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

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FORM APPROVED
OMB NO. 0938-0391

RECEIVED
OCT 29 2012
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185182		10/04/2012
NAME OF PROVIDER OR SUPPLIER: PINEVILLE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE: 850 RIVERVIEW AVENUE, PINEVILLE, KY 40977	

(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		
	A standard health survey was conducted on 10/02-04/12. Deficient practice was identified with the highest scope and severity at "E" level.			
F 156 SS=B	483.10(b)(6) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F 156	F 156 On October 23, 2012, letters were sent to the residents #10, A, and B and/or their legal representatives describing the appeals process along with the required notice for the Nursing Facility stays cited in the deficiency. (See attached letters)	10/26/12
	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.		On October 19, 2012, the Social Services/Activities Coordinator provided one resident and/or their legal representatives that had received an Advanced Beneficiary Notice (ABN) with the required notice of appeal information/rights. (See attached notice to resident)	
	The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged, those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.		On October 5, 2012, the Case Management Director updated the policy/procedure titled "Clinical Decisions SNF" to include the provision of the detailed explanation of right to appeal to be provided with the Advanced Beneficiary Notice (ABN) to residents. (See attached policy/procedure titled "Clinical Decisions SNF") Education on the Advanced Beneficiary Notice (ABN) and appeals information was provided by the Case Management Director on October 5, 2012 to the Discharge Planner and Social Services/Activities Director. (See attendance record with attachments)	
	The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,		F 156 *Continued on page 2*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO (X6) DATE: 10/29/12

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	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. 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; 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. 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. 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	F 156	F 156 *Continued from page 1* A Quality Improvement Study has been developed by the Case Management Director to monitor for compliance with providing the detailed explanation of appeal information to residents receiving an Advance Beneficiary Notice (ABN). The Social Services/Activities Director will check weekly all residents/ legal representatives who have received an ABN to ensure that the resident/legal representative is in receipt of the appropriate information. Findings will be reported quarterly to the Nursing Facility Committee.	

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 04/18

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F 156	Continued From page 2 provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide information that included the appeal process for one of ten sampled residents (Resident #10) and two unsampled residents (Residents A and B) when a Medicare Non-Coverage letter was provided to the resident or responsible party. The notice failed to include the appeal information for the beneficiary to request an appeal. The findings include: Review of the facility's Resident Admission and Information Packet included information on how the resident can apply for benefits under	F 156		

10/29/2012 14:28 5063374284 PINEVILLE COMM HOSP PAGE 05/18

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F 156	Continued From page 3 Medicare and Medicaid. The information related to Medicaid/Medicare Services noted the resident or responsible party would be notified in writing if Medicare services were not covered; however, the information did not include information regarding the resident or responsible party's right to appeal. 1. A review of Resident #10's closed record revealed the facility issued an "Advance Beneficiary Notice of Non-coverage" to Resident #10 on 08/03/12. The notice stated Medicare would cover 80 percent of skilled nursing services beginning on 08/07/12. However, the notice failed to include information regarding appeal information/rights. 2. Record review of Resident A revealed the facility issued an Advance Beneficiary Notice to the resident's responsible party on 09/13/12 to inform the resident's responsible party that beginning on 09/17/12 Medicare would only cover 80 percent of skilled services. However, the notice failed to include information regarding appeal information/rights. 3. Record review of Resident B revealed the facility issued an Advance Beneficiary Notice to the resident's responsible party on 09/14/12 to inform the resident's responsible party that beginning on 09/20/12 Medicare would only cover 80 percent of skilled services. However, the notice failed to include information regarding appeal information/rights. Interview conducted with the Activity Director/Social Services Coordinator on 10/04/12 at 4:00 PM, revealed she had been sending the	F 156		

