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

PRINTED: 04/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185443		04/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENSINGTON CENTER	225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED SOD A Standard Health Survey was conducted 04/08/14 through 04/10/14 and a Life Safety Code Survey was conducted on 04/09/14 and deficiencies were cited with the highest scope and severity of an "E".	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to provide necessary care and services according to physician orders for one (1) of seventeen (17) sampled resident. Resident #9. The facility failed to obtain a physician order to change the Peripherally inserted Central Catheters (PICC) flushes after an antibiotic medication was completed for Resident #9. The findings include: Review of the facility's policy titled Central Venous Catheter flushing (that included PICC) from the	F 309	F 309 1. The Physician was notified on 4/8/2014 concerning residents # 9 PICC line flushes by the Unit Manager. Orders obtained at that time to discontinue current flush orders and flush PICC line once weekly. R.N. #1 was counseled by the Director of Nursing on 04/08/14 regarding following Physician orders and the facility policy on Central Venous Catheters. 2. The Director of Nursing, Assistant Director of Nursing and/ or Unit Managers will reviewed all current resident physician orders including resident with Central Venous Catheters (including PICC lines) to determine Physicians orders and the policy covering Central Venous Catheters were followed by date 04/25/14. Any concerns identified will be addressed at that time. F 309 continued on page 2	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: x Vicki Bradley | TITLE: x Administrator | (X8) DATE: x 4/30/14

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

OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 1 Omnicare Nurses Infusion Manual for Long Term Care Facilities, revision date of 07/01/12, revealed a physician/licensed independent practitioner order was required to flush a catheter. The order must include the flushing agent, the strength or concentration, the volume, and the frequency. The specific flush orders must be documented. Flushing was performed to ensure and maintain catheter patency and to prevent the mixing of incompatible medications/ solutions. The policy instructed the nurse to verify physician's order prior to the flush. Observation during a Medication Pass, on 04/08/14 at 2:15 PM, revealed RN #1 flushed the catheter lumen with Normal Saline (10 units) and then administered Heparin 5 ml (10 units/ml) to equal 50 units. The nurse used pre-measured syringes from the pharmacy. Review of the April 2014 Medication Administration Record (MAR) for Resident #9 revealed the Vancomycin (antibiotic medication) had been discontinued on 04/02/14. However, the PICC flushes were still scheduled for twice a day using the Saline Antibiotic Saline Heparin (SASH) flush. Review of the clinical record revealed the facility admitted the resident on 03/07/14 with diagnoses of Diabetes, Unspecific Osteomyelitis, and After Care Following Surgery. The record revealed a PICC line was inserted on 03/17/14 with physician orders to flush the PICC daily using the SASH protocol. The Vancomycin was ordered on that day to be administered daily for fourteen (14) days. On 03/26/14, the physician changed the antibiotic order from daily to every twelve (12) hours with flushes using the SASH protocol. Further review of the record revealed no new order for PICC flushes after the antibiotic	F 309	F 309 continued from Page 1 3. The Director of Nursing and/or the Assistant Director of Nursing will re-educate Licensed Nurses on following Physicians orders and the facility policy regarding Central Venous Catheters. Re-Education included notifying the residents Physician when an antibiotic was administered through a Central Venous Catheter for flush order changes when the antibiotic order has ended. A post test was completed to determine understanding of the re-education on date 04/25/14. 4. The Director of Nursing, Assistant Director of Nursing and /or the Unit Managers will document an audit of 10 residents charts weekly for 4 weeks, then 10 charts twice a month for 2 months, then monthly for 3 months to determine Physician orders are followed and new orders are obtained when an antibiotic has been administered through a Central Venous Catheter for flush order changes when the antibiotic order has ended. Any concerns identified will be corrected at that time. The Director of Nursing will submit a summary of the audit finding to the Performance Improvement Committee monthly for 6 months for further review and recommendations.	04/26/14

