 076 On 1/13/15, the Director of Medical Inpatient Services removed the unsecured oxygen tank from the MC3 Clean Utility Room and delivered it to the Respiratory Therapy Department for storage. On 1/13/15, the Director of Medical Inpatient Services assessed all rooms within and around the Skilled Nursing Facility for unsecured oxygen tanks. No other unsecured tanks were found. Patient Care Policy 0209-0012 O2 TANK USAGE AND SECURITY states tanks available on units for patient ambulation are to be secure in a stand or holder and are considered in use. Full tanks are stored in the Respiratory Therapy Department. Empty tanks are taken to the Respiratory Therapy Department for a replacement. (continue)	2/20/15



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

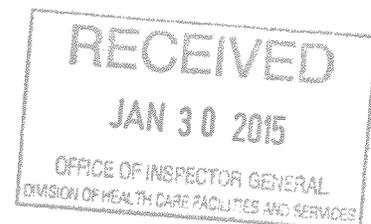
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 076	Continued From page 5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility has the capacity for fifteen (15) beds and at the time of the survey, the census was eleven (11).  The findings include:  Observation, on 01/13/15 at 12:22 PM, with the Supervisor of Plant Engineering revealed an oxygen tank storage room #MC3 Clean Utility and the oxygen tank was not stored in a rack to prevent the tank from falling over and was not labeled full or empty.  Interview, on 01/13/15 at 12:23 PM, with the Supervisor of Plant Engineering revealed he was not aware the tank was being stored in the room.  The census of eleven (11) was verified by the Administrator, on 01/13/15. The findings were acknowledged by the Administrator and verified by the Supervisor of Plant Engineering at the exit interview on 01/13/15.  Reference: NFPA 99 (1999 edition)	K 076	K 076 (continued) On 1/23/15, the Manager and Unit-based Educator of MC3 created an education plan for staff to ensure the deficient practice will not recur. On 1/23/15, the Manager of MC3 created a handout including instructions for securing oxygen tanks in holders at all times and how to obtain a replacement from the Respiratory Therapy Department. She posted a copy in the communication book and hung in various staff areas on 1/23/15. She also sent the handout to the Manager of Transport Services. The Manager and the Unit-based Educator of MC3 will educate each Unit Secretary, Patient Care Assistant, and Registered Nurse face to face using Patient Care Policy 0209-0012 O2 TANK USAGE AND SECURITY. Each nurse will sign a roster indicating the education was received and understood. The education began 1/26/15 and will be completed for all MC3 staff on all shifts by 2/20/15. The Manager of Transport Services educated each Transporter face to face using the handout and Patient Care Policy 0209-0012 O2 TANK USAGE AND SECURITY. Each transporter signed a roster indicating the education was received and understood. The education began on 1/27/15 and was completed for all transport staff on all shifts on 1/29/15. To monitor the effectiveness of the education, and to ensure sustained compliance, the Manager of MC3 will monitor all the rooms of the MC3 unit for unsecured oxygen tanks during daily rounding Monday through Friday, beginning 1/26/15 through 5/1/15. The Manager will follow up with staff on shift if unsecured oxygen tanks are identified. In addition, on 1/23/15, the Supervisor of Plant Engineering created a Preventive Maintenance work order for a weekly tour of the Skilled Nursing Facility and surrounding halls and (continue)		



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

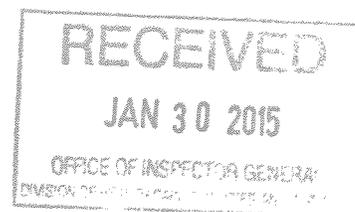
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 6 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (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 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 (5 ft) 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	K 076	K 076 (continued) rooms by Facilities Maintenance staff to monitor security of oxygen tanks. The work order includes weekly tours for 3 months and monthly tours for the remainder of the year. The Supervisor of Plant Engineering will report the audit results to the Manager of the Skilled Nursing Facility who will report the data to the QAPI Committee. The QAPI Committee will determine any further requirement for monitoring.	



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

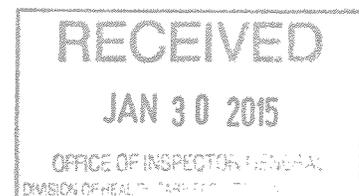
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 076	Continued From page 7 locations and within 20 ft (6.1 m) 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: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b>	K 076			
K 144 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, fifteen (15) residents, staff and visitors. The facility has the capacity for fifteen (15) beds and on the day of the survey the census was eleven (11).	K 144	<b>K 144</b> On 1/14/15, the Supervisor of Plant Engineering contacted the Generator Service Contractor for a generator battery change. On 1/26/15, the Generator Service Contractor installed a new lead-acid battery to the Type I emergency generator for the Skilled Nursing Facility. The battery allows for removal of the cell caps to check the fluid visually and to check the specific gravity. On 1/14/15, the Supervisor of Plant Engineering reviewed the procedure for preventive battery maintenance checks face to face with each Facilities Management staff who will conduct performance maintenance checks. To ensure sustained compliance, the Supervisor of Plant Engineering created an ongoing Performance Maintenance work order for generator battery maintenance checks beginning 1/26/15, to include a weekly visual fluid check and a monthly specific gravity. Results of the maintenance checks will be maintained in a log by Facilities Management staff. Any variances identified will be reported to the Supervisor of Plant Engineering who will determine the need to request maintenance from the Generator Service Contractor.	1/26/15	



