

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

PRINTED: 02/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/04/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 An Onsite Revisit to the 12/03/15 Recertification Survey was conducted on 02/04/16 and determined the facility was in compliance on 01/11/16 as per the acceptable PoC.	{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.

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185275	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/4/2016	Y3
NAME OF FACILITY SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix <u>F0279</u>	Correction	ID Prefix <u>F0282</u>	Correction	ID Prefix <u>F0323</u>	Correction
Reg. # <u>483.20(d), 483.20(k)(1)</u>	Completed	Reg. # <u>483.20(k)(3)(ii)</u>	Completed	Reg. # <u>483.25(h)</u>	Completed
LSC _____	01/11/2016	LSC _____	01/11/2016	LSC _____	01/11/2016
ID Prefix <u>F0328</u>	Correction	ID Prefix <u>F0332</u>	Correction	ID Prefix <u>F0490</u>	Correction
Reg. # <u>483.25(k)</u>	Completed	Reg. # <u>483.25(m)(1)</u>	Completed	Reg. # <u>483.75</u>	Completed
LSC _____	01/11/2016	LSC _____	01/11/2016	LSC _____	01/11/2016
ID Prefix <u>F0514</u>	Correction	ID Prefix <u>F0520</u>	Correction	ID Prefix _____	Correction
Reg. # <u>483.75(l)(1)</u>	Completed	Reg. # <u>483.75(o)(1)</u>	Completed	Reg. # _____	Completed
LSC _____	01/11/2016	LSC _____	01/11/2016	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) <u>DH</u>	DATE <u>02/09/16</u>	SIGNATURE OF SURVEYOR <u>Deborah C. Henderson, NCH, OR</u>	DATE <u>02/09/16</u>
---	----------------------------------	----------------------	--	----------------------

REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
---	------------------------	------	-------	------

FOLLOWUP TO SURVEY COMPLETED ON 12/3/2015	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
--	--

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 279	<p>Continued From page 1</p> <p>objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the Resident Assessment Instrument (RAI) Manual, it was determined the facility failed to ensure a care plan was developed to address the code status of one (1) of nineteen (19) sampled residents (Resident #11).</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 4:00 PM, revealed the facility did not have a specific policy related to the development, review, revision or implementation of resident care plans. The DON stated, "The care plan policies, in general, were determined by the guidelines of the Resident Assessment Instrument (RAI) manual."</p> <p>Review of the RAI Manual, Chapter Four, page 4-2, revealed "When implemented properly, the Care Area Assessment (CAA) process should</p>	F 279	<p>2. On 12/22/2015, the Social Service Director reviewed 100% current residents' charts and ensured appropriate care plans in place regarding resident code status. All concerns found were corrected at that time.</p> <p>3. The systemic changes put in place to prevent reoccurrence in the facility is Director of Nursing and/or Assistant Director of Nursing in-serviced all Licensed nurses in the policy and procedure of updating the resident plan of care 1/8/16 This training will also be included in new hire orientation done by ADON. Social Service Director did a chart audit of 100% of the residents and all issues were addressed. Also, the Director of Nursing/assistant Director of Nursing will be responsible for reviewing the 24 hour shift reports and the condition change forms at the morning meeting. During this review, the Director of Nursing/Assistant Director of Nursing will ensure the care plans are updated as needed and code status in place, by auditing 10% of resident's care plans</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	
(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 279	<p>Continued From page 2</p> <p>help staff: Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function; Identify areas of concern that may warrant interventions; Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences for interventions; and, Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management."</p> <p>Record review revealed the facility admitted Resident #11 on 02/28/14 with diagnoses which included Chronic Heart Failure, Acute to Chronic Kidney Disease and Asthma.