

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

PRINTED: 10/27/2010
FORM APPROVED
OMB NO. 0938-D391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/13/2010
NAME OF PROVIDER OR SUPPLIER HYDEN NURSING HOME, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH, P O BOX 618 HYDEN, KY 41749	
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 156 SS=B		F 156	<p><u>F-156</u></p> <ol style="list-style-type: none"> Residents #6, #8, #13, #19, and #20 have all been issued the Notice of Medicare Provider Non-Coverage Denial Notice. All Residents of the facility who have a change in payor source are being issued a Notice of Medicare Provider Non-Coverage Denial Notice prior to the effective date of the non-coverage with detailed explanation as to the reason for non-coverage. Documentation is being made of the acknowledgement of receipt of notice by the resident / responsible party. Any notification made by telephone is documented with the name of the person spoken to and the date of 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Melissa Sparks ADMINISTRATOR
TITLE
DATE
11-3-10

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

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F 156	<p>Continued From page 1</p> <p>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 I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and</p>	F 156	<p>the call. All notices provide an acceptable, detailed explanation of the reason for non-coverage.</p> <p>3. Educational material from the Centers for Medicare and Medicaid Services website regarding content and timeliness of Medicare denial notices was reviewed by the Administrator and the admissions coordinator, who issues the notices. The Administrator re-educated the staff member regarding the appropriate documentation to be included in the notice, documentation of acknowledgment and timeliness of the notice issuance to resident or responsible party. This</p>		

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F 156	<p>Continued From page 2</p> <p>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.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the appropriate information to the resident or resident responsible party (R/P) when a change in payor source occurred for five (5) of five (5) residents (residents #6, #8, #13, #19, and #20). The Notice of Medicare Provider Non-Coverage denial notice failed to include the appropriate date of the notice, an acceptable reason for non-Medicare coverage, and/or acknowledgement of information regarding receipt of the denial notice.</p> <p>The findings include: A review of the denial notices for non-Medicare coverage for residents #6, #8, #13, #19, and #20</p>	F 156	<p>information was reviewed on October 13, 2010.</p> <p>4. Any resident that requires a Medicare Provider Non-Coverage Denial Notice will have the notice reviewed by a designated member of the CQI committee prior to issuance for timeliness and after issuance for acknowledgement and content. The Denial Notice will be reviewed prior for timeliness of notice and explanation of reason for denial. The notice will be reviewed after issuance for documentation of acknowledgement by resident or responsible party. The notices will be reviewed weekly for one month and then monthly for three months. Any irregularity will be correctly immediately and</p>	

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F 156	Continued From page 3 revealed that the notices sent to the resident/responsible party failed to include specific reasons for non-Medicare coverage. In addition, the denial notices for residents #19 and #20 failed to provide verification of receipt of the notice, and the denial notice sent to resident #13 was dated August 27, 2010. However, the Medicare benefit days ended on August 24, 2010, for resident #13. An interview conducted with the Billing Manager on October 13, 2010, at 1:00 p.m., revealed the Billing Manager was responsible for issuing the denial notices to the residents/responsible parties. The Billing Manager stated the denial notices were only mailed to the resident's R/P if the R/P did not routinely visit the facility. The Billing Manager stated that no contacts made via telephone had been documented. The Billing Manager stated the notice was to be sent at least two days prior to the end of benefits date.	F 156	reported to the CQI committee for further review. 5. F-156 Date of Completion: 11/10/10		
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, and record review, the facility failed to provide the necessary care and services for 1 (one) of 20 (twenty) sampled residents. Resident #5 was assessed to	F 309	<u>F-309</u> 1. Resident #5 was assessed and the MD was notified of incident when resident was observed to have become strangled and although resident was able to clear with cough, staff requested MD to order a bedside swallowing evaluation to confirm that resident could safely consume food and fluids by mouth. The bedside swallowing evaluation was completed 10/11/10 and the resident was		

