

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

PRINTED: 10/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2015
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NAME OF PROVIDER OR SUPPLIER TREYTON OAK TOWERS	STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 156 SS=E	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the</p>	F 156	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. F 156 Notice of Rights, Rules, Services, Charges.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Criteria 1: The posters which display/explain written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits have been obtained by the Administrator and were displayed prominently in the facility on 10/1/2015. A letter was provide to all residents and family members on 10/29/15 informing them of the posted information pertaining to their Medicare/Medicaid rights, and the availability in the facility of CMS informational posters about these rights.</p>	10/30/2015

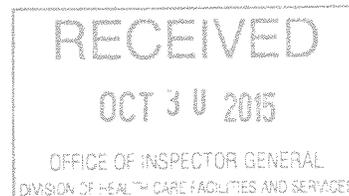
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Mike Wildeman</i>	TITLE <i>X ADMINISTRATOR</i>	(X6) DATE <i>X 10/30/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may 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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F 156	Continued From page 1 facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.	F 156	Criteria 2: The Administrator obtained the posters which display/explain written information about how to apply for and use Medicare/Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. He then verified that these posters were prominently displayed in the facility for easy access by residents and visitors. Criteria 3: On 10/16/15 the Administrator and Accounts Receivable Manger reviewed the regulatory requirements for prominently displaying written information in the facility, and providing residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. They then reviewed the information displayed and provided to residents and applicants for admission to verify compliance. Criteria 4: The QAPI indicator for monitoring of notice of rights , rules, services and charges will be utilized monthly X 2 months and then annually as per the established QAPI calendar under the supervision of the Administrator. This tool will be completed by the Administrator or Accounts Receivable Manager, and includes monitoring and observation of the posting of required information for residents/families pertaining to their Medicare and Medicaid rights and contact information for pertinent State Advocacy groups. See QAPI tool A-1.		



QAPI Indicator: F156

A-1

Posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

	October, 2015	November, 2015	October, 2016	October, 2017...
Posting meets Content criteria as defined by Regulation.				
Date of Verification:				
Verified by Whom:				
If posting does not meet criteria as defined by regulation (see above), deficient practice reported to Administrator by whom and on what date.				

Indicate compliance with "X," and non-compliance with "0."

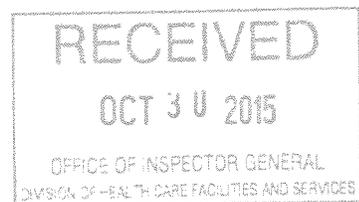
Date completed: _____

By Whom: _____

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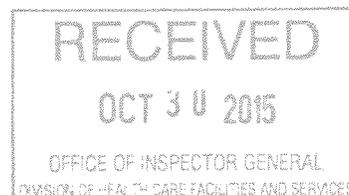
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F 156	<p>Continued From page 2</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to prominently display two (2) of two (2) signs in the facility with written information about how to apply for and use Medicare and Medicaid benefits.</p> <p>The findings include:</p> <p>Interview with the Administrator, on 10/01/15 at 2:20 PM, revealed the facility did not have a policy regarding the posting of information with the signs on how to apply and use Medicare or Medicaid benefits.</p> <p>Observation of the lobby during the entrance tour to the facility, on 09/29/15 at 8:45 AM, revealed no evidence of the required posted information on how to apply for and use Medicare and Medicaid.</p> <p>Observation of the nursing unit during tour, on 09/29/15 at 9:55 AM, revealed no evidence of the required posted information on how to apply for and use Medicare and Medicaid.</p> <p>Observation of the facility, on 09/30/15 at 10:15 AM, revealed no evidence of the required posted</p>	F 156		