</p> <p>Review of Resident #11's December 2015 Physician's Orders; the "Do Not Resuscitate (DNR) Residents' List,"; the December 2015 Medication Administration Record (MAR); and, the Treatment Administration Record (TAR), revealed the resident was a "Full Code". However, review of the "Kentucky Emergency Medical Services DNR Order" and the red, circular sticker on the medical chart spine and a DNR sticker, located in the front of the chart, indicated the resident had a "Do Not Resuscitate" ("DNR") status.</p> <p>Review of the Comprehensive Care Plan, dated 03/11/14, revealed there were no problems, goals, or interventions developed in the care plan to address Resident #11's code status.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/03/15 at 11:30 AM, revealed the code</p>	F 279	<p>weekly for four weeks, then monthly for three months and be brought to monthly Quality Assurance Performance Improvement (QAPI) meeting to determine if more auditing is needed.</p> <p>4. The Interdisciplinary team of Administrator, Director of Nursing, Social Service Director, Dietary Manager, Activity Director, MDS RN coordinator and assistant MDS coordinator will track and trend results and bring results to monthly QAPI meeting to be reviewed by the QAPI committee for needed changes.</p> <p>The audits will continue on a weekly basis until the time the QAPI committee determines they can be decreased in frequency.</p> <p>5. Completion Date: 1/11/2016</p>	1/11/16

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	
(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 279	Continued From page 3 status of the resident should have been placed on his/her Comprehensive Care Plan and the Certified Nurse Aide Care Plans, by the licensed nurse who admitted the resident. LPN #1 stated she was unsure why the resident did not have his/her code status addressed in the care plan. Further interview with LPN #1 revealed any licensed staff could have updated the care plan to include the resident's code status. Further interview with the DON, on 12/03/15 at 4:00 PM, revealed a DNR care plan was not developed for Resident #11. The DON stated, "We don't normally prepare a care plan for the code status."	F 279	<u>F282</u> 1. Residents # 1 and #14's Care plans and CNA Care plans were reviewed for accuracy by interdisciplinary team, which includes, Administrator, Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, and Activity Director on 12/22/2015. Therapy re-assessed Resident #1 and #14 with no new recommendations for transfer status at this time CNA #13 was educated by RN charge nurse on proper use of Hoyer lifts and following care plans after incident on 8/9/15. CNA #3 and CNA #12 were educated on proper use of Hoyer lifts on 11/20/15 by LPN charge nurse and Assistant Director of Nursing. Resident #13's Care Plan and CNA Care plan was reviewed for accuracy by interdisciplinary team on 12/22/2015. Resident #13's Oxygen "E" tank was changed to a full tank and nasal cannula was properly placed by Charge nurse at time of incident and resident monitored for adverse events with none noted.	1/11/16
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Hospital Emergency Room Report and Discharge Summary, and review of the Resident Assessment Instrument (RAI) Manual, it was determined the facility failed to ensure the services provided or arranged were provided by qualified persons and/or in accordance with each resident's written plan of care for three (3) of nineteen (19) sampled residents (Residents #1, Resident #14 and Resident #13). Resident #1 was care planned to be transferred	F 282		

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 282	<p>Continued From page 4</p> <p>by two (2) staff with the use of a "Hoyer" (brand of mechanical lift) lift (no weight bearing required). However, on 08/09/15, Resident #1 fell when one (1) staff Certified Nurse Aide (CNA) #13 transferred him/her with a sit to stand lift (weight bearing required) instead of with a Hoyer lift and two (2) staff, as care planned. In addition, CNA #13 used a Hoyer lift sling instead of the sit to stand sling with the transfer because he did not know the difference between the lift slings. Resident #1 sustained a hip fracture requiring surgery.</p> <p>Resident #14 was care planned to be transferred by two (2) staff with the use of a Hoyer lift. On 11/20/15, CNA #3 and CNA #12 transferred Resident #14 with the Hoyer lift, but failed to ensure the legs of the lift were spread out during the transfer; the lift tipped over. Resident #14 fell to the floor and sustained a laceration to the head that required seven (7) staples.