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F 309	<p>Continued From page 4</p> <p>require aspiration precautions including small bites/sips, no straws, and to be spoon fed by staff secondary to dysphagia. However, observations made on October 11, 2010, revealed aspiration precautions were not provided for resident #5 as recommended by the occupational therapist.</p> <p>The findings include:</p> <p>Review of resident #5's medical record revealed the resident was admitted to the facility on September 3, 2009, with diagnoses of status post Cardiac Arrest, Sleep Apnea, Chronic Airway Obstruction, Obesity, Congestive Heart Failure, and a history of CVA causing dysphagia. A review of the Minimum Data Set (MDS) dated September 17, 2010, revealed the resident was assessed to require total assistance for eating. A review of the Nutritional RAP revealed the resident received aspiration precautions for all meals, with no straws in fluids.</p> <p>Review of resident #5's comprehensive care plan dated September 14, 2010, revealed the resident was assessed related to history of a CVA with a dysphagia diagnosis to require: spoon-feed resident every meal and to observe for difficulties, elevate the head of the bed for meals as needed, and aspiration precautions, small bites/sips, and no straws.</p> <p>Review of a bedside swallowing evaluation conducted on January 27, 2010, by Occupational Therapy revealed the therapist recommended precautions consisting of universal aspiration precautions, and to be upright at 90 degrees during meals.</p> <p>Interview on October 12, 2010, at 2:45 p.m., with</p>	F 309	<p>determined to safely consume food and fluids by mouth. MD orders were clarified and the care plan, kardex, MAR, and diet card were updated to reflect current status.</p> <p>2. The physician orders, diet cards, care plans, MAR, and kardexes of each resident were reviewed by the interdisciplinary team to ensure that all residents are receiving the appropriate diet with special feeding instructions as ordered by his or her physician.</p> <p>3. An in-service was conducted on October 11 & 12, 2010 for all nursing staff regarding following physician's orders, ensuring orders</p>	

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F 309	<p>Continued From page 5</p> <p>the occupational therapist (OT) who performed the bedside swallowing evaluation on January 27, 2010, revealed the OT recommended universal aspiration precautions. Review of the universal aspiration precautions provided by the OT stated to avoid using a straw, because this usually causes overly large sips that pass too quickly into the throat, small bites, and sips. However, this information concerning universal aspiration precautions was not provided to direct care staff.</p> <p>Review of resident #5's current Kardex revealed no documentation of aspiration precautions and the need to avoid the use of straws.</p> <p>Observation of resident #5 on October 11, 2010, at 11:55 p.m., 12:35 p.m., and 2:00 p.m., revealed the resident in the bed, and a glass of water with a straw in the glass sitting on the resident's bedside table.</p> <p>Observations on October 11, 2010, at 2:55 p.m., revealed Certified Nursing Assistant (CNA) #3 provided resident #5 with a drink from the straw. Resident #5 started to cough after taking a drink and CNA #3 raised the head of the bed to approximately 90 degrees.</p> <p>Observation on October 11, 2010, at 5:05 p.m., revealed Licensed Practical Nurse (LPN) #2 administering medication to resident #5. LPN #2 gave the resident a drink with a straw to take the medications with.</p> <p>Observation on October 11, 2010, at 5:06 p.m., revealed CNA #4 feeding resident #5 the evening meal. CNA #4 assisted the resident with a drink of water using a straw. Resident #5's tray card that was on the resident's evening meal tray</p>	F 309	<p>are transcribed appropriately to the care plan, kardex, MAR, diet cards, signs and symptoms of swallowing difficulties and aspiration, and special feeding instruction. The in-service also addressed the importance of completing a dietary communication form with any diet order changes and/or special feeding instruction. The in-service was conducted by the Director of Nursing and Administrative Nursing Staff. The Dietary staff was also in-serviced by the Registered Dietitian regarding the updating of diet cards with the physician's orders and ensuring that the tray served is in accordance with the diet card.</p>		