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 06/18

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F 156	Continued From page 4 Advance Beneficiary Notices for approximately one year. The AD/SSC stated she was not familiar with the appeal information required to be provided to the resident/responsible party when issuing an Advance Beneficiary Notice.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	F 157 On 10/08/12 at 9:46am, the Nursing Facility Supervisor notified resident #1 daughter that the resident had a positive PPD on 10/28/11. Daughter was instructed of actions that would be taken to monitor the resident for signs/symptoms of TB. (See attached Patient Progress Notes) There were 3 other residents with positive PPD's. Family members/legal representatives have been notified of positive PPD results. (See attached Patient Progress Notes) The Notification of Changes Policy was revised to include a positive (+) PPD result as a clinical complication requiring notification per Federal and State regulation. Inservice education on the revised policy was conducted the week of October 22-28, 2012 for all licensed nurses working the Nursing Facility. (See attached Inservice Attendance Record and Policy) The "Notification of Changes" Performance Improvement Study was revised to include a positive PPD as a type of notification requiring evidence of family members/legal representative notification per policy. Monitoring will continue to be done concurrently monthly with results of findings to be reported quarterly to the Nursing Facility Committee. (See attached performance Improvement data collection tool and reporting calendar)	10/28/12

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 07/18

Received Time Oct. 29. 2012 2:21PM No. 2115

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F 157	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to notify the resident's responsible party when there was a significant change in the resident's condition for one of ten sampled residents (Resident #1). A review of the medical record for Resident #1 revealed on 10/25/12 the resident had a positive "PPD" (Purified Protein Derivative - a method used to diagnose tuberculosis). However, the facility failed to inform the resident's responsible party of the positive PPD. The findings include: A review of the facility's policy titled "Notification of Changes," with a revision date of October 2010, revealed the facility would notify the resident, family member, or legal representative immediately with any significant change in the resident's condition (life threatening conditions or clinical complications). Review of the medical record for Resident #1 revealed the facility admitted the resident on 09/23/10, with diagnoses including Severe Cerebral Degeneration, Endocarditis, Atrial Fibrillation, Seizure Disorder, and Dementia. Further record review revealed facility staff administered a tuberculin skin test to Resident #1 on 10/25/11 with a Purified Protein Derivative (PPD - a method used to diagnose tuberculosis). The record revealed facility staff documented the resident's skin test as "20 millimeters" in	F 157		

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 08/18

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F 157	Continued From page 6 induration (with anything greater than 10 millimeters of induration considered positive). In addition, the resident's medical record had a sticker on the front of the record indicating the resident was "Positive PPD." A review of the most current Quarterly Minimum Data Set Assessment dated 09/18/12 revealed the resident had been assessed by the facility to have severely impaired cognition and therefore was not interviewable. Observation of Resident #1 on 10/02/12 at 10:25 AM, revealed the resident was lying in bed on his/her left side with eyes closed. Oxygen was also observed to be administered to the resident at 2 liters by nasal cannula. An interview conducted with the responsible party of Resident #1 on 10/04/12 at 9:25 AM, revealed the responsible party had not been notified when the resident was assessed to have a positive PPD on 10/25/11. An interview conducted with the Nursing Supervisor (NS) on 10/04/12 at 11:50 AM, revealed she had been the nurse who read the resident's PPD and had assessed the test to be positive. The NS revealed she was also responsible for notifying the resident's family of the positive PPD. The NS stated she had not notified the resident's responsible party and should have. An interview with the Director of Nursing (DON) on 10/04/12 at 5:50 PM, revealed staff was required to notify the resident's responsible party for any change in condition. The DON acknowledged when the results of a TB skin test	F 157		

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 09/18

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F 157	Continued From page 7	F 157		
	was positive it would be considered a significant change in the resident's condition and the resident's responsible party should be notified.			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F 279	10/26/12
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.		Resident #1 Care Plan was updated to reflect monitoring of signs/symptoms of residents with a positive (+) PPD on 10/04/12 and again on 10/11/12.	
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.		Resident #6 Care Plan was updated to reflect monitoring of signs/symptoms of residents with a positive (+) PPD on 10/04/12 and again on 10/11/12.	
	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).		Resident #7 Care Plan was updated to reflect monitoring of signs/symptoms of residents with a positive (+) PPD on 10/04/12 and again on 10/11/12.	
			Resident #8 Care Plan was updated to reflect monitoring of signs/symptoms of residents with a positive (+) PPD on 10/04/12 and again on 10/11/12. (See copies of care plans attached)	
	This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to develop a comprehensive plan of care for four of ten sampled residents (Residents #1, #6, #7, and #8). Residents #1, #6, #7, and #8 were identified to have a history of positive tuberculin skin testing; however, the facility failed to develop a plan of care to ensure these residents were		A line listing of residents due for annual PPD skin testing or semi-annual questionnaire will be maintained by the Nursing Unit Supervisor and Infection Control Preventionist. The Nursing unit Supervisor will be responsible for review of the resident's care plan to ensure that the residents care plan addresses a positive (+) PPD. (See attached line listing)	
			F 279 *Continued on page 9*	

