

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

PRINTED: 02/20/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2014
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NAME OF PROVIDER OR SUPPLIER
NIM HENSON GERIATRIC CENTER

STREET ADDRESS (including PO Box) AND ZIP CODE
Division of Health Care
State Health Enforcement Branch
JACKSON, KY 41339

(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 000	INITIAL COMMENTS A standard health survey was conducted on 02/04-06/14. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	<u>THIS PLAN OF CORRECTION CONSTITUTES MY WRITTEN ALLEGATION OF COMPLIANCE FOR THE DEFICIENCIES CITED. HOWEVER, SUBMISSION OF THE PLAN OF CORRECTION IS NOT AN ADMISSION THAT A DEFICIENCY EXISTS OR THAT ONE WAS CITED CORRECTLY.</u>	
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	<u>THIS PLAN OF CORRECTION IS SUBMITTED TO MEET REQUIREMENTS ESTABLISHED BY STATE AND FEDERAL LAW.</u> Resident #11 received a follow up x-ray on 2-27-14. No fracture noted. MD and Family were notified of results. On 2-12-14 100% of Residents notification of change compliance audit was completed from 12-19-13 by DON, Nursing Supervisors and MDS worker for all current Residents. The audit included comparing all orders, assessments, and notification of changes (MD, Resident and/or family.) All issues were corrected by the above or by notifying the responsible party (Nursing or MD), who made corrections.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Phillip Fitteral TITLE: Administrator (X6) DATE: 2-27-14

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.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's policies, the facility failed to ensure staff immediately informed the physician when one of sixteen sampled residents experienced a change in condition (Resident #11). On 12/19/13, facility staff assessed Resident #1 to have bruising of the left foot and ankle. However, there was no evidence the resident's physician was notified of the bruises.</p> <p>The findings include:</p> <p>Review of the Change in Resident's Condition or Status policy (no date) revealed the charge nurse would notify the resident's attending physician when an accident or incident occurred that resulted in injury; when a significant change was identified in the resident's physical, mental, or psychosocial status; when there was a need to alter treatment; when the resident refused medications or treatments; when the resident was discharged without proper medical authority; and/or when deemed necessary or appropriate in the best interest of the resident.</p> <p>Review of the medical record revealed the facility admitted Resident #11 on 10/09/07 with diagnoses including Schizophrenia, Non-Insulin Dependent Diabetes Mellitus, Congestive Heart Failure, End-Stage Renal Disease, and Advanced Dementia.</p> <p>Review of the nurse's notes dated 12/19/13 revealed Resident #11 was transferred to the local Emergency Room for evaluation of chest and arm pain on 12/19/13 at 9:45 PM. At 11:15</p>	F 157	<p>DON, Supervisors/MDS held an in-service on 2-18-14 for all nursing staff pertaining to when and how to initiate notification of changes for residents and notification of MD and family. On 2-24-14 another in-service addressed what to chart on the 24 hour shift report. The DON, Supervisor or designee will review the shift reports and orders during the morning meeting. Any notification compliance issues will be addressed during that shift.</p> <p>25% of all residents will be audited every month by DON, Supervisors/MDS for compliance to the process of notification of change. Charting, assessments and/or orders will be compared to the actual resident. This protocol will be used for 30 days beginning 2-24-14. Then it will be reviewed to verify compliance is being met. The person responsible for correcting any monitoring issues will be notified in documentation form or verbally. The process will continue if compliance is being met or revised if</p>		