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F 156	Continued From page 3 information on how to apply for and use Medicare and Medicaid. Interview with the Administrator, on 09/30/15 at 3:30 PM, revealed the Title 18 and Title 19 posters were received sometime ago. He stated the posters were currently at the frame shop. He stated the information was not posted anywhere else in the facility.	F 156		
F 323 SS=D	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 record review, it was determined the facility failed to ensure the resident's environment remained free of accident hazards for two (2) of nine (9) resident rooms and one (1) of one (1) therapy rooms, (Room 235, 236 and the therapy room). The facility failed to monitor the mixing valve and water temperatures. The water temperatures for rooms 235 and 236 were confirmed by the facility at 114 degrees Fahrenheit (F) and the therapy room was 118 degrees (F). The findings include: Interview with the Administrator, on 09/30/15 at 12:05 PM, revealed the facility did not have a	F 323	Accidents and Supervision. The facility must ensure that the resident environment remains as free of accident hazards as is possible. Criteria 1: An adjustment of the hot water mixing valves was completed by the Director of Plant Operations on 10/1/2015. Water temperatures were found to be within acceptable parameters on 10/1/15. Further inspections and repairs of the hot water mixing valves supplying water to rooms 235, 236 and the therapy rooms were completed 10/15/15 by the facility plumber under the supervision of the Director of Plant Operations. Criteria 2: Water temperatures were checked throughout the facility 3 X per day by maintenance and security staff between 10/1/15 and 10/15/15 to assure that the hot water temperatures were maintained within an acceptable range. Water temperatures were checked daily throughout the facility through 10/20/15 to assure that the repairs maintained hot water in an acceptable range.	10/20/2015



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F 323	<p>Continued From page 4</p> <p>policy and procedure for checking water temperatures in the resident rooms.</p> <p>Observations of water temperatures during the initial tour, on 09/30/15 at 8:50 AM to 9:37 AM, utilizing a calibrated thermometer at 32 degrees revealed water temperatures in room 235 registered at 114 degrees (F) and room 236 was also 114 degrees (F). The water temperature in the therapy room registered at 118 degrees (F).</p> <p>Interview and observation, on 09/30/15 from 9:40 AM to 9:55 AM, of the Plant Operations Director calibrating a food thermometer, revealed it recalibrated at 45 degrees (F). New thermometers were obtained and calibrated at 32 degrees (F).</p> <p>1. Observations during the environmental tour, on 09/30/15 at 10:12 AM, utilizing the facility's calibrated thermometer at 32 degrees (F) revealed Room 236 bathroom sink water temperature was confirmed at 114 degrees (F). Unsampled Resident B was seated in the wheelchair in the room. In addition, a sitter was present in the room.</p> <p>Review of the facility's list of Brief Interview of Mental Status (BIMS) for Unsampled Resident B revealed the facility had assessed the resident's BIMS as a three (3) meaning the resident was not interviewable. Interview with the Sitter/CNA at this time revealed she had no concerns with water temperature.</p> <p>2. Continued observations with the Plant Operations Director, on 09/30/15 at 10:15 AM, revealed Room 235 bathroom sink water temperature was confirmed at 114 degrees (F).</p>	F 323	<p>Criteria 3: Maintenance staff have received inservice education on 10/16/2015 by the Administrator on the need to monitor the water temperatures daily during the week, and to immediately address any water temperatures out of the acceptable range. Security Staff members were trained by the Director of Plant Operations on the need to monitor water temperatures each weekend day and to address any water temperatures out of the acceptable range on 10/02/2015. Daily, including weekends, water temperatures will be checked in either room 235 or 236. Additionally, one room each from the East and the West corridors will be checked daily by either maintenance or security staff members. This will be done on a rotating basis until all rooms have been checked, with the process of monitoring restarted and continuing.</p> <p>Criteria 4: The QAPI indicator for the monitoring of water temperatures will be utilized monthly X 2 months and then quarterly thereafter as per the established QAPI calendar under the supervision of the Administrator. The QAPI tool will be completed by the Administrator or the Director of Plant Operations and includes the review and monitoring of daily water temperature monitoring logs and monthly preventative maintenance to circulating pumps, temperature control valves, and the water heater/boiler with any issues identified timely. Any trends in water temperature</p>		