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 10/18

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F 279	Continued From page 8 monitored for signs/symptoms of active tuberculin disease. The findings include: A review of the facility's Resident Assessment and Care Plan policy (no date) revealed a comprehensive care plan would be developed for each resident after the comprehensive assessment had been completed. 1. Review of the medical record revealed the facility admitted Resident #8 on 08/02/06 with diagnoses including Dementia, Osteoporosis, Degenerative Joint Disease, Hypertension, Alzheimer's with Hallucinations, and Psychosis. Further record review revealed the resident's chart was flagged "Positive PPD" (Purified Protein Derivative - a skin test for tuberculosis). However, a review of the comprehensive care plan for Resident #8 revealed there was no evidence the facility had developed a plan of care to address the resident's history of positive tuberculin skin testing (PPD) to include monitoring for the development of signs/symptoms of active tuberculosis. Interview conducted with the Minimum Data Set (MDS)/Care Plan (CP) Coordinator on 10/04/12 at 11:45 AM, revealed she believed residents with a history of positive PPD testing would be monitored with routine standards of care. The MDS/CP Coordinator stated she had not developed a care plan to address the resident's positive PPD history with interventions to include monitoring the resident for the development of signs/symptoms of active pulmonary disease.	F 279	F 279 *Continued from page 8* The Infection Control Preventionist developed a new policy for screening Residents for Tuberculosis in the Nursing Facility. Mandatory classroom education was provided to Licensed Nurses on 10/23, 10/24 and 10/26/12 by the Infection Control Preventionist related to procedures for screening residents for tuberculosis and follow-up procedure for residents with a positive (+) PPD. Education included notification of the Nursing unit Supervisor and MDS Coordinator for all residents with a prior positive PPD, a PPD done on admission with a reading of 10 mm or more induration), or for a resident who converts to 10 mm or greater induration so that the care plan can be updated. (See attached Inservice Attendance Record and Policy/Procedure) An indicator has been added to the Data management Performance Improvement Study to monitor for compliance with care plan reflecting interventions and updates for a positive (+) PPD. Concurrent review will be conducted by the Nursing Unit Supervisor monthly with results of findings reported quarterly to the Nursing Facility Committee. (See attached Data Management Performance Improvement data collection tool and reporting calendar)	

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 11/18

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F 279	Continued From page 9 2. Review of the medical record revealed the facility admitted Resident #6 on 11/19/07 with diagnoses including Chronic Dementia with Behavior Disturbances, Anxiety, Hypothyroidism, Cerebral Vascular Accident, Arteriosclerotic Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Degenerative Joint Disease, and Cystitis. Further record review revealed the resident's chart was flagged "Positive PPD" (Purified Protein Derivative - a skin test for tuberculosis). A review of the comprehensive care plan implemented on 02/15/12 and reviewed on 08/14/12 for Resident #6 revealed there was no evidence the facility had developed a plan of care to address the resident's history of positive skin testing (PPD) to include monitoring for the development of signs/symptoms of active tuberculosis. Interview with RN #1 revealed she was responsible for the development of Resident #6's care plan. However, RN #1 stated she did not realize a plan of care was required for residents with a history of a positive PPD. RN #1 stated she had not developed a care plan related to Resident #6's positive PPD. 3. Review of the medical record for Resident #1 revealed the facility admitted the resident on 09/23/10 with diagnoses including Severe Cerebral Degeneration, Endocarditis, Atrial Fibrillation, Seizure Disorder, and Dementia. Further record review revealed the resident's medical record was marked "Positive PPD."	F 279		