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F 157	<p>Continued From page 2</p> <p>AM, the resident was returned to the facility with no new physician's orders. Further review of the nurse's notes revealed Licensed Practical Nurse (LPN) #5 was called to the resident's room by the nurse aides on 12/20/13, at 5:15 AM. According to the nurse's notes, LPN #5 assessed Resident #11 to have two bruises on the left foot, one on the left ankle, and one bruise on the third toe of the left foot. LPN #5 documented the resident stated the bruising occurred during a recent hospitalization. However, there was no evidence the physician was contacted regarding the newly assessed bruising of the resident's left foot.</p> <p>Review of the quarterly MDS assessment dated 01/14/14, revealed the facility assessed Resident #11 to have a Brief Interview for Mental Status (BIMS) score of 10, and revealed the resident had fluctuating behaviors with inattention and disorganized thinking as well as resistance to care.</p> <p>Interview conducted with the resident's attending physician, Physician #1, on 02/06/14, at 5:50 PM, revealed he did not recall if the facility staff had notified him of the bruises on the resident's left foot/ankle on 12/20/13. Physician #1 stated he would probably have wanted to obtain an x-ray of Resident #11's left foot/ankle if he had been informed of the bruising.</p> <p>Interview with the Director of Nursing (DON) on 02/06/14, at 7:30 PM, revealed nurses were responsible to contact the resident's physician when a change in condition was identified. The DON stated LPN #5 should have reported the bruises identified on Resident #11 to the resident's physician on 12/20/13. The DON further stated he reviewed the 24-hour shift report</p>	F 157	<p>necessary. QA committee will be consulted id a problem with compliance continues. (2A-2B)</p> <p>Completion Date:</p>	2-24-14
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F 157	Continued From page 3 daily and did not recall reviewing any bruises noted for Resident #11 on 12/20/13. According to the DON, LPN #5 was no longer employed by the facility. LPN #5 was not able to be reached by telephone for interview.	F 157			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policy, it was determined the facility failed to administer medications to one of sixteen sampled residents (Resident #9) as prescribed by the physician. Resident #9 had a psychiatric consultation on 01/27/14. The Psychiatrist wrote an order to discontinue the use of the resident's current dose of 2 milligrams of Haldol (antipsychotic) on an as needed (PRN) basis and to increase the resident's dosage of Zoloft (antidepressant) from 50 milligrams to 75 milligrams every morning. Resident #9's guardian refused the Psychiatrist's recommendations and the resident's physician wrote orders for staff to continue with the previous medication orders. However, facility staff failed to transcribe the physician's order to resume the previous medication orders to the Medication Administration Record (MAR) and as a result, Resident #9 received the incorrect dosage of medications. The findings include:	F 281 An order clarification was obtained from MD on resident #9 on 2-6-14 to ensure correct dosages of medications were being administered. On 2-12-14 100% of all residents orders were compared to medication given from 1-27-14 to ensure no discrepancies were found. MAR's and TAR's were all checked to insure accuracy. This was completed by DON and Nurse Supervisors. An in-service was held on 2-12-14 including the 3 part order form being filled out completely. An in-service was also held on 2-24-14 regarding comparing actual medications with the monthly recopy orders, doing correct chart checks by comparing the order with the MAR/medication itself and comparing the new monthly MAR's/TAR's with the old before placing them out for			