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F 309	Continued From page 2 was discontinued. Interview with RN #1, on 04/08/14 at 2:30 PM, revealed she had reviewed the resident's April MAR prior to flushing the PICC line. She stated the MAR instructed the nurse to flush using the SASH protocol and the flushes was scheduled twice a day; at 2:00 AM and 2:00 PM. RN #1 stated SASH flushes were used when an Intravenous (IV) antibiotic medication was administered. After reviewing the MAR, she stated it appeared the physician had not been called to obtain new PICC flushes after the antibiotic medication was discontinued. She stated the normal flush for PICC lines without medication administration would be to flush weekly. Closer review of the MAR revealed RN #1 had initialed she had flushed the PICC line on 04/03/14 (the day after the antibiotic was discontinued) even though the PICC line had been flushed at 2:00 AM that day. She indicated she had not looked at the MAR closely and when she looked in the clinical record, she could not find a new flush order for the PICC. Interview with the Director of Nursing (DON), on 04/10/14 at 1;35 PM, revealed the facility utilized the Omnicare Infusion Manuel as their policy. She stated there must be a physician order to flush the PICC line. She stated the nurse should have called the physician when the antibiotic medication was completed to obtained a new flush order. The nurses should not have continued to flush the PICC twice a day. She revealed the resident's physician had been at the facility since the medication was discontinued and the nurse could have obtained a new flush order then. The protocol was to flush a PICC line weekly whenever a medication was completed.	F 309		

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F 309	Continued From page 3 There was a risk to the resident because the PICC line was flushed with Heparin (blood thinning medication). She stated she had not filled out an incident report, but she would have to check with RN #1 to see if she had. She stated all nurses are educated on the PICC line including flushes, but she had not provided oversight to ensure they were completing PICC flushes as ordered by the physician. She stated the nurse did not follow the facility's policy. Review of the clinical record, on 04/09/14, revealed an telephone order was obtained on 04/08/14 to d/c current flushes with a new order to flush the PICC line once weekly.	F 309		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was	F 514	F 514 1. The Physician was notified on 04/08/14 of delay in transcription of orders received on 4/4/2014 for resident #3, #11 and #14 by the Unit Manager. Orders received to transcribe orders . Resident #3, #11 and #14 were assessed on 04/08/14 by unit manager, no increase in behaviors was identified. 2. An audit was conducted of current residents orders to include residents receiving Psychiatric services on 04/08/14 by the Director of Nursing, Assistant Director of Nursing and/or the Unit Managers to determine orders had been transcribed the day received, no concerns were identified. F 514 continued on page 5	

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F 514	Continued From page 4 determined the facility failed to maintain an accurate record of physician orders when the staff failed to transcribe physician orders for changes in medications for three (3) of seventeen (17) sampled residents. Resident #3, #11 and #14. The findings include: Review of the facility's policy regarding Transcription of Orders, effective date 12/01/06, revealed orders from an authorized licensed independent practitioner are transcribed by trained staff. The facility responds to written orders by establishing a system to notify staff of new orders (e.g., flagging the chart); respond to telephone or verbal orders by transcribing telephone/verbal order on to the appropriate form; establish a system to ensure facility physicians co-signs the telephone/verbal orders according to state requirements; communicate the orders to the pharmacy; and transcribe the orders on to the Medication Administration Record (MAR) or Treatment Administration Record (TAR). 1. Review of the clinical record for Resident #14 revealed the facility admitted the resident, on 05/06/11, with diagnoses of Dementia with Behavior Disturbance and Bipolar Disorder. Review of the 02/11/14 Psychiatric Medication Evaluation revealed the resident received Abilify 2 mg daily, Celexa 5 mg every day for Depression, Ativan 1 mg twice a day for Anxiety, and Namenda 10 mg twice a day for Dementia. Review of the 04/04/14 Psychiatric Follow Up Evaluation revealed new orders to discontinue Namenda 10 mg twice a day, and start Namenda XR 28 mg by mouth every day for Dementia.	F 514	F 514 continued from page 4 3. The Director of Nursing and the Assistant Director of Nursing re-educated the licensed nurses and the Social Service Director on the process of transcription of Physician orders on date 04/25/14. Re-education included Psychiatric service order process, the facility Social Service Director will give orders to the Director of Nursing and/or the Assistant Director of Nursing. The Director of Nursing and/or the Assistant Director of Nursing will review the orders and distribute the orders to the licensed nurse for transcription. The Director of Nursing, Assistant Director of Nursing and /or the Unit Managers will review orders in the Morning Clinical Meeting to determine orders have been transcribed. Areas of concern will be corrected when identified. A post test was given to determine understanding of re-education on date 04/25/14. F 514 continued on page 6	