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 12/18

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F 279	Continued From page 10 A review of the comprehensive plan of care implemented on 03/20/12, and reviewed on 09/18/12, for Resident #1 revealed there was no evidence the facility had developed a plan of care to address the resident's history of positive tuberculin skin testing (PPD) to include monitoring for the development of signs/symptoms of active tuberculosis. 4. Review of the medical record for Resident #7 revealed the facility admitted the resident on 12/16/05 with diagnoses including Alzheimer's, Cerebral Vascular Accident, and Arthritis. Further record review revealed the resident's chart was marked "Positive PPD." A review of the comprehensive plan of care implemented on 12/14/11, and reviewed on 09/16/12, for Resident #7 revealed there was no evidence the facility had developed a plan of care to address the resident's history of positive tuberculin skin testing (PPD) to include monitoring for the development of signs/symptoms of active tuberculosis. An interview with RN #1 on 10/04/12 at 1:35 PM, revealed she was responsible for developing the plan of care for Resident #1 and Resident #7. The RN stated she had not developed a plan of care to address Resident #1's and Resident #7's history of a positive PPD. The RN stated she had not been aware that a plan of care was required for residents that had positive PPD skin tests.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 13/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185162	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	

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F 315	Continued From page 11 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure residents with an indwelling catheter had a clinical condition to support the use of an indwelling catheter for one of ten sampled residents (Resident #5). Resident #5 was admitted to the facility with an indwelling urinary catheter in place; however, there was no evidence the facility identified a clinical condition to support the use of the indwelling catheter. The findings include: A review of the facility's policy titled "Policy for Urinary Catheters," with a revision date of March 2011, revealed indwelling catheters should only be used for clinical reasons and only remain in place as long as necessary. The facility admitted Resident #5 on 11/14/11 with diagnoses including End Stage Renal Disease, Cerebral Vascular Accident, Diabetes Mellitus, and Hypertension. An observation of Resident #5 conducted on 10/02/12 at 10:30 AM, revealed an indwelling	F 315	F 315 Resident #5 Physician issued a diagnosis of nocturia, dysuria with incontinence and urogenic bladder on 10/03/12 to support the continued use of the indwelling catheter. Seven (7) other residents were assessed and medical records reviewed for evidence of a clinical condition to support use of indwelling catheters. All of the residents with catheters had a clinical condition for use documented. There were no other residents identified with potential for urinary incontinence and potential for use of an indwelling catheter. Licensed Nurses in the Nursing Facility were inserviced 10/22-10/28/12 on the need to ensure that a diagnosis is present in the Medical Record on every resident with orders for an indwelling urinary catheter. (See attached Inservice Attendance Record) An indicator was added to the Foley Catheter Performance Improvement Study to monitor all residents with a catheter for presence of a diagnosis to support use of the catheter. Concurrent Monitoring will be accomplished monthly by the Nursing Unit Supervisor. Results of Findings will be reported quarterly to the Nursing Facility Committee. (See attached Foley Catheter Care Performance Improvement data collection tool and reporting calendar)	10/28/12

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	185182		10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE COMMUNITY HOSPITAL	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

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F 315	Continued From page 12 catheter was intact. A review of a Care Areas Assessment (CAA) dated 12/07/11, revealed staff assessed Resident #5 to require extensive assistance with toileting and noted the resident had an indwelling urinary catheter. A review of the most current physician's orders for Resident #5 dated 09/15/12, revealed a physician's order for a urinary catheter. However, the physician's orders did not contain a medical diagnosis for the use of a urinary catheter. An interview conducted on 10/04/12 at 5:40 PM, with the Nursing Supervisor (NS) revealed Resident #5 had been admitted to the facility with an indwelling urinary catheter. The NS stated she was responsible for reviewing resident medical records to ensure staff obtained a medical diagnosis to support the use of an indwelling urinary catheter when physician's orders were received for catheter use. The NS stated Resident #5 did not have a medical diagnosis for the indwelling urinary catheter and she felt the catheter had been in use for urinary retention. The NS could not locate a clinical reason for the use of the urinary catheter in Resident #5's medical record. An interview conducted with the Director of Nursing (DON) on 10/04/12 at 6:50 PM, revealed the NS's responsibilities included reviewing medical records and to ensure the medical records contained evidence of a clinical justification for use of indwelling urinary catheters. The DON stated staff was required to obtain a medical diagnosis when a physician's order was	F 315		