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F 281	<p>Continued From page 4</p> <p>A review of the facility's policy for "Following Medical Doctor (MD)" orders revealed each shift was required to conduct a review of medical records to ensure that physician orders were properly transcribed, placed on the Medication Administration Record (MAR), and followed.</p> <p>A review of the medical record for Resident #9 revealed the facility admitted the resident on 01/14/10 with diagnoses including Dementia, Insomnia, Psychosis, and Depression. Review of a psychiatric consultation dated 01/27/14 revealed the Psychiatrist had written orders to discontinue the use of the 2-milligram (mg) dose of Haldol (antipsychotic) as needed (PRN) for Resident #9, and to increase the resident's Zoloft (antidepressant) from 50 mg to 75 mg every morning.</p> <p>Review of the nurse's notes dated 01/29/14 revealed the resident's guardian notified the facility that he refused any further psychiatric consultations for the resident and also refused the psychiatric recommendations for Resident #9 dated 01/27/14. Documentation revealed facility staff notified the resident's attending physician of the guardian's request and the physician gave the facility orders to restore the previous orders for Haldol (2 mg PRN) and Zoloft (50 mg every morning).</p> <p>Review of the Medication Administration Record (MAR) for Resident #9 dated February 2014, revealed the facility continued to administer Zoloft 75 mg every day instead of the current physician's order for Zoloft 50 mg every day. Furthermore, the current physician's order for 2 mg of Haldol, PRN, had not been transcribed to the MAR for February 2014.</p>	F 281	<p>use. The nursing staff will also perform chart check every 12 hours to ensure physician orders are followed correctly.</p> <p>The DON, Supervisor, or designee will review the 3 part order form during the morning meeting. Any noncompliance issues will be addressed during the shift. 25% of all residents will be audited every month by the DON, Supervisors/MDS for compliance of following MD orders, charting, and assessments. This all will be compared to the actual resident for correct compliance. This protocol will be used for 30 days beginning 2-24-14. Then it will be reviewed to verify compliance is being met. The person responsible for correcting any monitoring issues will be notified in documentation form or verbally. The process will continue if compliance is being met or revised if necessary. QA committee will be consulted if a problem with compliance continues. (attachment 2B.)</p> <p>Completion Date:</p>	2-24-14
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F 281	Continued From page 5 Observation of Resident #9's medications at 11:00 AM on 02/06/14 revealed the resident continued to receive Zoloft 75 mg every day instead of the current physician's order for Zoloft 50 mg every day. An interview was conducted with Licensed Practical Nurse (LPN) #1 at 10:20 AM on 02/06/14. The LPN confirmed that, in accordance with Resident #9's current physician's orders, Resident #9 should receive 50 mg of Zoloft every day and 2 mg of Haldol on an as needed basis. However, the LPN acknowledged staff had administered 75 mg of Zoloft to Resident #9 instead of the current order for 50 mg of Zoloft since 01/27/14.	F 281		
F 329 SS=D	483.25(j) 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	F 329	Resident #8 was discharged from the Nim Henson Geriatric Center on 2-4-14. The DON and Nurse Supervisors reviewed all resident records for accuracy. On 2-12-14, 100% of all current residents were assessed from the date of 1-15-14 to ensure that all had a supportive diagnosis for current medication. An in-service was held on 2-12-14 by DON/Supervisors with nursing staff on having a diagnosis to support all medications being given.	

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F 329	<p>Continued From page 6</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and a review of the facility's policies, it was determined the facility failed to ensure one of sixteen sampled residents (Resident #8) was free from unnecessary drugs. The facility failed to ensure there was adequate indications for the use of Claritin (anti-allergy), Haldol (antipsychotic), Benzotropine (anti-Parkinson's), and Neurontin (anticonvulsant) for Resident #8.</p> <p>The findings include:</p> <p>A review of the facility's Medication policy (no date) revealed residents' medications and treatment orders would be reconciled upon admission and readmission to the facility by the nurse admitting the resident. The policy revealed the nurse would be responsible to request a medication order clarification when any discrepancy was identified.</p> <p>Review of the medical record revealed the facility admitted Resident #8 on 01/15/14 with diagnoses including Dementia, Hypertension, Previous Head Injury secondary to a fall, Alzheimer's Disease, Hiatal Hernia, History of Urinary Retention, and Bilateral Knee Replacement. Review of the admission Minimum Data Set (MDS) assessment, dated 01/27/14, revealed Resident</p>	F 329	<p>All admits/re-admits will have a supporting diagnosis. Nursing staff compared all orders and diagnosis with hospital discharge summaries or clarification from physicians for accuracy.</p> <p>Chart checks on all new admits/re-admits will be done by DON/Supervisor/designee by next business day to include medications and supporting diagnosis. MDS will also assess all medication and supporting diagnosis with scheduled MDS assessments. QA committee will be consulted as needed.</p> <p>Completion date:</p>	2-1214
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F 329	<p>Continued From page 7</p> <p>#8 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was interviewable. The resident was also assessed to have mood and behaviors of feeling down/depressed, difficulty sleeping, feeling tired, and trouble concentrating. Further review of the MDS assessment revealed Resident #8 had frequent complaints of pain.</p> <p>Review of the admission physician's orders dated 01/15/14, revealed the resident was admitted with orders to receive Claritin (anti-allergy) 10 milligram (mg) once a day; Haldol (antipsychotic) 1 mg once a day; Benztropine (anti-Parkinson's) 0.5 mg twice a day; and Neurontin (anticonvulsant) 100 mg three times a day. However, there was no evidence the facility had consulted with the physician to ensure there was an indication or diagnosis for the use of these medications.</p> <p>Observation of Resident #8 on 02/04/14, at 11:50 AM, revealed the resident was lying on the bed with a pillow behind his/her back for positioning and an alarm device was on the resident's bed. The resident stated he/she was waiting on a family member to come and take him/her home.</p> <p>An interview conducted with Registered Nurse (RN) #1 on 02/05/14, at 2:50 PM, revealed she admitted Resident #8 from the hospital to the facility on 01/15/14. RN #1 stated she had spoken with the hospital physician to obtain a discharge summary for Resident #8 and had used the discharge summary as a source for the resident's admission orders. The RN further stated she was not aware each medication prescribed required a diagnosis or indication for use and did not clarify the medications and</p>	F 329		

