

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

PRINTED: 11/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2015
NAME OF PROVIDER OR SUPPLIER BAPTIST CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 MAIN STREET NEWPORT, KY 41071		
(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 A Recertification Survey was initiated on 06/02/15 and concluded on 06/04/15. Deficiencies were cited with the highest Scope and Severity of an "E".	F 000			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/26/2015

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 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a thorough investigation and reporting of alleged misappropriation of property was performed for one (1) unsampled resident (Unsampled Resident C) who reported missing money.</p> <p>The findings include:</p> <p>Review of the facility's, 'Abuse Prohibition Policy", revised on 08/21/14, revealed the purpose was prompt reporting of any suspected abuse, mistreatment, involuntary seclusion, neglect or misappropriation of property belonging to residents. Continued review of the Policy, under the Identification/Investigation section, revealed a full investigation would always occur which would include the notification of all management, Physicians, and designated responsible parties be immediately initiated. Per the Policy, documentation of all steps taken and outcomes would be recorded, dated and signed by the staff assisting with the investigation and timeliness of investigation was to occur, not taking longer than five (5) working days from the date of the incident. Review of the section titled, reporting, of the policy revealed all incidents were reported and investigated as they occurred. Further review revealed all reports would be called/faxed</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>into the Community Based Services (CBS) office and the Office of Inspector General (OIG), as soon as possible, but not to exceed twenty-four (24) hours. In addition, a follow up call/fax with the results of the internal investigation was to be made to CBS and OIG within five (5) working days of the original report.</p> <p>Review of Unsampled Resident C's medical record revealed the facility admitted the resident on 09/17/12, with diagnoses which included Diabetes, Chronic Obstructive Pulmonary Disease, Osteoarthritis, Depression, Chronic Kidney Disease and Esophageal Reflux. Review of Unsampled Resident C's Annual Minimum Data Set (MDS) Assessment, dated 05/26/15, revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating no cognitive impairment. Review of Unsampled Resident C's Comprehensive Care Plans revealed no documentation of the resident making false accusations against staff or any documentation of misplacing personal items including money.</p> <p>Interview with Unsampled Resident C, on 06/02/15 at 4:00 PM and on 06/04/15 at 3:30 PM, during the Surveyors Group Interview, revealed when the Surveyor asked the residents present about their personal property, Unsampled Resident C stated he/she had seen an agency person employed by the facility leaving his/her room in the past and when the resident entered the room after that, he/she discovered money missing from the night stand drawer. Unsampled Resident C stated the incident was reported to the facility, and the facility reimbursed the resident for the missing money. Continued interview with Unsampled Resident C revealed</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>the resident was returning to his/her room after lunch one (1) day and saw a State Registered Nursing Assistant (SRNA) leaving the room and pulling the door shut. Unsampld Resident C stated he/she did not close the door to his/her room. Per interview, when Unsampld Resident C entered the room after the SRNA left it and checked the drawer of the bed side table, he/she discovered money was missing. Unsampld Resident C stated he/she "told the girls downstairs" about the incident and stated they encouraged him/her to report it to the Social Worker.</p> <p>Interview with the Social Services Director (SSD), on 06/04/15 at 2:45 PM, revealed the definition of misappropriation of property was the misuse or theft of a resident's property or funds. The SSD stated once reported, the facility would start the investigation to determine the validity and/or the credibility of the allegations. Per interview, the initial findings would be faxed to the appropriate state agencies, as well as, submitting the final report. Continued interview revealed the Physician and the next of kin would be notified of the allegations. The SSD revealed in regards to the incident with Unsampld Resident C she checked the nursing staff schedule to try to identify the alleged perpetrator, and an agency SRNA who fit the description given by Unsampld Resident C to the office who was brought to the SSD's office and interviewed. Per the SSD, the agency SRNA denied the allegations. The SSD stated at that point, the facility did not feel it was misappropriation of property and did not see the need to report it to the state agencies.</p> <p>Interview with the Administrator, on 06/04/15 at 2:30 PM and at 3:50 PM, revealed the facility was</p>	F 225			

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F 225	Continued From page 4 aware of the allegation made by Unsampled Resident C regarding missing money and the Administrator stated there was an investigation conducted which consisted of talking to some of the nursing staff members working on the unit on the day of the reported allegations of missing money. Per interview, the staff interviewed denied seeing the alleged perpetrator on the floor/unit on the day in question. The Administrator revealed no other residents were interviewed, and the facility needed to investigate to see if missing items could be located with any report of misappropriation of property. Per interview, any time there was an allegation regarding an agency nursing staff member, the staff member was sent home and the agency was notified not to have the individual to return to the facility. Continued interview revealed it was unclear if the allegation was thoroughly investigated. The Administrator stated the alleged perpetrator was not assigned to Unsampled Resident C's unit the day in question, and stated during meal times, no staff from any other units would be on a unit not assigned to them because it would be against the facility's policy. Per the Administrator, interviews with selected nursing staff members revealed no one had seen the alleged perpetrator on the unit during the time frame indicated. Further interview revealed the Administrator felt the allegation was resolved and the resident was reimbursed the amount of money missing. In addition, the Administrator revealed there was no formal documentation of an investigation regarding Unsampled Resident C's allegation, but she did have the staff interviews documented. Review of the Administrator's documentation revealed the Administrator interviewed three (3) staff members regarding seeing the alleged perpetrator on the	F 225			