</p> <p>The facility failed to ensure staff training was effective in ensuring the staff was qualified in operating the lifts. The facility provided verbal training during orientation and left it to other aides to demonstrate the use of the lift on the floor; however, there was no hands on training provided by Administrative staff and no follow up to ensure the training was effective.</p> <p>In addition, Resident #13 was ordered Oxygen (O2) at two (2) liters per minute (LPM) via a nasal cannula to keep oxygen saturations within normal limits (90-100 %). Two (2) observations revealed Resident #13 was sitting in his/her wheelchair with an "E" cylinder on the back of the wheelchair that was empty.</p>	F 282	<p>2. Residents who require the use of a mechanical lift were re-assessed by Therapy with only one new recommendation for transfer status at this time. Residents' who require the use of a mechanical lift, Care plans and CNA Care plans were reviewed on 12/23/2015 by interdisciplinary team to ensure that care plan interventions were appropriate. Observation of transfer audits will be done for all staff that use Hoyer lift completed by DON/ADON/Restorative RN/Charge Nurses by 1/8/2016 to ensure care plan interventions were followed in regards to appropriate number of assists with use of mechanical lifts. The Director of Nursing and Assistant Director of Nursing audited residents with Oxygen orders to ensure proper tubing placement and to ensure adequate oxygen is administered as ordered. No other concerns were identified. Respiratory in-service was held on 12/3/15 and on 12/8/15 by Recover Care, our oxygen company and all licensed nurses educated on proper use of E cylinders and</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 282	<p>Continued From page 5</p> <p>The findings include:</p> <p>Interview with Director of Nursing (DON) on 12/03/15 at 4:07 PM, revealed the facility did not have a specific Care Plan Policy in regards to an Interdisciplinary Care Plan or a Daily Nursing Assistant Care Plan. She stated the facility used the Resident Assessment Instrument (RAI) Manual for a Care Plan Policy.</p> <p>Review of the RAI User Manual Version 3.0 under section 4.7, "The RAI and Care Planning", revealed the comprehensive care plan was an interdisciplinary communication tool. It must include measurable interventions and time frames and must describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.</p> <p>1. Record review revealed the facility admitted Resident #1 on 01/22/13 with diagnoses which included Muscle Weakness, Lack of Coordination, Abnormal Posture, Contracture to Left Knee, and Acute Osteomyelitis to Left Foot and Ankle. Review of the Significant Change Minimum Data Set (MDS) assessment, dated 10/06/15, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of five (5), which indicated this resident was not interviewable. Further review of the MDS assessment revealed Resident #1 required two (2) staff for transfers.</p> <p>Review of Resident #1's Comprehensive Care Plan for "Alteration in Physical Mobility" and "At Risk for Falls"; and, Resident #1's Daily Nursing Assistant Care Plan, dated August 2015, revealed</p>	F 282	<p>following MD orders pertaining to Oxygen administration. In-service scheduled for 12/23/15 by RecoverCare to educate CNAs/CMTs on identifying low or empty E cylinders and reporting protocols.</p> <p>3. Formal in-service education was completed by Signature Loss Control Manager, for Licensed Staff and CNAs on 12/28/2015 on proper usage of Hoyer lifts including proper sling, how many assists should be used and following the care plan interventions for each resident's care needs in regards to assists with transfers. Charge Nurses will be responsible for monitoring Oxygen usage and tubing placement every shift.</p> <p>10% Mechanical lifts and 100% of residents who require oxygen will have audits done by Director of Nursing/Assistant Director of Nursing each shift during resident's wake hours. These audits include checking accuracy of Resident Care Plans and CNA Care plans, observation of transfers with residents to ensure appropriate</p>	1/14/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 282	<p>Continued From page 6</p> <p>staff was to transfer the resident with two (2) assist and the use of a Hoyer Lift.