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F 309	Continued From page 6 stated no straws, small bites, and sips, however, CNA #4 did not look at the card while feeding resident #5. Interview on October 11, 2010, at 6:40 p.m., with CNA #4 revealed the CNA was not aware resident #5 had a swallowing problem, nor was the CNA aware of any aspiration precautions for resident #5. Interview on October 11, 2010, at 6:44 p.m., with LPN #2 revealed the LPN was unaware that resident #5 had a swallowing problem, nor was the LPN aware of any aspiration precautions resident #5 was to receive when eating or drinking. Review of an x-ray taken on October 11, 2010, revealed the lungs were clear of any pneumonia.	F 309		
F 372 SS=F	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage and refuse properly. Observation of the outdoor garbage storage area on October 12, 2010, revealed two (2) dumpster lids incompletely closed. The facility staff had deposited three (3) bags of garbage on top of the open trash receptacle lids. The findings include: Observation of the outdoor trash storage area	F 372	4. All residents with specialized feeding instructions will be observed and documentation reviewed to ensure the care plan, kardex, diet card, MAR and physician's orders are being followed and reflect the residents current status by the CQI committee designee. These observations / record reviews will be conducted for 5 residents weekly for one month and then monthly for three months. Any discrepancies or irregularity will be corrected immediately and reported to the CQI committee for further review. 5. F-309 Date of Completion: 11/10/10	

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F 372	Continued From page 7 revealed two metal dumpsters. The dumpster receptacle area was full and the dumpster lids were unclosed. The trash receptacle also had three bags of refuse lying on top of the dumpster exposed to the harborage and feeding of pests. An interview was conducted with a facility housekeeper on October 12, 2010, at 3:00 p.m. The facility housekeeper stated the facility sometimes had so much garbage the staff must place the bags in the unclosed area around the bottom of the dumpsters.	F 372	<u>F-372</u> 1. Contracted Waste Management company was contacted and the dumpster receptacles were emptied on 10/12/10.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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 (3) Maintains a record of incidents and corrective actions related to infections. (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	F 441	2. The dumpsters are being emptied 4-5 times per week or daily, if needed until the additional dumpster is received from the waste management company. The lids are closed after refuse is deposited in them. 3. Notification was made to contracted Waste Management Company to obtain an additional dumpster for our facility to better accommodate our needs. In-service education was conducted on 10/12/10 with housekeeping and dietary	

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F 441	<p>Continued From page 8</p> <p>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 and interview, the facility failed to maintain an infection control program and proper infection control practices while two (2) Certified Nursing Assistants (CNAs) were passing ice to residents on October 11, 2010. The CNAs left the ice scoop on the ice inside the ice cooler after filling each resident's water pitcher.</p> <p>The findings include:</p> <p>Observation during the afternoon of October 11, 2010, at 3:45 p.m., revealed two CNAs were passing ice to residents. Each of the CNAs was observed to enter resident rooms and return to the hallway with the resident's water pitcher where the ice cooler was located. The CNAs were observed to go from one resident's room to another, to fill residents' water pitchers with ice from the cooler. Each time the CNAs filled a resident pitcher with ice, the CNA placed the ice scoop back into the cooler and closed the lid. Further observation revealed the ice scoop handle came into direct contact with the ice being</p>	F 441	<p>5. F-372 Date of Completion: 11/10/10</p> <p><u>F-441</u></p> <ol style="list-style-type: none"> 1. The ice was removed and the cooler and scoop were both sanitized. Residents received fresh pitchers of ice water in accordance with facility infection control practices. Staff that were passing ice water to residents were in-serviced immediately on ice pass procedures. 2. All residents are receiving fresh ice water in accordance with infection control practices. 3. All nursing staff was in-serviced by the Director 	