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F 225	Continued From page 5 unit during lunch on 05/02/15. Continued review of the documentation revealed the staff interviews were not dated, timed, nor signed according to the facility's policy. Further review of the documentation revealed there was no evidence any other residents were interviewed regarding missing money or items, nor was there any documentation of any attempts to search the resident's room and other areas to try to locate the missing funds. Further interview with the Administrator revealed according to facility's policy, all allegations should be investigated and reported to the appropriate agencies.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policy, it was determined the facility failed to implement operational policies and procedures for the investigation and reporting of alleged misappropriation of property for one (1) unsampled resident (Unsampled Resident C). The findings include: Review of the facility's Abuse Prohibition Policy, revised on 08/21/14, revealed the purpose was prompt reporting of any suspected abuse, mistreatment, involuntary seclusion, neglect or	F 226			

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F 226	<p>Continued From page 6</p> <p>misappropriation of property belongings to residents. Continued review of the Abuse Prohibition Policy, under the Identification/Investigation section, revealed a full investigation will always occur which would include the notification of all management, physicians, and designated responsible party to be immediately initiated. Further review of the Abuse Prohibition Policy, revealed documentation of all steps taken and outcomes will be recorded, dated and signed by those staff assisting with the investigation and timeliness of investigation will occur, not taking longer than five working days from the date of the incident. Review of the section titled Reporting, revealed all incidents are reported and investigated as they occur. Continued review revealed all reports will be called/faxed into the Community Based Services (CBS) and Office of Inspector General (OIG), Division of Long Term Care (LTC) as soon as possible but ought not to exceed twenty four (24) with a follow up call/fax with the results of the internal investigation to be made to CBS and OIG within five (5) working days of the original report.</p> <p>Review of Unsampled Resident C's medical record revealed the facility admitted the resident on 09/17/12 with diagnoses which included Diabetes, Pulmonary Disease, Osteoarthritis, Depression and Esophageal Reflux. Review of Unsampled Resident C's Annual Minimum Data Set (MDS), dated 05/26/15, revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating the resident had no cognitive impairment.</p> <p>Interview with Unsampled Resident C, on 06/02/15 at 4:00 PM during the Group Interview, revealed, when the residents were asked about</p>	F 226			

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F 226	<p>Continued From page 7</p> <p>their personal property, Unsampld Resident C stated he/she had seen an agency employee leaving her room in the past and when the resident entered the room, the resident discovered money missing from the night stand drawer. Unsampld Resident C stated the incident was reported to the facility and the facility reimbursed the resident for the money missing.</p> <p>Interview with the Social Services Director, on 06/04/15 at 2:45 PM, revealed the definition of misappropriation of property was the misuse or theft of a resident's property or funds. The Social Services Director stated once reported, the facility soul start the investigation to determine the validity of the allegations. The Social Services Director further stated the initial findings would be faxed to the appropriate state agencies as well as submitting the final report. She further stated the Physician and the next of kin would be notified of the allegations. The Social Services Director stated, related to the incident will Unsampld Resident C, she got a description of the alleged perpetrator from Unsampld Resident C and she checked the nursing staff schedule to try to identify the alleged perpetrator. She said she brought the agency State Registered Nursing Assistant (SRNA) who fit the description given by Unsampld Resident C to the office and interviewed the individual who denied the allegations. The Social Service Director stated at that point, the facility did not feel it was misappropriation of property and did not see the need to report it to the state agencies.</p> <p>Interview with the Administrator, on 06/04/15 at 3:50 PM, revealed there was a need to investigate to see if the missing items could be located with any report of misappropriation of</p>	F 226			

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F 226	<p>Continued From page 8</p> <p>property. The Administrator stated any time there was an allegation regarding an agency nursing staff member, the staff member was sent home and the agency notified not to have the individual to return to the facility. The Administrator further stated the alleged perpetrator was not assigned to Unsampld Resident C's unit the day in question and stated during meal times, no staff for any other units would be on a unit not assigned to them because it would be against their policy. The Administrator further stated interviews with selected nursing staff members revealed none had seen the alleged perpetrator on the unit during this time frame. She stated she felt the allegation was resolved and the resident was reimbursed the amount missing and felt there was no reason to report this allegation to the state agencies listed on the facility's policy. Continued interview with the administrator revealed no formal documentation of a thorough investigation regarding the allegation was completed. Further during the interview, the Administrator stated, according to facility policy, all allegations should be thoroughly investigated and reported to the appropriate agencies.</p> <p>Further interview with the Social Services Director, on 06/04/15 at 4:50 PM, revealed neither the physician nor Unsampld Resident C's next of kin were notified of the allegation according to facility's Abuse Policy.</p> <p>Review of the Administrator's documentation regarding the investigation of the allegation revealed the Administrator interviewed three (3) staff members regarding whether or not the alleged perpetrator was seen on the unit during lunch on 05/02/15. These interviews were not dated, timed, nor signed according to the facility's</p>	F 226			