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F 329	Continued From page 8 diagnoses list with the resident's attending physician. An interview conducted with the Director of Nursing (DON) on 02/06/14, at 7:20 PM, revealed a chart audit was conducted after each admission and readmission to ensure the information was accurate. However, the DON stated the audit did not include a review of the medications to ensure there was a diagnosis or indication for medications when the orders were received. The DON stated he was not aware Resident #8 had medications prescribed that did not have a diagnosis or indication for the use of the medications.	F 329			
F 514 SS=D	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, record review, and facility policy review, the facility failed to ensure an accurate clinical record was maintained for one of	F 514	Resident #8 was discharged from the facility on 2-4-14. An audit by DON and Supervisor of 100% of current residents Code Status was done on 2-10-14 to ensure accuracy between the Resuscitation Status Requests form, the MD orders and the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) order form. Any discrepancies were clarified with the Resident, Family and Physician. The Code Status options and the Kentucky Medical Services Do Not Resuscitate (DNR) order form will be		

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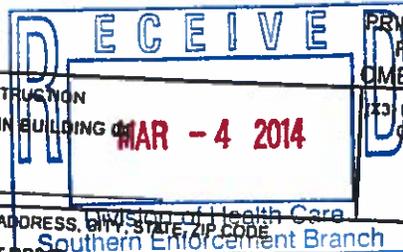
F 514	<p>Continued From page 9</p> <p>sixteen sampled residents (Resident #8). The facility admitted Resident #8 on 01/15/14 and the resident's responsible party signed a "Do Not Resuscitate" (DNR) document and a "Full Code" request form on 01/15/14. However, the facility failed to ensure Resident #8's resuscitative status was clarified with the resident's responsible party in order to ensure an accurate medical record was maintained and that staff was aware of the resident's responsible party's wishes.</p> <p>The findings include:</p> <p>Review of the Code Status policy (no date) revealed each resident has a choice of code status, whether to be a Full Code or DNR. The policy noted if the resident was unable to make this decision, the resident's responsible party would make the decision for the resident.</p> <p>Review of the medical record revealed the facility admitted Resident #8 on 01/15/14 from another long-term care facility. Review of the January 2014 physician orders received from the transferring facility revealed the resident's code status was documented as Full Code on the physician's orders. However, review of the resident's physician's orders at the time of admission, dated 01/15/14 (the same date as the resident's admission to the facility), revealed the resident's resuscitative status was blank and incomplete.</p> <p>Further record review revealed a Resuscitation Status Request was signed by Resident #8's responsible party on 01/15/14. The request provided the option for a "Full Code" or "DNR." The box "I do wish to be a full code" was checked and noted the responsible party's desire to have</p>	F 514	<p>reviewed by the SSD with the Resident and/or resident's responsible party upon admission if during business hours. If the resident arrives after business hours the nursing staff will review them with the resident and/or responsible party. The SSD did an in-service for nurses regarding the responsibilities of resident code status on 2-24-14.</p> <p>The SSD will do an audit of 25% of the Resident's code status every month. The forms will also be checked for Accuracy during the admits/re-admits Chart check done by the DON, Supervisor or designee. Any discrepancies will be clarified with the Resident, Family and Physician. QA committee will be asked for input should the need arise.</p> <p>Completion Date:</p>	2-24-14
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2014
NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339		
(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 514	<p>Continued From page 10</p> <p>measures taken in resuscitation in the event of cardiac/respiratory arrest. However, continued review of the medical record revealed a document titled the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order form, and revealed this document that indicated Resident #8's code status was "DNR" was also signed by the resident's responsible party on 01/15/14.</p> <p>Interview with Registered Nurse (RN) #1 on 02/05/14, at 2:50 PM, revealed she had admitted Resident #8 to the facility on 01/15/14, and stated the facility's Social Services Director (SSD) had discussed the resident's code status options with the resident's family at the time of admission. RN #1 stated she did not know both code status request forms had been signed by the resident's responsible party. RN #1 further stated the code status should have been clarified by either the nurse or the SSD when the resident was admitted on 01/15/14.</p> <p>Interview with the Social Services Director (SSD) on 02/06/14, at 3:15 PM revealed she reviewed the code status options upon admission with each resident and/or the resident's responsible party, obtained signed documents, and communicated the code status requests to facility staff. The SSD stated she did not realize Resident #8's responsible party had signed both documents and, as a result, the resident's code status for Resident #8 had not been clearly defined in the medical record.</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (000)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 02/04/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p>	K 000		
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire</p>	K 029	<p>No resident was found to be affected by rooms 161 and 162 having hazardous storage without door</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Phillip Futral* TITLE: *Administrator* (X6) DATE: *2-27-14*