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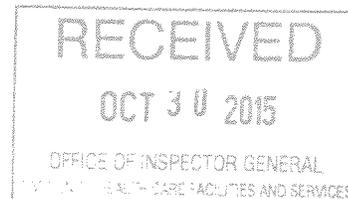
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F 323	<p>Continued From page 5</p> <p>Review of the facility's list of Brief Interview of Mental Status (BIMS) for Unsampled Resident C revealed the facility assessed the resident's BIMS as a twelve (12) meaning the resident was interviewable.</p> <p>3. Additional observations with the Plant Operations Director, on 09/30/15 at 10:19 AM, revealed the Therapy Department water temperature was confirmed at 118 degrees (F).</p> <p>Review of the facility's Water Temperature Log, dated 12/09/14 through 09/29/15, revealed a single water temperature was documented for the date and time specified. There was no room identified for each of the temperatures recorded. The temperature ranges were 106 to 108 degrees (F).</p> <p>Interview with the Plant Operations Director, on 09/30/15 at 9:55 AM, revealed water temperatures should not exceed 110 degrees (F). A resident could become scalded if the water was too hot. He stated if the water temperatures were to high this could be a problem. The water temperature checks in Rooms 235, 236 and the therapy room were not done. He stated there was no place to list a resident room number on the water temperature log. The Plant Operations Director further stated the mixing valve was not working correctly and the temperature registering on the mixing valve was at 109 degrees (F). He further stated the facility was not monitoring the mixing valve for temperatures.</p> <p>Interview with Maintenance #1, on 09/30/15 at</p>	F 323	variances will be reviewed with the outside contractor for necessary adjustments and/or repairs. See QAPI tool: A-2		

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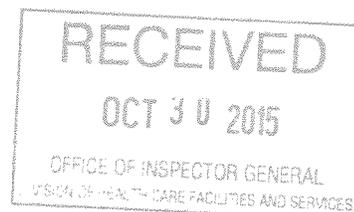
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F 323	Continued From page 6 11:15 AM, revealed the water temperature should not be in excess of 110 degrees (F), the water should be 105-108 degrees (F). If the water temperature was below 100 degrees (F), he would notify the Plant Operations Director. Maintenance #1 stated the water temperature monitoring was not conducted in Room 235 or 236. He also stated there was no place to list a resident room number on the water temperature log. Maintenance #1 stated the Plant Operations Director educated him on how to take water temperatures and he had never recalibrated his thermometer during the two (2) years working at this facility. Interview with Maintenance #2, on 09/30/15 at 11:37 AM, revealed the water temperature checks in Room 235 and 236 were not conducted. He stated there was no place to list a resident room number on the water temperature log. He stated they randomly check resident rooms, but they do not write them down. Interview with the Administrator, on 09/30/15 at 12:05 PM, revealed no reports of burns to residents and/or staff had been made. The Administrator stated there was no place to list a resident room number on the water temperature log. The Administrator concurred with the Plant Operations Director that the mixing valve was not monitored for temperatures.	F 323			
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12	F 497			



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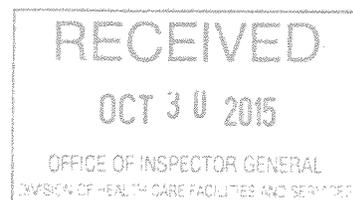
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F 497	<p>Continued From page 7</p> <p>months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's continued education records, it was determined the facility failed to provide evidence of the required twelve (12) hours per year of continued education for one (1) of five (5) Certified Nurse Assistants (CNA), CNA #3 completed nine (9) hours of the required twelve (12) hours of continuing education.</p> <p>The findings include:</p> <p>The facility did not provide a policy related to the CNA continuing education requirement.</p> <p>Review of the facility's CNA continuing education hours revealed CNA #3's date of hire was 02/11/14 and completed nine (9) of twelve (12) continued education hours.</p> <p>Interview with CNA #1, on 10/01/15 at 11:15 AM, revealed CNAs were required to complete twelve (12) hours of continuing education each year as</p>	F 497	<p>F 497 Nurse Aide Perform Review</p> <p>The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.</p> <p>Criteria 1: SRNA # 3 was provided the necessary inservice training hours to complete the 12 required as determined by the DON/ADON and completed on 10/01/15.</p> <p>Criteria 2: An audit was completed on 10/01/15 by the DON/ADON for all SRNA staff to determine that inservice hours are current/up-to-date and comply with the 12 hour annual requirement. One SRNA was identified with less than the required 12 hours and was provided the necessary training hours as determined by the DON/ADON and completed on 10/01/15.</p> <p>Criteria 3: The facility tracking process for CNA inservice education has been revised to provide quarterly reviews of hours for quick identification of SRNA staff who are behind in completion. This includes accessing the computer generated summary reports indicating the number of inservice education hours completed by each SRNA within each quarter. This will be monitored by the DON with the first quarterly review completed on 10/01/2015. Any SRNA found to not be in compliance will be removed from the</p>	10/02/15	