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F 226	Continued From page 9 policy. There was no evidence any other residents were interviewed regarding missing items nor was there any documentation of any attempts to search the room and other areas to try to locate the missing money.	F 226			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as was possible. Observations were made of medications left unsecured and accessible to residents. The findings include: Review of the facility's policy titled, "Medication Storage in the Facility, ID1: Storage of Medications", undated, revealed medications and biologicals were to be stored safely, securely, and properly, following the manufacturer's or supplier's recommendations. Per the Policy, the medication supply was to be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer	F 323			

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F 323	<p>Continued From page 10</p> <p>medications, such as, Medication Aides. Further review revealed medication rooms, carts, and medication supplies were to be locked or attended by persons with authorized access only.</p> <p>1. Observation of a med pass on 06/02/15 at 4:30 PM, conducted by Licensed Practical Nurse (LPN) #2, revealed the nurse removed a packet of Metoprolol (an anti-hypertensive medication) 25 milligram (mg) medication which contained twenty (20) tablets from the medication cart and laid the medication packet on the nurse's station on the facility's second floor. Observation revealed the nurse's station was unattended and no nursing or pharmacy personnel were observed in the nearby area of the nurse's station. After placing the medication on the counter of the nurse's station, LPN #2 was observed to continue with her med pass administering medication in Resident #16's room, which was out of view of the nurse's station. After administering Resident #16's medication, LPN#2 was observed to return to the medication cart, document Resident #16's medication administration. Further observation revealed at 4:40 PM, LPN #2 then secured the Metoprolol medication in a locked pharmacy tote in the locked medication room behind the nurse's station. However, the packet of twenty (20) tablets of the Metoprolol medication was observed unsecured for ten (10) minutes at the nurse's station, and was accessible to any person presenting to the nurse's station, such as, residents, staff or visitors.</p> <p>Review of the facility's list of resident with a Brief Interview for Mental Status (BIMS) score of less than eight (8), which was indicative of cognitive impairment, for 06/02/15, revealed there were forty-two (42) residents listed who were also</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>ambulatory or mobile per wheelchair, who could have accessed the Metoprolol medication lying on the counter unsecured and unlocked at the second floor nurse's station from 4:30 PM to 4:40 PM, a ten (10) minute timeframe.</p> <p>Interview on 06/04/15 at 5:15 PM, with LPN # 2 revealed she realized she had made a mistake when she left the Metoprolol medication unattended at the nurse's station. Per interview, the medication should have either been placed back into the locked medication cart or placed in the locked pharmacy tote in the medication room and not left lying out unsecured. LPN #2 revealed she really did not know why she left the medication lying out, except she had been nervous because she was being observed by the Surveyor.</p> <p>Interview, on 06/04/15 at 2:30 PM, with LPN #3, the second shift Charge Nurse revealed a nurse should never leave medication unsecured and unattended lying on the nurse's station counter. Per interview, since the Metoprolol medication had been discontinued it should have been removed from the medication cart and placed in the locked pharmacy box in the medication room to prevent anyone from taking the medication from the nurse's station.</p> <p>2. During an observation of the unattended and unlocked medication room at the nurse's station on the fourth floor, on 06/04/15 at 3:05 PM, revealed there were two (2) pharmacy totes observed on the back counter of the medication room. One (1) of the pharmacy totes was locked; however, the other pharmacy tote was unlocked. Observation inside the unlocked pharmacy tote revealed there was twenty-five (25) tablets of</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>Trazadone 50 mg medication. Continued observation revealed the Trazadone medication was unsecured from 3:05 PM to 3:15 PM, a ten (10) minute timeframe, and accessible to any person present in the area of the nurse's station, such as, residents, visitors, as well as, facility staff.</p> <p>According to the Physician Desk Reference (PDR.net), the medication Trazadone was an anti-depressant used in the treatment of Major Depressive Disorder in Adults.</p> <p>Review of the facility's list of resident with a BIMS score of less than eight (8), which was indicative of cognitive impairment, for 06/02/15, revealed there were forty-two (42) residents listed who were also ambulatory or mobile per wheelchair, who could have accessed the Trazadone medication in the unsecured and unlocked pharmacy tote in the unlocked medication room at the nurse's station on the fourth floor from 3:05 PM to 3:15 PM, a ten (10) minute timeframe.</p> <p>Interview, on 06/04/15 at 3:15 PM, with LPN #4, the Unit Manager of the 4th floor revealed the medication should have been locked in the pharmacy tote. She related once a medication had been discontinued, the medication was pulled from the medication cart and placed in the locked pharmacy box to be sent to pharmacy for crediting to the resident.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/02/15 at 4:40 PM, revealed it was her expectation that all medication was properly stored and locked at all times. When a medication was removed from the locked medication cart, it should be placed in the locked</p>	F 323			