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F 441	Continued From page 9 passed to the residents. Interviews were conducted on October 11, 2010, at 4:00 p.m., with the two CNAs that passed ice to the residents. CNA #1 stated he/she had been trained to place the ice scoop in the holder instead of the ice, but that he/she was in a hurry to complete the task. CNA #2 stated he/she had never been trained to place the ice scoop in a holder rather than in the ice cooler. An interview was conducted with the Licensed Practical Nurse (LPN #1) responsible for supervising the CNAs on October 11, 2010, at 4:05 p.m. LPN #1 stated the CNAs should have known better and were trained not to store the ice scoop inside the cooler.	F 441	of Nursing and clinical coordinators on proper infection control practices relating to ice pass on 10/12/10. Specifically, instruction included not allowing the ice scoop handle to come into contact with the ice and the scoop being placed in the appropriate holder when not in use.	
F 465 SS=F	483.70(H) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Soiled resident room doors and soiled toilets were observed in several resident rooms. Baseboards and doorframes were observed to have a heavy buildup of wax at the edges next to the floors. The dining room was observed to have soiled baseboards with areas of missing paint and dusty, soiled chair rails. The popcorn popper was observed to have a heavy buildup of	F 465	4. Ice pass to residents will be monitored by designated member of the CQI committee to ensure proper infection control practices are being followed. The ice pass monitoring will be 5 times per week on various shifts for one month and then 5 times monthly for three months. Any irregularity will be corrected immediately	

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F 465 Continued From page 10
grease. Rusted fixtures and stained caulk were observed in rooms 116 and 132. A soiled floor mat was observed in resident room 126. The Medication Room air conditioner was dusty and the drawers in medication carts 1, 2, and 3 were observed to be soiled and contained powdery residue in the drawers.

The findings include:

Observations of the facility for October 11-13, 2010 revealed the following areas were in need of maintenance/housekeeping services:

1. Resident room doors were observed with a buildup of soil on the bottom of the doors in rooms 107, 108, 109, 110, 111, 112, 113, 114, 115, 117, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 136, 139, 142, 143, 144, 146, 147, and 207.
2. Soiled toilet seats and/or bowls were observed in resident rooms 111, 113, 138, and 204.
3. Bedside commodes with dried brown substances were observed in resident rooms 122 and 135.
4. Rusted lavatory fixtures and soiled/stained caulk around the lavatory were observed in resident room 132.
5. The caulking around the backsplash was soiled/stained and the door frame had chipped areas of paint in resident room 116.
6. A soiled fall mat was observed in resident room 126.

F 465

and reported to the CQI Committee for further review.

5. F-441
Date of Completion:
11/10/10

F-465

1. The following items have been cleaned :
 - A) resident room doors;
 - B) Toilet seats and bowls in room 111, 113, 138, and 204;
 - C) Bedside commodes in room 122 and 135;
 - D) The lavatory fixture and caulk in room 132;
 - E) The chipped paint on door and the caulking on the

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PRINTED: 10/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/13/2010
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NAME OF PROVIDER OR SUPPLIER HYDEN NURSING HOME, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH, P O BOX 518 HYDEN, KY 41749
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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 465	<p>Continued From page 11</p> <p>7. The portable air conditioner in the medication room was soiled/dusty.</p> <p>8. Medications carts 1, 2, and 3 were observed to be soiled with a powdery residue inside the drawers;</p> <p>9. The dining room was observed to have soiled baseboards with areas of missing paint and the chair rails were also observed to be soiled/dusty.</p> <p>10. The popcorn popper was observed to have a very heavy buildup of grease inside and out.</p> <p>11. A heavy buildup of a black substance was observed where the baseboards and the floor join and in the corners where the door frames meet the floors throughout the facility.</p> <p>An interview with the Housekeeping Supervisor was conducted during the environmental tour of the facility on October 12, 2010. The Housekeeping Supervisor stated he/she tried to do spot checks around the facility every week, but did not get around to every room. The Housekeeping Supervisor further stated he/she "guess I should do more."</p>	F 465	<p>also included completion of the CQI referral form for any items needing maintenance or replacement. The Administrator met with Maintenance Director on 10/13/10 to discuss areas needing touch up painting in the facility.</p>	
F 520 SS=E	<p>483.75(e)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance</p>	F 520	<p>4. A CQI Committee designee will make walking rounds observing for items/ environmental concerns in need of repair and cleaning. The walking rounds will be done weekly for one month, then monthly for one quarter. Any identified concern will be corrected immediately and forwarded to the CQI committee for further review and follow-up.</p>	