</p> <p>Review of Nursing Note, dated 08/09/15 at 11:15 AM, revealed Resident #1 was being transferred by CNA #13 for toileting in the shower room in a sit to stand lift. Resident #1 slipped out of the lift pad landing on the floor on his/her left side. The resident was crying with severe pain and had to be sent to the emergency room. Staff notified the Advanced Practice Registered Nurse (APRN) of the fall and an order was received to send the resident to the Emergency Room (ER) for evaluation and treatment. Emergency Medical Services (EMS) arrived and Resident #1 was transferred to the ER.</p> <p>Interview with CNA #13, on 12/02/15 at 2:08 PM, revealed he was by himself attempting to transfer Resident #1 to the commode in the shower room with a sit to stand lift when Resident #1 fell on 08/09/15. CNA #13 stated he was not sure if he had looked at the Daily Nursing Assistant Care Plan to see that Resident #1 was to have two (2) staff for transfers but he was told to use the sit to stand lift. He stated he had been trained to use the Daily Nursing Assistant Care Plan in orientation. CNA #13 further stated in hindsight he should have had another staff to assist him prior to attempting a sit to stand lift transfer for Resident #1. In addition, CNA #13 revealed he had used a Hoyer lift transfer sling on the Sit to Stand lift when he transferred Resident #1 because he was not aware there was a difference in the slings. He stated he did not recall ever receiving any hands on training on the mechanical lifts prior to Resident #1's fall.</p> <p>Review of Resident #1's Hospital Discharge</p>	F 282	<p>number of assists are used and appropriate implementation of care plan interventions, usage of mechanical lift is appropriate, ensuring adequate oxygen is being administered by following Physician order and Plan of Care with use of E Cylinders. The Administrator or DON will review these audits weekly X4 weeks then monthly X3 months. Care plans will be reviewed and updated as needed in the Clinical meeting by the Interdisciplinary Team. Findings will dictate if more audits are needed.</p> <p>4. Findings of the above stated audits will be discussed and reviewed in the QAPI meeting monthly for 3 months then quarterly for 3 quarters for further recommendations and follow-up as indicated.</p> <p>5. Completion Date 1/11/2016</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 282	<p>Continued From page 7</p> <p>Summary, dated 08/14/15, revealed the resident was admitted to the hospital on 08/09/15 and discharged on 08/14/15. Further review revealed Resident #1 had a Supracondylar Fracture of the left distal femur (lift hip fracture) and received a surgical procedure during the hospital stay of an "Open Reduction and Internal Fixation of the Femur".</p> <p>Interview with RN #5, on 12/03/15 at 11:22 AM, revealed she expected all nursing staff to utilize a minimum of at least two (2) staff for all mechanical lift transfers and it was also the facility's expectations for mechanical lift transfers to have at least two (2) staff present. She stated all nursing staff was responsible for knowing what was on the resident's care plan.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 12/02/15 at 12:20 PM, revealed she expected all CNAs to do what they were taught in orientation; which was to review and follow the Daily Nursing Assistant Care Plan during each shift they work as this explains to the CNA what type of care and assistance the residents require. She stated she was responsible for the CNA's training regarding mechanical lifts during the CNA's general orientation to the facility. She stated she verbally discusses the use of the mechanical lifts but there was no hands on training with lifts. The ADON stated the CNAs would see the lifts being used during their orientation working with another CNA on the floor.</p> <p>Interview with Director of Nursing (DON), on 12/02/15 at 1:50 PM, revealed she expected the Interdisciplinary Care Plan and the Daily Nursing Assistant Care Plan to be followed by the nursing staff as both of these care plans call for Resident</p>	F 282		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 282	<p>Continued From page 8</p> <p>#1 to have had two (2) staff for transfers. She stated she expected all staff to be sure at least two (2) staff was in place for all mechanical lift transfers and it was unacceptable for less than that to be in place for any mechanical lift transfers. She also stated Resident #1 potentially could have not been injured or injured as severely if two (2) staff were present at the time of Resident #1's fall instead of just one (1) staff. The DON stated the reason for Resident #1's care plan stating he/she was a Hoyer Lift Transfer and, not a sit to stand lift was due to the sit to stand lift was being used on a trial basis to see if this would be helpful for toileting Resident #1.