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F 323	Continued From page 13 pharmacy box in the medication room to be returned to the pharmacy, and credited to the resident's account.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure nutritional supplements were provided for one (1) of three (3) unsampled residents (Unsampled Resident A). Unsampled Resident A had a Physician's Order dated 05/27/15, for Ensure pudding two (2) times a day between meals to aid in weight maintenance. Review of Unsampled Resident A's meal ticket revealed the fortified Ensure pudding was noted on it. However, observation of Unsampled Resident A's meal tray revealed no Ensure pudding on the tray. Interviews with nursing staff revealed they thought Unsampled Resident A's Ensure pudding was being placed on his/her meals trays. Interviews with dietary	F 325			

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F 325	<p>Continued From page 14</p> <p>staff revealed however, they thought nursing staff was giving Unsampld Resident A's Ensure pudding between meals. Therefore, Unsampld Resident A was not receiving the fortified Ensure pudding.</p> <p>The findings include:</p> <p>Review of the facility's, "Resident Nutritional Care", undated, revealed new diet orders and diet changes would be communicated to the Food Service Director in writing by the Director of Nursing (DON) or the Charge Nurse. Continued review revealed all residents' diet orders, likes and dislikes, meal locations, allergies, and eating aids would be entered into the facility's Computrition Tray Program which was used to fill residents' meals trays. Further review revealed the Dietary Consultant would complete the nutritional assessment form and formulate recommendations for the nutritional support of identified at risk residents.</p> <p>Review of the facility's policy titled, "Nourishment Carts", revised 04/06/14, revealed a variety of snacks was available at all times in the nourishment rooms behind the nurse's station. Per the Policy, those snacks were distributed in the afternoon and evening, and on an as needed (PRN) basis by resident request. Further review revealed the snacks were updated and/or changed per resident preferences and the Dietitian's recommendation.</p> <p>Review of Unsampld Resident A's medical record revealed the facility admitted the resident on 12/18/12, and readmitted the resident on 09/13/13, with diagnoses of Late Effects of Cerebrovascular Disease, Senile Dementia,</p>	F 325			

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F 325	<p>Continued From page 15</p> <p>Depressive Disorder, Anxiety State, Vitamin D Deficiency and Vitamin B12 Deficiency. Review of Unsampled Resident A's Physician's Orders revealed an order dated 05/27/15, for the resident to receive Ensure pudding two (2) times a day between meals to in weight maintenance.</p> <p>Observation, during the lunch meal service on 06/02/15 and 06/04/15, revealed Unsampled Resident A's meal ticket noted Ensure pudding; however, there was no Ensure pudding on the resident's meal tray.</p> <p>Interview with Dietary Aide #1 on 06/02/15 at 1:00 PM, revealed meal tray instructions listed on the meal tickets didn't mean what was listed was for every meal, nor, did it mean any certain meal. Per interview, if Unsampled Resident A did not get Ensure pudding with the lunch meal, then the pudding would be served with the dinner meal.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 on 06/04/15 at 4:30 PM, revealed she was not aware Unsampled Resident A had the Ensure pudding ordered. Per interview, Unsampled Resident A usually ate in the dining room and dietary served any nutritional supplement at meal times which were listed on the meal ticket. Further interview revealed the SRNA's had a Kardex for information regarding any resident's nutritional supplement, such as, Ensure pudding.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 on 06/04/15 at 4:25 PM, revealed Unsampled Resident A's Ensure pudding should be on the resident's meal tray in the dining room, as it was listed on his/her meal ticket. Per interview, LPN #5 not aware of Unsampled Resident A being</p>	F 325			

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F 325	Continued From page 16 given Ensure pudding between meals. Interview with the Dietary Manager (DM) on 06/04/15 at 3:50 PM, revealed Unsampld Resident A's Ensure pudding should be served in between meals as per the Physician's Order. Per interview, the DM was aware of Unsampld Resident A's Ensure pudding being listed on the lunch tray meal ticket; however, he was not aware the resident was not receiving the Ensure pudding. Review of Unsampld Resident A's dinner tray meal ticket with the DM revealed the resident's Ensure pudding was not listed on it. The DM stated the Ensure pudding should not have been placed on meal trays, but sent to the floor as a snack. Per the DM, he had the Ensure pudding listed on the meal tray ticket to make sure it was being sent to the floor for a snack. Continued interview revealed the DM felt he had "failed" Unsampld Resident A by not ensuring the resident was receiving the Ensure pudding. The DM revealed the facility's process was confusing and he was going to remove the Ensure pudding from the meal tray ticket at lunch. Further interview revealed the DM expected staff to give residents' nutritional supplements, including Unsampld Resident A's Ensure pudding.	F 325			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that --	F 334			