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.

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NAME OF PROVIDER OR SUPPLIER NIM HENSON GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 JETT DRIVE JACKSON, KY 41339		
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K 029	<p>Continued From page 1</p> <p>extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected one of six smoke compartments, staff, and approximately fifteen residents. The facility has the capacity for 120 beds with a census of 76 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 02/04/14, at 12:20 PM, with the Director of Maintenance (DOM), rooms 161 and 162 were observed to contain combustible storage and the doors did not have a door-closing device. Rooms that are considered to be a hazardous area are required to have a door-closing device. An interview with the DOM on 02/04/14, at 12:20 PM, revealed the DOM was not aware which rooms are considered hazardous areas that would require a door-closing device.</p> <p>The findings were revealed to the Administrator</p>	K 029	<p>closures. Door closures were installed on room 161 and 162 on 2-18-14 by maintenance supervisor.</p> <p>Any resident could be affected by improper hazardous storage. Maintenance and housekeeping supervisors inspected the facility on 2/07/14 and did not find any other areas needing closures.</p> <p>Housekeeping and maintenance supervisors were in-serviced by the Administrator on 2-7-14 on Life Safety Code rules on storage areas with hazardous material.</p> <p>Maintenance and housekeeping supervisors will monitor the building during their daily duties. The Administrator will monitor for compliance quarterly. Any major problems will be addressed by the QA committee.</p> <p>Completion date:</p>	2-18-14	

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K 029 K 076 SS=D	<p>Continued From page 2 upon exit.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain oxygen tanks as required. This deficient practice affected one of six smoke compartments, staff, and approximately nineteen residents. The facility has the capacity for 120 beds with a census of 76 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 02/04/14 at 12:40 PM with the Director of Maintenance (DOM), six oxygen cylinders were observed to be unsecured in the oxygen storage room. Oxygen tanks must be secured due to safety precautions.</p>	K 029 K 076	<p>No resident was found to be affected by the unsecured oxygen cylinder in the oxygen storage room. All tanks were secured by maintenance supervisor on 2-4-14.</p> <p>Any resident could be affected by not securing oxygen cylinders properly. A visual inspection by maintenance supervisor on 2-4-14 did not reveal any other problems.</p> <p>An in-service was done by DON for nurses and CMA's on 2-24-14 on the importance of securing all oxygen tanks properly.</p> <p>Compliance monitoring will be done daily by housekeeping supervisor and nurses while performing their duties. The DON will do monthly checks and the Administrator will do quarterly inspections. QA committee will be consulted as needed.</p> <p>Completion date:</p>	2-24-14
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K 076	<p>Continued From page 3</p> <p>An interview with the DOM on 02/04/14 revealed he was aware the oxygen tanks should be secured; however, he was unsure why staff left the tanks unsecured.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>4-3.1.1.2 3. Provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation.</p> <p>4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft.) above the floor as a precaution against their physical damage.</p> <p>4-3.5.2.2 2. If stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.</p> <p>4-5.1.1.1 Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.</p>	K 076		