</p> <p>2. Record review revealed the facility admitted Resident #14 on 12/21/11 with diagnoses which included End Stage Neurodegenerative Disease and Upper and Lower Extremity Contractures. Review of the Quarterly MDS assessment, dated 09/30/15, revealed the facility assessed Resident #14 as unable to complete a BIMS and determined the resident's cognition was severely impaired. Review of the resident's Activity of Daily Living (ADL) Assistance status revealed the resident required total dependence of two (2) plus persons for physical assist with transfers.</p> <p>Review of Resident #14's Comprehensive Care Plan for Self Care Deficit and Risks for Falls, dated 01/04/12, revealed an intervention to transfer with a "Hoyer" lift and two (2) person assist. It was also noted that staff was to utilize the large sling with the Hoyer lift and follow standards of care.</p> <p>Review of Nursing Note, dated 11/20/15 at 6:41 PM, revealed two (2) CNAs (CNA #3 and #12) were attempting to transfer Resident #14 using a</p>	F 282		1/11/16

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 282	<p>Continued From page 9</p> <p>Hoyer lift, when the lift tipped causing the resident to slide out of the lift pad onto the floor landing on his/her left hip, then hitting his/her head on the floor. The resident was sent to local Emergency Room for treatment of head laceration, which required seven (7) staples to close the wound.</p> <p>Review of the Emergency Room Report, dated 11/20/15, revealed the resident was dropped three (3) feet from a mechanical lift, which resulted in neck and head trauma along with a three (3) centimeter (cm) laceration to the left side of his/her head requiring seven (7) staples to close the wound. Further review of the Emergency Room Report revealed the resident required Dilaudid (pain medication) one (1) milligram (mg) for pain during the examination.</p> <p>Interview with CNA #3, on 12/03/15 at 3:15 PM; and, on 12/07/15 at 3:11 PM (Post Survey), and with CNA #12 on 12/02/15 at 3:17 PM revealed they went into Resident #14's room to transfer him/her into a reclined shower chair. CNA #12 was operating the lift, and when the lift raised the resident all the way up, the CNA started to swing the resident around, the lift started to tip over and the resident fell out of the sling onto the floor.</p> <p>During interview with CNA #12, she stated she was hired in June 2015 and she did not receive any formal mechanical lift training. She stated she was educated on what type of pad to use with what type of lift. She also received hands on training on the use of the sit to stand lift in August 2015, and after this incident in November 2015 on the Hoyer lift. She stated the ADON did the sit to stand training in August 2015 and the nurses on the floor did the Hoyer training in November 2015.</p>	F 282		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 282	<p>Continued From page 10</p> <p>CNA #3 stated she was hired on 09/16/15 (after Resident #1's fall and it was identified staff needed hands on training). She stated one of the other CNAs on the units showed her how to use the lift. CNA #3 stated the ADON only talked to her about each thing on the skills check list, she did not demonstrate anything or ask her to complete a return demonstration on any skill.</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 4:10 PM, revealed the Assistant Director of Nursing (ADON) is responsible for the skills check list for all staff during their orientation process. She stated after the orientation they are assigned to work with another employee for a least one (1) week of training and then someone from administration follows up with them after a few days of working on the floor to see if they have any questions. She stated after the initial skills check off no one monitors them to ensure they are using the equipment properly.</p> <p>3. Record review revealed the facility admitted Resident #13, on 03/17/15 with diagnoses which included Dysphagia, Cerebrovascular Accident, Hypertension, Chronic Kidney Disease (Stage III), and Anxiety. Review of the quarterly MDS assessment, dated 10/30/15, revealed the facility assessed Resident #13's cognition was severely impaired with a BIMS score of 03, indicating he/she was not interviewable.