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F 334	<p>Continued From page 17</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse</p>	F 334			

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F 334	<p>Continued From page 18 immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to develop policies and procedures that ensure each resident was offered an influenza (flu) immunization for one (1) of twenty five (25) sampled residents (Resident #15). Resident #15 refused the flu vaccine in 2013 and was not offered the vaccine in 2014.</p> <p>The findings include: Review of Resident #15's medical record revealed the facility admitted the resident on 04/12/13 with diagnoses which included Alzheimer's Disease, Senile Dementia and Mood</p>	F 334			

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F 334	<p>Continued From page 19</p> <p>Disorder in conditions, classified elsewhere. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/16/15, revealed that resident rarely/never understood or understands, long/short term memory impaired, and decision making was severely impaired.</p> <p>Record review for Resident #15 noted that the last "Influenza Vaccine Consent/ Declination" was signed on 04/11/13 as Resident #15 declined the influenza vaccine. The "Flu Vaccine Information and Consent Form" was signed on 06/03/15 during survey revealing that Resident #15 declined the vaccine per telephone order from POA (Power of Attorney), however there was no documented evidence the facility received consent/declination in 2014 for the flu vaccine.</p> <p>Interview with Licensed Practical Nurse (LPN) #4/Fourth Floor Unit Manager, on 06/03/15 at approximately 3:00 PM, revealed that he/she thought the consent/decline form only needed to be refused one time and not offered yearly. She stated staff nurses administer flu shots after the Unit Manager writes the order and makes sure consent forms (the original) was in the medical record. She stated the facility did not do annual consent forms for acceptance or denial.</p> <p>Interview with Director of Nursing (DON), on 06/04/15 at 4:30 PM, revealed the facility offered yearly flu vaccines. She said the facility did not have a policy offering the flu vaccine yearly. The DON stated that the flu vaccine should be offered yearly. She stated it was her expectation to offer the vaccine to each resident, every year, usually in the fall.</p>	F 334			
F 369	483.35(g) ASSISTIVE DEVICES - EATING	F 369			

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F 369 SS=D	<p>Continued From page 20 EQUIPMENT/UTENSILS</p> <p>The facility must provide special eating equipment and utensils for residents who need them.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide special eating equipment and utensils for residents who needed them for one (1) of twenty-five (25) sampled residents (Resident #14). Observation on 06/02/15 revealed Resident #14 had not received built-up utensils with his/her meal as ordered and as listed on the meal card.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled "Resident Nutritional Care", undated, revealed the food service director would maintain a current list of residents and their diet orders. Continued review revealed all diet orders, likes and dislikes, meal locations, allergies and eating aids would be entered into the Computrition Tray Program that would generate the tray ticket and be utilized to fill the residents' meal trays.</p> <p>Observation, on 06/02/15 at 5:32 PM, of the evening meal service revealed Resident #14 received his/her meal tray. Continued observation revealed the meal card indicated Resident #14 was to have received built-up utensils on the meal tray. However, further observation revealed no built-up utensils were present on Resident #14's meal tray available for</p>	F 369			

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F 369	Continued From page 21 the resident's use. Review of the medical record revealed, the facility admitted Resident #14 on 07/29/14, with diagnoses which included Paralysis Agitans, Alzheimer's Disease, Transient Cerebral Ischemia, Esophageal Reflux Disease, Anemia, Abnormal Posture and Depressive Disorder. Review of Resident #14's Physician's Orders revealed, an order dated 09/22/14, for white handled built up utensils to be utilized for all meals to improve safety and independent self feeding. Review of Resident #14's Comprehensive Care Plan, dated 08/06/14, revealed the resident was to utilize built-up utensils. Interview with State Registered Nursing Assistant (SRNA) #2, on 06/02/15 at 5:43 PM, revealed the resident meal trays should be delivered with the appropriate utensils on the trays; however, she further stated the tray should be checked by the staff that deliver the tray to the resident for appropriate contents of the meal tray. Continued interview revealed the resident should not have been served his/her meal until the correct utensils were available for the resident to utilize. Interview with the Director of Dietary Services, on 06/04/15 at 3:00 PM, revealed the dietary staff check the meal trays three (3) times before the trays leave the kitchen to be served. Continued interview revealed, the dietary staff should have identified the error and immediately corrected it prior to the tray leaving the kitchen. She indicated the built-up utensils should have been on Resident #14's meal tray as ordered.	F 369			
F 411	483.55(a) ROUTINE/EMERGENCY DENTAL	F 411			