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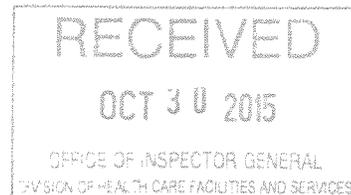
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F 497	Continued From page 8 part of their job. Interview with CNA #6, on 10/01/15 at 11:18 AM, revealed each CNA was required to complete twelve (12) continued education hours each year. She stated it was a requirement. Interview with the Director of Nursing, on 10/01/15 at 5:00 PM, revealed they had an education system in place; however, that was not tracking the continued educational hours. She stated the facility was in a transitional time and the tracking for completion of education was not kept in one central location. Interview with the Administrator, on 10/01/15 at 5:10 PM, revealed the continued education hours for the CNAs were kept in two (2) different systems. In addition, the responsibilities for the continued education had been under the direction of different staff. The process over the last year had not allowed tracking to ensure the CNAs completed the continued education, as required.	F 497	schedule until compliant. Criteria 4: The QAPI indicator for the monitoring of staff inservice education compliance will be utilize monthly X 2 months and then quarterly thereafter as per the established QAPI calendar. The QAPI tool audits the number of inservice education hours and topics completed by each SRNA. The QAPI audits will be completed by the DON, with results reported to the QAPI committee. See SRNA Education Audit Tool.		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514	F 514 Resident 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. Criteria 1: DON and LPN #1 completed a legal correction to the Medication Administration Records on 10/01/15, documenting the administration of the medications administered via the enteral	10/02/2015	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2015
NAME OF PROVIDER OR SUPPLIER TREYTON OAK TOWERS			STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203		
(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	Continued From page 9 and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to ensure clinical medical records were accurately documented for two (2) of twelve (12) sampled residents (Residents #2 and #5). Certified Medication Technician (CMT) #1 documented Resident #2 and #5's gastrostomy tube (G-Tube) medications as administered, in the computer; however, the medications were actually administered by a License Practical Nurse (LPN). The findings include: Review of the facility's policy regarding Guidelines for Charting and Documentation; Policy Interpretation and Implementation, not dated, revealed documentation of procedures/treatment should include the name and title of the individual(s) who provided the care. 1. Review of Resident #2's clinical record revealed the facility admitted the resident on 08/07/15 with diagnoses of Aftercare for Cervical Spine Fusion Surgery, Diabetes and Muscle Weakness with a G-Tube in place. Review of Resident #2's Admission Minimum Data Set (MDS) assessment, completed on 08/14/15, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of fifteen (15) and was interviewable.	F 514	tube route. Criteria 2: All residents receiving medications via the enteral route have the potential to be affected. Criteria 3: -All CMT staff have received inservice education on the documentation of medication administration, including but not limited to: the need to log in under the assigned password to document medications that have been administered so this will accurately reflect the staff performing the care, as completed on 10/01/15 by the DON/ADON. Criteria 4: The QAPI indicator for the monitoring of medication administration documentation will be utilized monthly X 2 months and then quarterly as per the established CQI calendar. This tool audits the medication administration record for all residents with g-tubes for accuracy. The audits will be completed by the DON with results reported to the QAPI committee. See G-Tube Medication Administration Audit Tool.		