</p> <p>Review of the Comprehensive Care Plan for "Alteration in respiratory status related to recent Upper Respiratory Infection, wheezing, and moist lung sounds", dated 05/20/15 and last revised 11/2015, revealed to administer O2 at two (2) LPM via a nasal cannula.</p>	F 282		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 282	Continued From page 11 Observation during a breakfast meal, on 12/02/15 at 8:00 AM, revealed Resident #13 had an Oxygen "E" cylinder tank to the back of his/her wheelchair and the tank was empty. Additional observation, on 12/03/15 at 9:30 AM, revealed Resident #13 was sitting in the front lobby with an "E" tank on the back of the wheelchair and it was empty. In addition, the resident's nasal cannula was off to the side of his/her nose. Licensed Practical Nurse (LPN) #4 obtained Resident #13's O2 saturation at the time of the observation and it was eighty-one percent (81%). Interview (Post Survey) with CNA #16, on 12/10/15 at 9:00 AM, revealed when she got Resident #13 ready for breakfast on 12/02/15, she asked the Charge Nurse if she thought there was enough O2 in the "E" tank to last throughout the breakfast meal and she was told the tank had enough O2 in it to last. She stated on 12/03/15 when the tank was observed empty again at approximately 9:30 AM, she had gotten the resident up and as before, there was O2 in the tank. She stated if she or anyone else noticed a tank reading empty, they were supposed to notify the Charge Nurse for a new tank. Interviews on 12/03/15 with Certified Nursing Assistant (CNA) #14 at 10:45 AM, LPN #1 at 10:17 AM and LPN #4 at 11:03 AM revealed anyone could check the O2 tanks to ensure they were functioning properly. LPN #1 and LPN #4 stated if a resident was ordered O2 to be on continuous, then it should be on per the physician's order and per the care plan. Interview with Registered Nurse (RN) #3, on 12/03/15 at 10:23 AM, revealed the care plan	F 282		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	
(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 282	Continued From page 12 should be followed regarding O2 administration. Interview with the Director of Nursing (DON), on 12/03/15 at 1:30 PM, revealed she expected the care plan to be followed. Post survey interview, on 12/09/15 at 2:40 PM, revealed it was the licensed nurses responsibility to ensure the "E" tank was functioning properly when placed on the resident.	F 282		
F 323 SS=G	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, record review, facility policy review, review of a hospital Emergency Room Report and Discharge Summary, review of the Hoyer Lift Manual, Sit to Stand Manufacturer's Instruction, and Operator and Maintenance Manual for Patient Slings, review of the facility's Education Documentation, and review of a Material Safety Data Sheet and a hair spray can label, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible; and, failed to ensure adequate supervision was provided to prevent accidents for two (2) of nineteen (19) sampled residents (Residents #1 and #14). In addition, the facility failed to ensure	F 323	<u>F323</u> 1. Residents # 1 and #14's Care plans and CNA Care plans were reviewed for accuracy by interdisciplinary team on 12/22/2015. Therapy re-assessed Resident #1 and #14 with no new recommendations for transfer status at this time CNA #13 was educated by RN charge nurse on proper use of Hoyer lifts and following care plans after incident on 8/9/15. CNA #3 and CNA #12 were educated by Assistant Director of Nursing and LPN charge nurse on proper use of Hoyer lifts on 11/20/15. Aerosol cans and cleaning agents were immediately removed by the charge nurse from resident's rooms and given to respective Charge Nurses and families notified of findings and of facility protocols of not having these items in resident rooms by charge nurse. Social Service Director then mailed out letters to families by 1/8/2016. 2. Residents who require the use of a mechanical lift were re-assessed by Therapy with only	1/11/16