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F 411 SS=E	<p>Continued From page 22</p> <p>SERVICES IN SNFS</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide or obtain from an outside resource routine dental services or an annual inspection of residents' oral cavities for eight (8) of twenty-five (25) sampled residents (Residents #1, #2, #9, #11, #12, #16, #18 and #20). Record review revealed no documented evidence Residents #1, #2, #9, #11, #12, #16, #18 and #20 had been seen by a dental provider for routine annual dental service.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Dental Care Protocol", undated, revealed all residents were screened for oral/dental issues by the nurse at the time of admission to the facility, at the time of the Quarterly Minimum Data Set (MDS)</p>	F 411			

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F 411	<p>Continued From page 23</p> <p>Assessment and with each Comprehensive MDS Assessment. Continued review revealed "positive" findings, indicative of dental issues, were reported immediately to the facility's Social Services department in order for the resident and/or his/her family to determine if evaluation by a dentist was desired.</p> <p>1. Review of Resident #1's medical record revealed the facility admitted the resident on 11/17/11, and re-admitted him/her on 04/08/13, with diagnoses which included Bipolar Disorder, Hypertension, Depressive Disorder, Anxiety State, Dementia, Hypothyroidism, Anorexia, Dysphagia and Psychosis. Review of the Annual MDS, dated 02/10/15, revealed the facility assessed Resident #1 to have short and long term memory problems, to have no natural teeth or tooth fragments and to be edentulous. Further record review revealed no documented evidence Resident #1 had been seen by a dental provider for routine dental care and services since admission to the facility.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident to the facility on 02/14/14, with diagnoses which included Breast Cancer, Adult Failure to Thrive, Chronic Kidney Disease, Anemia, Hypertension and Esophageal Reflux. Review of the Annual MDS Assessment, dated 03/30/15, revealed the facility assessed Resident #2 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13) of fifteen (15), indicating the resident was cognitively intact and interviewable. Continued review of the MDS Assessment revealed the facility assessed Resident #2 to have no oral or dental issues. Further record review revealed no documented evidence</p>	F 411			

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F 411	<p>Continued From page 24</p> <p>Resident #2 had been seen by a dental provider for routine dental care and services since admission to the facility.</p> <p>3. Review of Resident #9's medical record revealed the facility admitted the resident on 01/29/14, with diagnoses which included Diabetes Mellitus and Vitamin D Deficiency. Review of the Quarterly MDS dated 04/16/15, revealed the facility assessed Resident #9 as severely cognitively impaired. Review of the monthly June 2015 Physician's Orders revealed an order dated 04/09/15, that Resident #9 might see dentist. Review of Resident #9's Comprehensive Care Plan, dated 02/08/14, revealed no documented evidence of a care plan for dental services or examinations by a qualified dentist. Further record review revealed no documented evidence Resident #9 had been seen for routine dental care and services since admission.</p> <p>4. Review of Resident #11's medical record revealed the facility admitted the resident on 09/04/12, with diagnoses which included Anemia, Depression, Diabetes and Anorexia. Review of the Significant Change MDS, dated 03/10/15, revealed the facility assessed Resident #11 to have short and long term memory impairment, and to have obvious or likely cavities or broken natural teeth. Further record review revealed no documented evidence Resident #11 had been seen for routine dental care and services since admission to the facility.</p> <p>5. Review of Resident #12's medical record revealed the facility admitted the resident on 07/23/12, with diagnoses which included Gastroesophageal Reflux Disease, Diabetes and Depression. Review of the Annual MDS</p>	F 411			

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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	
F 411	<p>Continued From page 25</p> <p>Assessment, dated 12/22/14, revealed the facility assessed Resident #12 to have a BIMS score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact, and to have no natural teeth or tooth fragments. Further record review revealed no documented evidence Resident #12 had been seen for routine dental care and services since admission to the facility.</p> <p>6. Review of Resident #16's medical record revealed the facility admitted the resident on 03/03/12, with diagnoses which included Diabetes, Congestive Heart Failure, Atrial Fibrillation, Hypertension and Depression. Review of the Annual MDS Assessment, dated 02/16/15, revealed the facility assessed Resident #16 to have a BIMS score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact, and to have no natural teeth or tooth fragments. Further record review revealed no documented evidence Resident #16 had been seen for routine dental care and services since admission to the facility.</p> <p>7. Review of Resident #18's medical record revealed the facility admitted the resident on 07/14/09, with diagnoses which included Paralysis Agitans, Chronic Kidney Disease, Diabetes, Congestive Heart Failure, Senile Dementia and Esophageal Reflux Disease. Review of the Annual MDS Assessment, dated 11/11/14, revealed the facility assessed Resident #18 to have a BIMS score of eight (8) out of fifteen (15), indicating moderate cognitive impairment, and to have no oral or dental issues or concerns. Further record review revealed no documented evidence Resident #18 had been seen by a dentist for routine dental care and services since admission to the facility.</p>	F 411			