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F 514	Continued From page 5 However, review of the transcribed physician's telephone orders revealed the change in medication was not transcribed until 04/08/14, or four (4) days later. Interview with the Social Services Director, on 04/10/14 at 1:39 PM, revealed she was responsible for getting the Psychiatric Reports, which she separates and makes copies, then gives copies to the Unit Coordinators. The Social Services Director stated they were responsible for acting on these orders. She also stated on the 4 th of April, she received the reports and distributed the copies. The Social Service Director stated since this was late on Friday, she was told by Unit Coordinator LPN #3 to put the reports in the mailbox, and she would look at them on Monday. Interview with the Unit Coordinator LPN #3, on 04/10/14 at 1:45 PM, revealed she knew that Social Services had papers on Friday; however, she did not know what they were at the time. In addition, LPN #3 stated not all nurses had been trained on putting new physician's orders in the computer yet, and wasn't sure if there were night shift nurses that could put the orders in the computer. The LPN stated had she known there were orders, she would have stayed and put them in herself. LPN #3 revealed she took the orders out of her mail box, on Monday 04/07/14, and delegated the orders to the day shift nurse to put in the computer. However, review of the transcribed order revealed the medication change was not transcribed, until 04/08/14 at 2:00 AM, by the night shift nurse. 2. Review of Resident #3's clinical record	F 514	F 514 continued from page 5 4. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers will document audits of 10 resident Physician orders to include Psychiatric service orders weekly for 4 weeks, bi-weekly for 2 months then monthly for 3 months to determine orders are transcribed when received. Any concerns identified will be addressed at that time. The Director of Nursing will submit a summary of the audit findings to the Performance Improvement Committee monthly for further review and recommendations for 6 months.	04/26/14

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F 514	Continued From page 6 revealed the facility admitted the resident on 04/02/13 with diagnoses of Cognition Deficit, Depressive Disorder and Dementia without Behavior. Review of Resident #3's Psychiatric Follow-Up Evaluation, dated 04/04/14, revealed an Advanced Registered Nurse Practioner (ARNP) wrote an order to discontinue Trazodone 25 mg as needed and Ativan 0.25 mg as needed related to non use of the medication. Review of Resident #3's Physician Orders, dated 04/07/14, revealed the medication Trazodone 25 mg as needed and Ativan 0.25 mg as needed was discontinued. The order was written three (3) days after the order was given to discontinue the medications. 3. Review of Resident #11's record revealed the facility admitted the resident on 10/11/11 with diagnoses of Persistent Mental Disorder and Dementia without Behavioral Disturbance. Review of Resident #11's Psychiatric Follow-Up Evaluation, dated 04/04/14, revealed an ARNP wrote an order to discontinue Trazodone 25 mg as needed due to lack of use of medication. Review of Resident #11's Physician Orders, dated 04/08/14 at 2:30 AM, revealed the medication Trazodone 25 mg as needed was discontinued. The physician's order was written four (4) days after the order was given to discontinue the medication. Interview with the Social Services Director, on 04/10/14 at 1:39 PM, revealed she was responsible for getting the Psychiatric Reports,	F 514		

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F 514	Continued From page 7 which she separates and makes copies, then gives copies to the Unit Coordinators. The Social Services Director stated they were responsible for acting on these orders. She also stated on the 4th of April, she received the reports and distributed the copies. The Social Service Director stated since this was late on Friday, she was told by Unit Coordinator LPN #3 to put the reports in the mailbox, and she would look at them on Monday. Interview with the Unit Coordinator LPN #3, on 04/10/14 at 1:45 PM, revealed she knew that Social Services had papers on Friday; however, she did not know what they were at the time. In addition, LPN #3 stated not all nurses had been trained on putting new physician's orders in the computer yet, and wasn't sure if there were night shift nurses that could put the orders in the computer. The LPN stated had she known there were orders, she would have stayed and put them in herself. LPN #3 revealed she took the orders out of her mail box, on Monday 04/07/14, and delegated the orders to the day shift nurse to put in the computer. However, review of the transcribed order revealed the medication change was not transcribed, until 04/08/14 at 2:00 AM, by the night shift nurse. Interview with Licensed Practical Nurse (LPN) #4, on 04/10/14 at 2:12 PM, revealed it was the practice of the facility to process psych orders one (1) or two (2) days later. LPN #4 stated the Psych orders usually came through another staff member before she would receive the orders. LPN #4 stated she did remember receiving medication orders from the Unit Coordinator on Monday. She then took off some of the orders	F 514		