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F 514	<p>Continued From page 10</p> <p>Review of the Medication Administration Record (MAR) for Resident #2, dated September 2015, revealed CMT #1 electronically initialed medications administered on 09/16/15, 09/17/15, 09/18/15, 09/21/15, 09/22/15, 09/23/15, 09/26/15, 09/27/15, and 09/28/15 during the 7:00 AM to 10:00 AM timeframe. The medications documented as give by the CMT were: Venlafaxine; Vitamin D; TheraNatal; Senna; ProMod; Reglan; Prilosec; Lisinopril; Metformin; Lipitor; Levemir; Lamictal; Isorbide; Glipizide; Furosemide; Flonase; Docusate; Ferrous Sulfate; Amoxicillin; Azelastine; Acetaminophen; Metoprolol; Mirapex and Zyprec. The medications were ordered for G-Tube administration.</p> <p>2. Review of Resident #5's clinical record revealed the facility admitted the resident on 08/18/15 with diagnoses of Aspiration Pneumonia, Abnormal Weight Loss and Muscle Weakness with a G-Tube in place.</p> <p>Review of Resident #5's Admission MDS assessment, completed on 08/25/15 revealed the facility assessed the resident with a BIMS score of ninety-nine (99), meaning the resident was severely cognitively impaired and not interviewable.</p> <p>Review of the MAR for Resident #5, dated September 2015, revealed CMT #1 electronically initialed medications administered on 09/16/15, 09/17/15, 09/18/15, 09/21/15, 09/22/15, 09/23/15, 09/26/15, 09/27/15, and 09/28/15 during the 7:00 AM to 10:00 AM timeframe. The medications documented as administered by the CMT was: Aspirin; Lepra; Norvasc; Nystatin; Lisinopril. The medications were ordered for G-Tube</p>	F 514			

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F 514	<p>Continued From page 11 administration.</p> <p>Interview with CMT #1, on 10/01/15 at 12:50 PM, revealed she likely did not log out of the computer and the nurse did not log in. Therefore, the G-Tube medications for Resident #2 and Resident #5 were initialed in the computer as if she administered the medications when she had not. CMT #1 stated only nurses were supposed to administer GT medications.</p> <p>Interview with LPN #2, on 10/01/15 at 2:40 PM, revealed the nurses and CMT's should log on the computer when beginning a medication pass and should log off the computer when a medication pass had been completed. LPN #2 stated she had received only a brief orientation to the electronic system that the facility had recently switched over to, but she should have known to log in and out of the computer. She was uncertain how this happened.</p> <p>Telephone interview with LPN #3, on 10/01/15 at 2:50 PM, revealed she just walks up to the medication cart and takes over the computer. The CMT should have logged out by hitting the walk away key and she should have logged in. LPN #3 stated the staff needed to be more careful and not continue this. CMT's are not supposed to administer GT medications.</p> <p>Interview with the Director of Nursing (DON), on 10/01/15 at 3:30 PM, revealed the staff was briefly trained on how to log in and out of the computer on the new computer system. The DON stated she thought that was Basic 101.</p> <p>Interview with the Administrator, on 10/01/15 at 3:50 PM, revealed the staff was trained about (4)</p>	F 514			

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F 514	Continued From page 12 weeks ago on the electronic MAR's.	F 514			

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NAME OF PROVIDER OR SUPPLIER TREYTON OAK TOWERS			STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203		
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{F 000}	INITIAL COMMENTS Based upon the implementation of the acceptable POC, the facility was deemed to be in compliance, 10/30/15 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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

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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: 1983</p> <p>Survey under: 2000 existing</p> <p>Facility type: S/NF DP on the second floor of a Health Care facility.</p> <p>Type of structure: Eleven (11) stories, Type II protected construction.</p> <p>Smoke Compartment: Six (6) smoke compartments on the second floor skilled nursing unit.</p> <p>Fire Alarm: Complete fire alarm system with heat and smoke detectors.</p> <p>Sprinkler System: Complete, automatic wet sprinkler system, hydraulically designed.</p> <p>Generator: Type II, 275 KW generator, fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 09/29/15. The second floor Skilled Nursing facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from</p>	K 000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p>		