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F 411	Continued From page 26 8. Review of Resident #20's medical record revealed the facility admitted the resident on 05/03/10, with diagnoses which included Pulmonary Insufficiency, Stricture and Stenosis of the Esophagus, Hypothyroidism, Chronic Airway Obstruction, Hypertension, Dysphagia and Esophageal Reflux Disease. Review of the Annual MDS Assessment, dated 07/24/14, revealed the facility assessed Resident #20 to have a BIMS score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact, and to have no dental or oral issues or concerns. Further record review revealed no documented evidence Resident #20 had been seen by a dentist for routine dental care and services since admission to the facility. Interview with the Social Services Director (SSD)/Assistant Administrator (AA), on 06/03/15 at 3:01 PM, revealed the facility's Social Services (SS) Department was responsible for arranging residents' dental appointments. Continued interview revealed the facility's process was for the MDS staff or nursing staff to inform the SS Department when issues were identified with a resident in order for SS staff to contact the resident and/or family to determine if a dental appointment was requested. Further interview revealed the facility did not have a system in place to ensure residents were offered routine yearly dental services. Interview with the Director of Nursing (DON) on 06/03/15 at 12:47 PM, revealed the facility did not have a dentist on contract with the facility. Continued interview revealed the MDS assessment was performed by nursing staff and dental appointments were made as indicated, per	F 411			

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F 411	Continued From page 27 the MDS Assessments. Further interview revealed the facility did not have a system in place to ensure annual dental examinations were offered to each resident.	F 411			
F 441 SS=D	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 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. (c) Linens	F 441			

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F 441	<p>Continued From page 28</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure respiratory treatment equipment was stored in a sanitary manner to help prevent the development and transmission of infection for one (1) of three (3) unsampled residents(Unsampled Resident C).</p> <p>Observations during the initial tour and survey revealed Unsampled Resident C's mini-nebulizer (a handheld apparatus which delivers a moisturizing agent or medication to the lungs upon inhalation) masks and tubing were not labeled and stored according to facility policy.</p> <p>The findings include:</p> <p>Review of the facility's, "APIC (Association for Professionals in Infection Control and Epidemiology), Infection Control Toolkit Series, Infection Control Manual for Long-Term Care Facilities", undated, revealed the purpose of the Infection Control Manual was to protect residents, healthcare workers, visitors to the facility and the community from infection whenever possible. Continued review revealed under the section titled, "General Infection Control Nursing Policies", the Policy noted all nursing activities would be performed in a manner to</p>	F 441			

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F 441	<p>Continued From page 29</p> <p>minimize the potential for infection in residents, staff, and visitors. Further review revealed all medical supplies would be monitored for expiration date and would be discarded and replaced as indicated.</p> <p>Review of the facility's, "Hand Held Nebulizer Treatment Policy", revised 05/22/14, revealed after administering a nebulizer treatment, the nurse should disassemble and clean the nebulizer, mask and mouthpiece in hot water, air dry and "store in a sanitary manner" for repeat treatments. Further review revealed the hand held nebulizer treatment tubing was to be dated and changed out weekly by Central Supply staff.</p> <p>Review of the facility's policy titled, "Infection Control Bags for Oxygen Tubing and Nebulizer's", undated, revealed the "Central Supply Tech", was to change out the black infection control bags used for oxygen and nebulizer equipment once a month per protocol. Per the Policy, this was to be done the first week of every month, and should include the resident's first initial and last name along with the month and year it was given to the resident.</p> <p>Review of Unsampled Resident C revealed the facility admitted the resident on 12/31/14, with diagnoses which included a history of Pneumonia, Cerebrovascular Disease and Diabetes. Review of Unsampled Resident C's Physician's Orders revealed orders Albuterol Sulfate (an bronchodilator inhalation solution used to treat or prevent bronchospasm in people with reversible obstructive airway disease) mini-nebulizer treatments to be administered every six (6) hours as needed (PRN) for episodes of shortness of breath and wheezing. Review of</p>	F 441			

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F 441	<p>Continued From page 30</p> <p>Unsampled Resident C's June 2015, Medication Administration Record (MAR) revealed the last two (2) times the resident had received a mini-nebulizer treatment was on 06/01/15 at 11:38 PM, administered by Licensed Practical Nurse (LPN) #3 and on 06/04/15 at 10:08 AM, administered by LPN #5.</p> <p>Observation during the initial tour of the facility on 06/02/15 at 12:10 PM, revealed Unsampled Resident C's mini-nebulizer mask and tubing lying uncovered and with a dated noted as "04/15" (April 2015). Continued observation revealed on 06/03/15 at 8:30 AM, Unsampled Resident C's mini-nebulizer continued to be lying uncovered and dated "4/15". Further observation on 06/04/15 at 8:30 AM, revealed Unsampled Resident C's mini-nebulizer equipment was again not covered and dated "4/15".</p> <p>Interview with Central Supply Staff #2, on 06/04/15 at 3:50 PM, revealed it was her responsibility to change out the mini-nebulizer masks and tubing every week. She stated for Unsampled Resident C, she had been changing the mini-nebulizer masks and tubing out and placing the new mask and tubing in the second drawer of the resident's bedside nightstand. Per interview, she was not aware the staff nurses had been using any other mini-nebulizer mask or tubing in the resident's room. Central Supply Staff #2 revealed she would speak with the nursing staff and her supervisor regarding Unsampled Resident C's mini-nebulizer tubing, to ensure no further miscommunication occurred.</p> <p>Observation, on 06/04/15 at 3:55 PM, revealed a mini-nebulizer mask and tubing in a black bag in the second drawer of Unsampled Resident C's</p>	F 441			