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 15/18

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F 315	Continued From page 13 received for use of a urinary catheter for a resident. The DON stated the NS should have identified that a medical diagnosis was not on the medical record for the indwelling catheter for Resident #5 through her medical record reviews.	F 315		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy/procedure, the facility failed to	F 329	F 329 A diagnosis for use of Xanax on Resident #2 was obtained and documented in the resident's Medical Record on 10/09, 2012 on the Medication Regimen Review Form. A diagnosis for use of Zoloft on Resident #4 was obtained and documented in the residents Medical Record in the Physicians Progress notes on 10/24, 2012. A diagnosis for use of Prevacid and Vistaril on Resident #5 was obtained and documented in the resident's Medical Record on 10/07, 2012 on the Medication Regimen Review Form. A diagnosis for use of Seroquel on Resident #7 was obtained and documented in the resident's Medical Record on the Medication Regimen Review Form on 10/24, 2012. A diagnosis for use of Zoloft on Resident #8 was obtained and documented in the resident's Medical record on the Medication Regimen Review Form on 10/05, 2012. F 329 *Continued on page 15*	11/14/12

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 16/18

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F 329	Continued From page 14 ensure the drug regimen for five of ten sampled residents was free from unnecessary drugs (Residents #2, #4, #5, #7, and #8). Resident #2 had physician's orders for an antianxiety medication, Resident #5 was to receive a stomach medication, and Residents #4, #7, and #8 received an antidepressant without documentation of the rationale for the medications. The findings include: Review of the facility Medication Monitoring policy revealed each resident's drug regimen would be free of unnecessary medications, and any antipsychotic medication would have a specific condition/diagnosis to support the use of the drug. 1. Review of the medical record revealed the facility admitted Resident #2 on 08/10/12 with diagnoses including Depression, Diabetes Mellitus, Hypothyroidism, Coronary Artery Disease, Dementia, Congestive Heart Failure, and Hypertension. Review of the physician's orders revealed the resident had an order for 0.25 mg of Xanax (antianxiety) to be administered two times every day. Further review of the medical record for Resident #2 revealed no evidence the resident had a diagnosis for the use of the Xanax. RN #1 confirmed in interview conducted on 10/04/12 at 5:00 PM, that Resident #2's medical record did not contain a diagnosis for the use of the Xanax. 2. Review of the medical record revealed the facility admitted Resident #4 on 04/05/05 with	F 329	F 329 *Continued from page 14* The Chief Pharmacist will complete a review of all resident's medication regimens to ensure that all medications ordered on each resident contain a documented indication for use in the Medical Record. The Chief Pharmacist has developed a tool that reviews past medical history, med list with monitoring parameters and diagnosis, notes and recommendations. (See attached sample resident form completed on 10/23/12) The Chief Nursing Officer provided inservice education 10/29 - 11/04/12 to Licensed Nurses working the Nursing Facility to reinforce the need for each medication to contain an indication for use. Nurses were instructed to notify the physician at the time a medication has no documented indication for use. (See attached Inservice Attendance Record) A memo was sent to all Medical Staff Members to reinforce the need for each medication ordered to have a documented indication for use. (See attached memo to Medical Staff Members)	

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 17/18

Received Time Oct. 29. 2012 2:21PM No. 2115

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F 329	Continued From page 15 diagnoses including Paranoia, Alzheimer's Type Senility Syndrome, and Dementia. Review of the annual comprehensive assessment with a reference date of 03/28/12 revealed Resident #4 was assessed to have a depression score of 2, indicating minimal depression. The quarterly assessment with a reference date of 09/27/12 revealed the resident's depression score was 0, also indicating minimal depression. Review of the comprehensive care plan revealed the facility implemented a plan of care on 04/08/09 for the potential development of side effects related to the use of antidepressant medications. Interventions included to monitor for side effects and to notify the physician if side effects were noted. Review of the September 2012 physician's orders revealed Resident #4 had physician's orders to receive 50 milligrams (mg) of Zoloft (antidepressant) once a day. Further record review revealed the Zoloft was originally ordered on 03/09/09. However, there was no evidence the physician had documented a clinical condition/diagnosis for use of the antidepressant medication for Resident #4.	F 329		
	3. A review of the medical record for Resident #5 revealed the facility admitted the resident on 11/14/11 with diagnoses including End Stage Renal Disease, Diabetes Mellitus, Depression, Hypertension, Chronic Obstructive Pulmonary Disease, and Degenerative Joint Disease. The medical record also revealed a physician's order dated 07/02/12, for 30 milligrams of Prevacid (used to treat and prevent stomach and intestinal ulcers) to be administered every morning. The			