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F 514	Continued From page 8 and delegated to the next shift to take off the remaining orders. LPN #4 stated it was not a good practice to process orders a couple of days later because you want to ensure residents received their medications timely. Interview with the Director of Nursing (DON), on 04/10/14 at 2:23 PM, revealed the nurses should have processed the orders as soon as they had received the information. The DON stated they want the orders processed as soon as possible because of changes to the medication. The DON stated this was the first time she had ever known something like this to happen.	F 514		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 04/26/14 as alleged.	{F 000}		

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

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 2000, Original building; 2010, Physical Therapy and Rehabilitation addition. SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III unprotected. SMOKE COMPARTMENTS: Six (6) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system. GENERATOR: Type II, 55KW generator, fuel source is natural gas. A standard Life Safety Code Survey was conducted on 04/09/14. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has eighty- two (82) certified beds and the census was eighty-one (81) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vicki Bradley | TITLE: Administrator | (X6) DATE: 4/30/14

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest deficiency identified at a "D" level.	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has eighty-two (82) certified beds and the census was eighty-one (81) on the day of the survey. The facility failed to ensure sprinkler head spray patterns were not obstructed. The findings include: Observation, on 04/09/14 at 11:22 AM, with the Maintenance Director revealed the sprinkler head within the Clean Linen Room located in the Rehab Wing had its spray pattern obstructed by a surface mounted fluorescent light fixture. The light fixtures were positioned less than four (4) inches from the sprinkler head and extended further down from the ceiling than the sprinkler	K 062	K 062 1. Gene Ray Electric, the original installers of the surface mounted florescent light was notified on 04/14/14 of the obstruction. The obstructed surface mounted fluorescent light fixture was relocated on 04/23/14 in accordance with the National Fire Protection Association (NFPA) standard. 2. The Maintenance Director conducted an audit of the facility sprinkler head obstructions on 04/09/14 to determine any other concerns. It was determine there were no other concerns to be addressed. 3. Reeducation of the Maintenance Director by the Administrator on the sprinkler system in accordance with the NFPA standard was completed on 04/25/14. 4. An audit of the facility will be completed by the Maintenance Director and/or Administrator monthly for 3 months to review any new fixture installations and once every quarter for 2 quarters. The Maintenance Director will submit a summary of the audit findings to the Performance Improvement Committee monthly for 9 months for further review and recommendations.	04/26/14

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185443		04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENSINGTON CENTER	225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701

(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 062	Continued From page 2 head diffusers did. Interview, on 04/09/14 at 11:24 AM, with the Maintenance Director revealed he was unaware the positioning of the surface mounted light fixtures would obstruct the spray pattern of the sprinkler heads upon activation of the automatic sprinkler system. The census of eighty-one (81) was verified by the Administrator, on 04/09/14 at 2:07 PM. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/09/14. Reference: NFPA 101 (2000 Edition) 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition. NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing Shall comply with 5-5.5.2. Table 5-6.5.1.2. Positioning of sprinklers to avoid obstructions to discharge requires at least one foot clearance between sprinkler heads and obstructions to spray patterns that are level with or taller than the sprinkler head.	K 062		

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	185443		04/09/2014

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KENSINGTON CENTER	225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701

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K 062	Continued From page 3 NFPA 25 (1998 Edition) 2-2.1.1. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.1.2*. Unacceptable obstructions to spray patterns shall be corrected.	K 062		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	185443		R **05/02/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENSINGTON CENTER	**225 SAINT JOHN ROAD** **ELIZABETHTOWN, KY 42701**

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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 04/26/14 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.