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

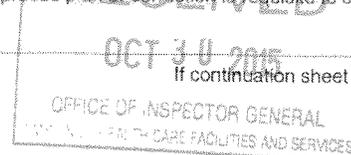
TITLE

(X6) DATE

X *Mike Wileman*

X ADMINISTRATOR X 10/30/15

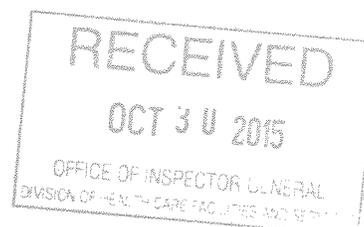
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K 000	Continued From page 1 Fire).	K 000			
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke</p>	K 018	<p>NFPA 101 Life Safety Code Standard: Fire Doors</p> <p>Criteria 1: The cross corridor doors identified in the survey at room 273 were repaired on 9/29/15 to eliminate the gap and are now smoke tight.</p> <p>Criteria 2: All doors protecting corridor openings have been inspected by the facility Director of Plant Operations to determine that there is only minimum clearance for operation.</p> <p>Criteria 3: The Director of Plan Operations and maintenance staff have received inservice education on the inspection of corridor doors for gaps and the need to correct/repair gaps to resist the passage of smoke by the Administrator on 10/16/2015.</p> <p>Criteria 4: The QAPI indicator (see QAPI tool LS-1) which includes the monitoring of cross corridor doors for gaps beyond minimum clearance shall be completed by the Administrator or the Director of Plant Operations monthly X 2 months and then quarterly thereafter as per the established QAPI calendar.</p>	10/17/2015	



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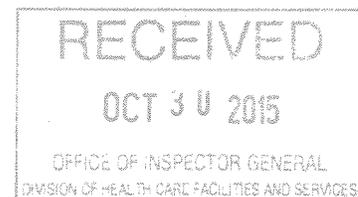
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K 018	<p>Continued From page 2</p> <p>compartments, residents, staff and visitors. The facility has sixty (60) certified beds and the census was forty-six (46) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/29/15 at 9:55 AM, with the Director of Plant Operations revealed the cross-corridor doors located in the East Hall between rooms 272 and 273 would not close completely when tested. There was a gap of approximately one (1) inch when the pair of doors stopped in the closed position. The doors should completely close and be smoke tight.</p> <p>Interview, on 09/29/15 at 9:57 AM, with the Director of Plant Operations revealed he was not aware of the cross-corridor doors not closing completely and acknowledged they were not capable of resisting the passage of smoke in the event of an emergency. He stated the door hardware required adjusting and stated the doors closed completely when the previous fire drill had been conducted.</p> <p>The census of forty-six (46) was verified by the Administrator on 09/29/15. The findings were acknowledged by the Administrator and verified by the Director of Plant Operations at the exit interview on 09/29/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation</p>	K 018			

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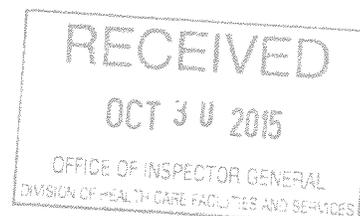
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K 018	Continued From page 3 and shall be without undercuts, louvers, or grilles. 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 018		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a clear egress path was maintained from the facility and doors equipped with fifteen (15) second delayed egress hardware were maintained in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility has sixty (60) certified beds and the census was forty-six (46) on the day of the	K 038	Life Safety Code Standard Egress Criteria 1: The wheelchairs observed in the back hallway during the annual survey have been relocated to an area designated for equipment storage on 09/30/2015 under the supervision of the Administrator. The exit door equipped with 15 second delayed egress hardware identified on survey which failed to release after 15 seconds was repaired by the Director of Plant Operations on 9/30/2015. Criteria 2: The Director of Plant Operations and Administrator completed an inspection of the Skilled unit on 10/1/2015 to determine that there was no other equipment observed stored in an egress area. The Director of Plant Operations completed an inspection of all exit doors equipped with 15 second delayed egress hardware to assure that all such doors released after 15 seconds on 10/1/2015.	10/26/2015