10/29/2012 14:28 6063374284 PINEVILLE COMM HOSP PAGE 18/18

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NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 880 RIVERVIEW AVENUE PINEVILLE, KY 40977	

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F 329	Continued From page 16 physician's orders also contained an order for 100 milligrams of Vistaril (used for itching from allergies, nausea and vomiting, motion sickness, anxiety, and alcohol withdrawal) to be administered every night. However, the medical record did not contain a medical diagnosis for use of the Prevacid or Vistaril. 4. A review of the medical record for Resident #7 revealed the facility admitted the resident on 12/16/05 with diagnoses including Cerebral Vascular Accident, Alzheimer's, Arthritis, and Cachexia. The medical record also revealed a physician's order dated 09/03/12, for 50 milligrams of Seroquel (medication for major depression, bipolar disease, or schizophrenia) to be administered every evening. However, the medical record contained no medical diagnosis for the Seroquel. An interview conducted with the facility's Pharmacy Director on 10/04/12 at 3:00 PM, revealed she conducted a review of each resident's medications on a monthly basis to determine a medical diagnosis was on the medical record for each medication. The Pharmacy Director stated if diagnoses to justify the use of the medications weren't identified in the medical record she had not been doing anything because she felt it was the physician's responsibility to ensure medical diagnoses were on the medical record. The Pharmacy Director stated she had been reviewing the medical records to try and decrease the amount of medications the residents received. An interview conducted with the Nursing Supervisor (NS) on 10/04/12 at 5:40 PM,	F 329		

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F 329	Continued From page 17 revealed even though she reviewed medical records to determine physician's orders had been carried out, she stated she had not reviewed the residents' medications and thought it was the pharmacist's responsibility to ensure there was a diagnosis to support the use of the medications, and to let the physician know of any irregularities. An interview conducted with the Director of Nursing (DON) on 10/04/12 at 5:50 PM, revealed she was under the impression the Pharmacy Director was responsible to ensure there was a medical diagnosis to support the use of medications and the reviews were to be documented in the resident's medical record during the monthly pharmacy reviews. The DON stated she had been unaware the Pharmacy Director had not been reviewing to ensure all medications had a diagnosis. 5. Review of the medical record revealed the facility admitted Resident #8 on 08/02/06 with diagnoses including Dementia, Alzheimer's with Hallucinations, and Psychosis. A review of the current physician's orders revealed the physician had prescribed 100 mg of Zoloft (antidepressant) to be administered once a day to Resident #8. Further record review revealed the medication was first ordered on 09/19/07. A review of the annual comprehensive MDS assessment (reference date 06/05/12) and the quarterly MDS assessment (reference date 09/05/12) revealed the facility assessed Resident #8 to have no indicators of delirium, to have 2-6 days of poor appetite, and no behaviors. The resident's depression score was noted to be 01, which indicated minimal depression. However,	F 329		

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F 329	Continued From page 18 there was no evidence the facility had consulted the resident's physician regarding a diagnosis to support the continued use of the antidepressant medication. Interview with the consultant pharmacist on 10/04/12 at 2:55 PM, revealed the pharmacist was responsible to conduct a drug regimen review monthly for each resident. The pharmacist stated she had not made any recommendations regarding medications that did not have a supporting diagnosis because she believed the physician was responsible to provide a diagnosis when the medication was ordered. Interview with the Unit Supervisor on 10/04/12 at 5:10 PM, revealed the nurse was responsible to consult the physician for a diagnosis when a new medication order was received. Interview with the Director of Nurses (DON) on 10/04/12 at 5:45 PM, revealed the nurse who received a new medication order was responsible to consult with the physician regarding a diagnosis for the medication. The DON also stated the consulting pharmacist was responsible to review the drug regimen to ensure a diagnosis was obtained from the physician.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	F 364 A new policy/procedure was developed by the Dietary Manager to address the time frame for holding foods on the steam table. (See attached policy/procedure). Monitoring will be accomplished by the Dietary Department Manager conducting direct observation using the attached Daily Temperature log (See attached). F 362 *Continued on page 20*	11/05/12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE COMMUNITY HOSPITAL	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