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F 441	<p>Continued From page 31</p> <p>bedside nightstand which was labeled with the resident's name and dated 06/15.</p> <p>Interview, on 06/04/15 at 6:30 PM, with LPN #1 revealed after administering a mini-nebulizer treatment, she always rinsed the mask and tubing, let it air dry, then put it all back together, and placed the mask and tubing in the black infection control bag with the resident's name and date on it.</p> <p>Interview with LPN #3 on 06/04/15 at 6:45 PM, revealed she remembered giving Unsampled Resident C his/her mini-nebulizer treatment on 06/01/15, on night shift. Per interview, she used the mini-nebulizer mask and tubing which was lying on the table, next to the wall beside Unsampled Resident C's bed. LPN #3 stated she did not remember looking at the name or date on the black bag though. Further interview revealed she was not aware of any additional nebulizer supplies being stored in a drawer of Unsampled Resident C's bedside nightstand when she administered the nebulizer treatment on 06/01/15.</p> <p>Interview with LPN #5 on 06/04/15 at 6:55 PM, revealed she remembered giving Unsampled Resident C's mini-nebulizer treatment on 06/04/15, that morning after breakfast and had used the mini-nebulizer mask and tubing which was lying on the table beside the resident's bed. Per interview, LPN #5 did not recall looking at the name or date on the bag from which she obtained the mask and tubing however. Further interview revealed she was not aware of any additional nebulizer supplies being stored in a drawer of Unsampled Resident C's bedside nightstand.</p> <p>Interview with the Assistant Director of Nursing</p>	F 441			

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F 441	Continued From page 32 (ADON) on 06/04/15 at 4:30 PM, revealed it was her expectation all staff nurses inspect the respiratory equipment, including mini-nebulizer mask and tubing, used for residents to ensure the equipment was properly labeled, dated and stored in the black infection control bag. Per interview, proper labeling, dating and storing was expected to maintain a safe sanitary environment, and protect residents from infection.	F 441			
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's vehicle safety inspection documentation, it was determined the facility failed to ensure its vehicles were in compliance with State Law. Review of the facility's safety inspection documentation revealed the facility failed to ensure the resident transportation vehicle was inspected annually for safety, as per the Kentucky Administrative Regulations (KAR). The findings include: Review of 603 KAR 5:072, Mandatory annual bus inspection, revealed buses should undergo a	F 492			

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F 492	<p>Continued From page 33</p> <p>safety inspection at least once each year. Per the KAR, the annual inspection would be performed by the Division of Motor Vehicle Enforcement, and might take place at any of Kentucky's weigh stations, or arrangements could be made by contacting the Division of Motor Vehicle Enforcement.</p> <p>Review of the facility's vehicle safety inspection documentation titled, "Bus Pre-trip Inspection", revealed inspections of the vehicle were performed by facility staff prior to resident outings. However, further review revealed no documented evidence of an annual safety inspection conducted by the Department of Transportation, Division of Motor Vehicle Enforcement.</p> <p>Interview with the Maintenance Director, on 06/03/15 at 3:15 PM, revealed he was not aware the state regulations required the facility's resident transportation bus to have a yearly safety inspection, conducted by the Department of Transportation, Division of Motor Vehicle Enforcement.</p> <p>Interview with the Director of Nursing (DON), on 06/03/15 at 4:30 PM, revealed she was not aware the facility was required to have the resident transportation bus inspected by the Department of Transportation yearly.</p>	F 492			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1948, 1967, 1989</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type I fire resistive construction</p> <p>Smoke Compartment: Twenty-one (21)</p> <p>Fire Alarm: Complete Fire alarm A Building: Smoke detectors in resident rooms/ Heat detectors in corridors B Building: Smoke detectors in resident rooms/ Heat detectors in corridors C Building: Single station Smoke Detectors in resident rooms/ Smoke detectors in corridors.</p> <p>Sprinkler System: Complete sprinkler system (wet)</p> <p>Generator: A Building: Diesel installed 1989 C Building: Diesel installed 1989</p> <p>A Short Form Life Safety Code Survey was conducted on 04/15/14. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was one hundred and fifty-seven (157). The facility is licensed for one hundred and sixty-seven (167).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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