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K 038	Continued From page 4 survey. The findings include: 1. Observation, on 09/29/15 at 9:05 AM, with the Director of Plant Operations revealed the Therapy Corridor clear path for exiting was obstructed by three (3) wheelchairs stored on one side of the corridor, reducing the required width for exiting in the event of an emergency. Interview, on 09/29/15 at 9:07 AM, with the Director of Plant Operations revealed he was not aware of the three (3) wheelchairs stored in the Therapy Corridor and acknowledged they should be stored in the storage closet when not in use and created an impediment to exiting the facility in the event of an emergency. 2. Observation, on 09/29/15 at 9:32 AM, with the Director of Plant Operations revealed the door to exit through the Center Stairwell was equipped with fifteen (15) second delayed egress hardware, but was malfunctioning and did not open when tested. The door would open upon activation of the fire alarm system. Interview, on 09/29/15 at 9:34 AM, with the Director of Plant Operations revealed he was not aware the door to exit from the Center Stairwell, equipped with fifteen (15) second delayed egress hardware, was malfunctioning and stated the door hardware functioned properly and opened with fifteen (15) seconds when conducting his weekly door checks. The census of forty-six (46) was verified by the Administrator on 09/29/15. The findings were	K 038	Criteria 3: All facility staff received inservice education by the ADON or Shift Supervisor between 10/16/15 and 10/25/2015 on the need to store resident equipment in designated storage areas, and not in an egress area. The Director of Plant Operations and maintenance staff received inservice education by the Administrator on 10/16/2015 on the need to inspect facility exit doors equipped with 15 second delayed release hardware weekly for release after 15 seconds and to address and failures to release immediately. Criteria 4: Facility egress at Therapy, East, West and Center hallways will be monitored daily X 2 weeks by the Administrator, Monday thru Friday and by the Unit Supervisor on Saturday & Sunday. Monitoring will continue by the Administrator as follows: weekly X 4 weeks, monthly X 2 and quarterly thereafter. (See attached audit tool, K038, LS-2.) The QAPI indicator for monitoring the proper storage of resident equipment will be utilized by the Administrator X 2 months and quarterly thereafter as per the established QAPI calendar. (see QAPI Tool, LS-2.) Magnetic locks on stairwell doors will be monitored daily by maintenance technician under the supervision of the Director of Plant Operations for each of the 3 hallways, East, West and Center. (See Inspection of Mag-Locks audit tool.)	



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K 038	<p>Continued From page 5</p> <p>acknowledged by the Administrator and verified by the Director of Plant Operations at the exit interview on 09/29/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration.</p> <p>Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.</p> <p>Reference: S&C-12-21-LSC</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided</p>	K 038	<p>The QAPI indicator for monitoring exit doors equipped with 15 second delayed release hardware for release after 15 seconds will be completed by the Administrator or the Director of Plant Operations monthly X 2 months and quarterly thereafter as per the established QAPI calendar. See QAPI Tool LS-2.</p>		

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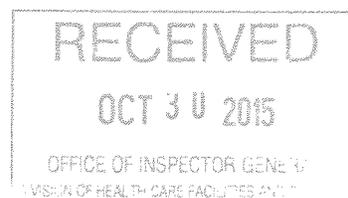
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185175	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2015
NAME OF PROVIDER OR SUPPLIER TREYTON OAK TOWERS			STREET ADDRESS, CITY, STATE, ZIP CODE 211 WEST OAK STREET LOUISVILLE, KY 40203	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 6 that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters	K 038		

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K 038	Continued From page 7 not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038			
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 056	NFPA 101 Life Safety Code Standard Automatic Sprinklers Criteria 1: A sprinkler head was installed in the closet in the DON office by the outside contractor on 10/13/15. Criteria 2: All office closets were inspected by the Director of Plant Operations to determine that there were no other closets that did not have a sprinkler head, as completed on 10/2/2015. Criteria 3: The maintenance staff have received inservice education by the Administrator on 10/16/2015 on the need to conduct an inspection of the office closets quarterly to determine that the sprinkler	10/17/2015	