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F 364	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prepare pureed food by methods that conserved the nutritive value and flavor of food items to be served to residents on pureed diets. Pureed food was observed to be stored on the steam table at 8:30 AM for the lunch meal to be served on 10/02/12. In addition, interview revealed the pureed food was not seasoned when prepared. The findings include: Interview with the Dietary Supervisor at 2:30 PM on 10/04/12 revealed, to his knowledge, the facility did not have a policy/procedure regarding storage/length of holding time for food items on the steam table. An initial tour of the kitchen was conducted at 8:27 AM on 10/02/12. Observation of the steam table at 8:30 AM on 10/02/12 revealed pureed carrots, meat, pinto beans, potatoes, cream soup, and two containers of broth were already stored on the steam table to be served at 11:40 AM on 10/02/12 for the lunch meal which compromises the nutritive value of the food due to prolonged storage on the steam table. Interview with the cook at 8:37 AM on 10/02/12 revealed the facility had eight residents that received a pureed diet. According to the cook, she always placed the pureed food on the steam table early to heat because there was not enough room in the steamer to heat all the food. The cook further stated that she did not season any of the pureed food.	F 364	F 364 *Continued from page 19* Monitoring will be accomplished daily and follow up on findings will be accomplished weekly at time of food safety audits. (See attached weekly Food Safety Audit) Results of findings will be reported quarterly to the Nursing Facility Committee. Dietary Department Staff will be educated on time frames for holding of foods on steam table and the new policy the week of 10/29-11/04/12. (See attached copy of Inservice Attendance Record and Policy)	

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F 364	Continued From page 20 Interview with the Director of Nursing (DON) at 5:00 PM on 10/03/12 revealed she was not aware the kitchen was storing the pureed food on the steam table for an extended period of time.	F 364		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on review of the facility policy/procedure, observation, and interview, it was determined the facility failed to serve food under sanitary conditions. A dietary employee serving hot foods on the steam table was observed to drop a baked potato on the floor, pick the potato up from the floor with gloved hands, and continue to serve food while wearing the soiled gloves. The employee failed to change her gloves or wash her hands after picking the baked potato up from the floor. The findings include: A review of the facility's policy/procedure (dated April 2002) revealed gloves should be changed immediately when they become contaminated.	F 371	F 371 The Dietary Manager reviewed and revised the Personal Hygiene policy for hand washing and glove usage. (See attached policy) Inservice education was provided by the Dietary Manger on 10/24/12 on proper hand washing and use of gloves. Each employee was required to complete a quiz upon completion of inservice. (See attached Inservice Attendance Records) Hand washing and glove usage will be monitored by the Dietary Manager during Weekly Safety Audits. Results of findings will be reported quarterly to the Nursing Facility Committee.	10/24/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 860 RIVERVIEW AVENUE PINEVILLE, KY 40977	

(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 371	Continued From page 21 Observation of the tray line at 11:25 AM on 10/02/12 revealed the dietary employee serving hot food on the steam table (wearing gloves) dropped a baked potato on the floor. The employee picked the potato up from the floor, proceeded back to the steam table without changing gloves, and continued serving the hot food on the steam table. Interview with the cook at 11:40 AM on 10/02/12 revealed she should have changed the gloves and washed her hands after picking up the baked potato from the floor. The employee stated staff was supposed to change gloves and wash hands when dropping something on the floor. Interview with the Dietary Manager on 10/04/12 at 1:35 PM, revealed the cook serving the food should have changed the soiled gloves after picking the baked potato up from the floor.	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428	F 428 Resident #1 DRR for September was conducted on 9/30/12 and October was completed on 10/16/12. Resident #2 DRR for September was conducted on 9/30/12 and October was completed on 10/05/12. Resident #3 DRR for September was conducted on 9/30/12 and October was completed on 10/16/12. Resident #4 DRR for September was conducted on 9/30/12 and October was completed on 10/09/12. F 428 *Continued on page 23*	10/25/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185182		10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE COMMUNITY HOSPITAL	850 RIVERVIEW AVENUE PINEVILLE, KY 40977