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

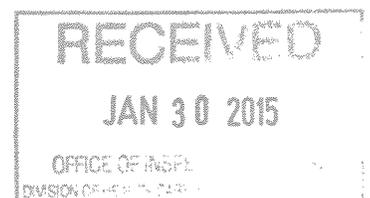
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	<p>Continued From page 8</p> <p>The findings include:</p> <p>Observation, on 01/13/15 at 2:55 PM, with the Supervisor of Plant Engineering revealed the Type I emergency generator had a maintenance free battery installed for starting.</p> <p>Interview, on 01/13/15 at 2:56 PM, with the Supervisor of Plant Engineering revealed he was aware of the requirement; however, he was not aware the battery had been replaced with a maintenance free battery.</p> <p>The census of eleven (11) was verified by the Administrator on 01/13/15. The findings were acknowledged by the Administrator and verified by the Supervisor of Plant Engineering at the exit interview on 01/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 Edition) 3-5.4.5* Type of Battery. The battery shall be of the nickel-cadmium or lead-acid type. Lead-acid batteries or dry-charged lead-acid batteries shall be furnished as charged when wet. Drain-dry batteries or dry-charged lead-acid batteries shall be permitted. Vented nickel-cadmium batteries shall be filled and charged when furnished and shall have listed flip-top, flame arrestor vent cap. The manufacturer shall provide installation, operation, and maintenance instructions, and, when shipped dry, electrolyte mixing instructions. Batteries shall not be installed until the battery charger is in service.</p> <p>All batteries used in this service shall have been designed for this duty and shall have demonstrable characteristics of performance and reliability acceptable to the authority having</p>	K 144		



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

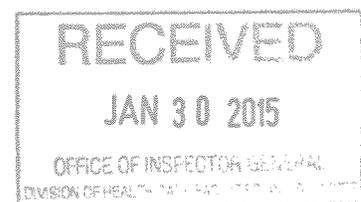
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	Continued From page 9 jurisdiction. Batteries shall be prepared for use according to the battery manufacturer ' s instructions. Starting batteries for Level 1 installations shall not be of the maintenance-free variety.	K 144			
K 147 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility has the capacity for fifteen (15) beds and at the time of the survey, the census was eleven (11).  The findings include:  Observation, on 01/13/15 at 12:15 PM, with the Supervisor of Plant Engineering revealed a power strip was plugged into another power strip located in the Hospitalist Office. Further observation in the Hospitalist Office revealed a coffee maker plugged into a power strip.  Interview, on 01/13/15 at 12:16 PM, with the Supervisor of Plant Engineering revealed he was aware of the requirements for the proper use of power strips; however, he was not aware the	K 147	K 147 On 1/13/15, the power strip was unplugged from the other power strip and the coffee maker was unplugged from the power strip immediately. On 1/13/15, the Supervisor of Plant Engineering assessed each room within and around the Skilled Nursing Facility for misused power strips. No other violations were found. On 1/14/15, the Director of Medical Staff Services placed a work order with Facilities Management for the installation of two additional permanent wall outlets in the Hospitalist office. The wall outlets were installed and the work order completed on 1/28/15. On 1/23/15, the Supervisor of Plant Engineering placed a work order with Facilities Management to install an additional two permanent wall outlets within the Skilled Nursing Facility in order to remove all power strips and prevent misuse. On 1/23/15, the Supervisor of Plant Engineering contacted the Purchasing Department and placed power strips on the restricted supply list with the supply vendor. Purchase of power strips will require approval from the Director of Facilities Management as of 1/23/15. To prevent Hospitalists from misusing power strips or bringing power strips into the facility, the Director of Medical Staff Services posted an educational poster in both sections of the Hospitalist office on 1/14/15. The poster specifies regulation against power strips being plugged into power strips and heat sources (continue)	2/18/15	



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 10</p> <p>power strips in the Hospitalist Office had been misused.</p> <p>The census of eleven (11) was verified by the Administrator on 01/13/15. The findings were acknowledged by the Administrator and verified by the Supervisor of Plant Engineering at the exit interview on 01/13/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended</p>	K 147	<p>K 147 (continued)</p> <p>being plugged into power strips. It also includes instructions to place a work order with Facilities Management for any further power source needs. The Director of Medical Staff Services will enforce the education posted on the poster during a staff meeting with the Hospitalists on 2/18/15.</p> <p>To ensure sustained compliance, the Supervisor of Plant Engineering created a Preventive Maintenance work order on 1/23/15 for a weekly tour of the Skilled Nursing Facility and surrounding halls and rooms by Facilities Maintenance staff to monitor for unauthorized power strips or inappropriate use of power strips. The work order includes weekly tours for 3 months and monthly tours for the remainder of the year. The Supervisor of Plant Engineering will report the audit results to the Manager of the Skilled Nursing Facility who will report the data to the QAPI Committee. The QAPI Committee will determine any further requirement for monitoring.</p>	



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

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185427</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	Continued From page 11 use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			