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NAME OF PROVIDER OR SUPPLIER HYDEN NURSING HOME, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH, P O BOX 618 HYDEN, KY 41749	
(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 520	<p>Continued From page 12</p> <p>committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary, and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain a quality assessment and assurance committee consisting of the Director of Nursing Services, a physician designated by the facility, and at least three (3) other members of the facility's staff that met at least quarterly to identify issues/concerns and to develop and implement appropriate plans of action to correct identified quality deficiencies. The facility conducted weekly quality assessment and assurance committee meetings; however, those meetings occurred without the presence of a designated physician. The facility failed to maintain attendance sign-in sheets to verify attendance and participation in the committee.</p> <p>The findings include: Interview with the Director of Nurses (DON) on October 13, 2010, at 3:10 p.m., revealed the</p>	F 520	<p>5. F-465 Date of Completion: 11/10/10</p> <p>F-520</p> <ol style="list-style-type: none"> 1. The Medical Director is scheduled to attend the CQI Meeting during the month of November 2010. The signature sheet will include all CQI Committee members including the Medical Director. 2. The Medical Director will sign the attendance sheet or minutes of the CQI Meeting at least quarterly to verify involvement in this committee. 3. The designated CQI coordinator was inserviced by the Director of Nursing on 10/13/10 	

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NAME OF PROVIDER OR SUPPLIER HYDEN NURSING HOME, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH, P O BOX 818 HYDEN, KY 41749	
(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 520	<p>Continued From page 13</p> <p>facility Medical Director (MD) was the designated physician for the Quality Assurance (QA) Committee. The DON stated the QA Committee meetings were conducted weekly on Thursday. The DON stated the Medical Director was aware of the dates for the weekly meetings. The DON stated the Medical Director did not always attend the QA meetings held on Thursdays. The DON further stated some meetings were conducted via conference call with the Medical Director. The DON stated an attendance list of each QA Committee meeting was maintained; however, the DON could not provide the attendance list from September 2009 through January 2010.</p> <p>A review of the attendance list for the QA Committee meetings revealed the MD was present during the March 19, 2010 meeting and via a conference call for the meeting conducted on June 22, 2010. However, there was no further evidence the MD had attended the QA Committee meetings from September 2009 through October 13, 2010.</p> <p>An interview conducted with the MD on October 13, 2010, at 3:30 p.m., revealed the MD did not always attend the weekly QA Committee meetings at the facility due to a busy schedule. The MD stated that most of the time the MD reviewed the QA Committee reports but did not attend the QA meetings.</p> <p>A review of the facility's QA policy/procedure (no date) revealed the committee was required to be composed of at least one physician, the Director of Nurses, and three staff members. The policy/procedure further noted the committee would meet quarterly to review continuous quality improvement activities, recommend action to</p>	F 520	<p>regarding the need to provide documentation of involvement of the Medical Director in the committee.</p> <p>4. A designated member of the CQI Committee will monitor the minutes of the meetings to ensure that the Medical Director's involvement in this committee is documented. The minutes will be verified weekly for one month, then monthly for one quarter. Any irregularity will be corrected immediately and forwarded to the CQI Committee for further review.</p> <p>5. F 520 Date of Completion: 11/10/10</p>	

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NAME OF PROVIDER OR SUPPLIER HYDEN NURSING HOME, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH, P O BOX 618 HYDEN, KY 41748		
(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 520	Continued From page 14 address concerns, and follow up on the status of all previous recommendations.	F 520			

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PRINTED: 08/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185193	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2010
NAME OF PROVIDER OR SUPPLIER HYDEN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 21040 US HWY 421 SOUTH, P O BOX 618 HYDEN, KY 41749		
(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>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on October 12, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	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.