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F 428	Continued From page 22 Based on record review, interview, and facility policy review, the facility failed to ensure the drug regimen for seven of ten sampled residents (Residents #1, #2, #3, #4, #6, #8, and #9) was reviewed at least once a month by a licensed pharmacist. The findings include: A review of the facility Medication Regimen Review policy (dated March 2009) revealed the consultant pharmacist was responsible to perform a comprehensive medication regimen review at least monthly for all residents. The policy further noted the findings and recommendations of the monthly review would be reported to the attending physician and the Director of Nurses (DON). 1. Review of the medical record of Resident #1 on 10/02/12 revealed the facility admitted the resident on 09/23/10 with diagnoses including Severe Cerebral Degeneration, Endocarditis, Atrial Fibrillation, Seizure Disorder, and Dementia. Continued review revealed the most recent pharmacy review had been conducted on 08/14/12, and there had not been a pharmacy review conducted in September 2012. 2. Review of the Medication Regimen Review for Resident #2 revealed no evidence a monthly drug review was conducted by the consultant pharmacist for the month of September 2012. 3. Review of the Medication Regimen Review for Resident #3 revealed there was no evidence a monthly review was conducted by the consultant pharmacist for the month of May and September 2012.	F 428	F 428 *Continued from page 22* Resident #6 DRR for September was conducted on 9/30/12 and October was completed on 10/15/12. Resident #8 DRR for September was conducted on 9/03/12 and October was completed on 10/05/12. Resident #9 DRR for September was conducted on 9/30/12 and October was completed on 10/16/12. All current residents', including newly admitted residents', drug regimen reviews have been completed for the month of October by a Pharmacist. A copy of recommendations has been forwarded to the Director of Nursing. (See attached copies of Medication Regimen Review) A Performance Improvement Study was developed to assess compliance with completion of monthly Drug Regimen Reviews. The Nursing Unit Supervisor will review the Medical Record of each resident by the last day of each month to ensure that the DRR has been completed and that the Chief Pharmacist and DON are notified if a DRR is not present. (See attached Performance Improvement data collection tool and reporting calendar) F 428 *Continued on page 24*	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	

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F 428	Continued From page 23 4. Review of the Medication Regimen Review for Resident #4 revealed the pharmacist failed to conduct a monthly medication review for March, May, June, and September 2012. 5. Review of the Medication Regimen Review for Resident #6 revealed no evidence a monthly review was conducted by the consultant pharmacist for September 2012. 6. Review of the Medication Regimen Review for Resident #8 revealed no evidence the consultant pharmacist conducted the monthly medication regimen since 05/29/12. No monthly reviews were available for June, July, August, and September 2012. 7. Review of the Medication Regimen Review for Resident #9 revealed the consultant pharmacist failed to conduct a monthly review for May and September 2012. Interview conducted with the Consultant Pharmacist on 10/04/12 at 2:55 PM, revealed she was responsible for conducting the monthly medication regimen review for each resident. The pharmacist stated she had not completed the monthly reviews for all residents as required due to not having enough time. Interview conducted with the Director of Nurses (DON) on 10/4/12 at 5:45 PM, revealed the pharmacist was required by facility policy to provide a monthly list of all residents' medication regimen reviews to the DON after the review was completed. The DON stated she had not received the monthly report consistently and was	F 428	F 428 *Continued from page 23* The Chief Pharmacist will continue to monitor for compliance with completion of Drug Regimen Reviews timely and Physician's acting upon recommendations. This was already being monitored as part of Pharmacy Performance Improvement Program. (See attached Interventions and ADR Reports and Clinical Intervention Table used by Pharmacy to collect data). Results of findings by both Nursing and Pharmacy will be reported quarterly to the Nursing Facility and Pharmacy and Therapeutics Committee.	

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	185182		10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE COMMUNITY HOSPITAL	860 RIVERVIEW AVENUE PINEVILLE, KY 40977

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F 428	Continued From page 24 not aware the medication regimen reviews had not been conducted monthly as required.	F 428		

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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
	185182		**10/03/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVILLE COMMUNITY HOSPITAL	**850 RIVERVIEW AVENUE** **PINEVILLE, KY 40977**

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 1 (322) SMOKE COMPARTMENTS: 3 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM PARTIALLY SPRINKLERED (WET SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 10/03/12, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. No deficiencies were identified during this survey.	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.