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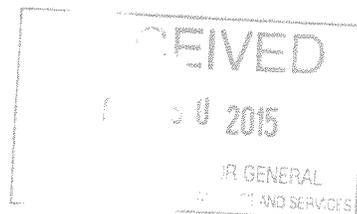
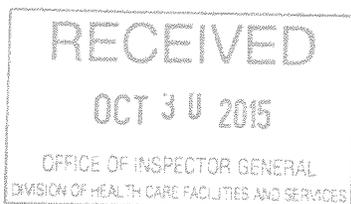
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K 056	<p>Continued From page 8</p> <p>determined the facility failed to ensure the building had a complete sprinkler system in accordance with the National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect residents, staff and visitors. The facility has sixty (60) certified beds and the census was forty-six (46) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/29/15 at 11:00 AM, with the Director of Plant Operations revealed the storage closet located within the Director of Nursing (DON) office, was not protected by automatic sprinkler coverage.</p> <p>Interview, on 09/29/15 at 11:02 AM, with the Director of Plant Operations revealed he was not aware the storage closet was not being protected by automatic sprinkler coverage. The storage closet was used to store narcotics, as informed by the DON and typically inaccessible to the Director of Plant Operations.</p> <p>The census of forty-six (46) was verified by the Administrator on 09/29/15. The findings were acknowledged by the Administrator and verified by the Director of Plant Operations at the exit interview on 09/29/15.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>9.7.1.1. Each automatic sprinkler system required</p>	K 056	<p>heads are present and free of obstruction. Criteria 4: All closets, resident rooms and common areas will be checked monthly by a maintenance technician for the presence of a sprinkler head under the supervision of the Director of Plant Operations. Any space found to be lacking a sprinkler head will be reported immediately to the Director of Plant Operations and the Administrator. The Director of Plant Operations will then contract with the facility's vendor for installation of sprinkler head at the earliest possible time. Once the installation of sprinkler head has occurred, verification of it's presence will be made by the Administrator and Director of Plant Operations. The QAPI indicator for the monitoring of the automatic sprinkler systems requirements will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Administrator. The QAPI tool will be completed by the Administrator or the Director of Plant Operations. See QAPI tool LS-3.</p>		

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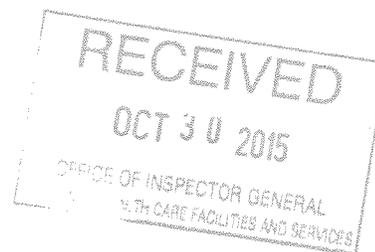
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K 056	Continued From page 9 by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Reference: NFPA 13 (1999 Edition) 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, approximately twenty (20) residents, staff, and visitors. The facility has sixty (60) certified beds and the census was forty-six (46) on the day of the survey. The findings include:	K 147	NFPA 101 Life Safety Code Standards Electrical Wiring and equipment is in accordance with NFPA 70. National Electrical Code 9.1.2 Criteria 1: The extension cord was removed immediately from room 278 by the Director of Plant Operations. Education was provided to the resident and family on the need to plug items directly into the outlets, by Administrator on 10/7/2015. Criteria 2: The Director of Plant Operations completed an inspection of all resident care and common areas with no other extension cords identified in use.	10/31/2015



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K 147	<p>Continued From page 10</p> <p>Observation, on 09/29/15 at 9:59 AM, with the Director of Plant Operations revealed a personal lamp was plugged into an extension cord located within Resident Room 278.</p> <p>Interview, on 09/29/15 at 10:01 AM, with the Director of Plant Operations revealed he was aware of extension cords being prohibited for use with personal lamps, but was not aware of the misuse of an extension cord within Resident Room 278.</p> <p>The census of forty-six (46) was verified by the Administrator on 09/29/15. The findings were acknowledged by the Administrator and verified by the Director of plant Operations at the exit interview on 09/29/15.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	<p>Criteria 3: The facility staff have received inservice education on the need to plug electrical equipment and appliances directly into the receptacles, with no use of extension cords in resident care or common areas as provided by the ADON and Shift Supervisors under the supervision of the Administrator, completed 10/17/2015 through 10/25/2015. A notice was also provided to all residents and families on 10/20/15 on the need to plug all electrical devices/equipment directly into outlets, and that no extension cords are to be utilized.</p> <p>Criteria 4: Monthly, under the supervision of the Administrator, each resident room and common area will be checked for Life Safety concerns, including the presence of extension cords, by members of the health care team including DON, ADON, SSD, MDS, Dietary, Activities, Medical Records The health care team members were trained to complete this Life Safety check on 10/30/15 by the Administrator.</p> <p>The results of the monthly checks will be incorporated into the QAPI indicator tool by the Administrator or the Director of Plant Operations monthly X 2 months and then quarterly thereafter as per the established QAPI calendar. See QAPI tool LS 4.</p>		



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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon the implementation of the acceptable POC, the facility was deemed to be in compliance, 10/31/15 as alleged.</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.