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 13</p> <p>flammable aerosols and cleaning products were not stored in resident rooms.</p> <p>Review of a list provided by the facility, revealed there were a total of fourteen (14) wandering residents in the facility.</p> <p>The facility care planned Resident #1 to be transferred by two (2) staff with the use of a "Hoyer" (brand) lift. The facility failed to assess the resident for the safe use of the sit to stand lift. On 08/09/15, Resident #1 fell when one (1) staff (Certified Nurse Aide (CNA) #13) transferred him/her with a sit to stand lift instead of with a Hoyer lift with two (2) staff, as care planned. In addition, CNA #13 used a Hoyer lift sling instead of the sit to stand sling with the transfer. Resident #1 sustained a hip fracture requiring surgery.</p> <p>The facility care planned Resident #14 for the use of a Hoyer lift with two (2) staff. On 11/20/15, Resident #14 fell approximately three (3) feet from the Hoyer Lift as staff failed to fully open the supporting legs of the device, causing it to tip over and the resident to fall out of the lift sling. staff. Resident #14 fell sustained a three (3) centimeter laceration to the back of the head that required seven (7) staples to close the wound.</p> <p>In addition, the facility failed to monitor staff training to ensure the staff was qualified in the use of the lifts. The facility provided verbal training during orientation and left it to the other aides to demonstrate the use of the lift on the floor. However, there was no hands on training provided by Administrative staff; and, no follow up to ensure the training was effective. The facility also failed to have the lifts checked to ensure</p>	F 323	<p>one new recommendation for transfer status at this time. Residents' who require the use of a mechanical lift, Care plans and CNA Care plans were reviewed on 12/23/2015 by interdisciplinary team to ensure that care plan interventions were appropriate. Observation of transfer audits will be completed by DON/ADON/Restorative RN/Charge Nurses by 1/8/2016 to ensure care plans were followed in regards to appropriate number of assists with use of mechanical lifts. Housekeeping Supervisor and housekeeping staff on 12/3/15 completed search of all residents rooms for these items and if found were removed from room and given to charge nurse.</p> <p>3. Formal in-service education will be completed by Signature loss control manager, for licensed staff and CNAs on 12/28/15 on proper use of Hoyer lifts including proper slings, how many assists should be used, and following the care plan interventions for each</p>	1/4/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 14 they were working appropriately.</p> <p>The findings include:</p> <p>Review of facility's policy 'Falls Management', dated 01/01/10, revealed the policy is to screen all residents to identify possible risk factors that may place a resident at risk for falls; to evaluate those risks; implement interventions to reduce these risks; and, monitor the interventions and modify when necessary. A Fall's Risk Screen is to be completed upon admission, readmission, quarterly and with a significant change. The facility is to complete an incident report for quality assurance reporting, document the incident in the nursing notes, complete a post fall's investigation tool, review the current plan of care; and, if necessary revise the interventions, initiate a fall's alert for any resident who falls in the facility; and, the fall's tracking is done individually, as well as facility wide to analyze trends for quality assurance reporting.</p> <p>Review of the facility's Hoyer lift Manual, dated 2011, revealed "Although the manufacturer recommends that two (2) assistants be used for all lifting preparation and transferring to and from procedures, the equipment will permit operation by one (1) assistant but the use of one (1) assistant is based on the evaluation of the health care professional for each individual case". Further review revealed the legs of the lift must be in the maximum open position and the shifter handle be locked in place for optimum stability and safety.</p> <p>Review of the manufacturer's "Sit to Stand Lift Instruction Guide", not dated, revealed individuals that use the sit to stand assist sling must be able</p>	F 323	<p>resident's care needs in regards to assists with transfers.</p> <p>Use of aerosol cans and cleaning agents will be discussed with residents and families upon admission to facility and Social Services Director will mail letters out to families regarding non-aerosol products and non-cleaning products only permitted in facility. Resident room searches will be done by Housekeeping Supervisor and housekeeping staff weekly x4 then monthly x3 months. Findings will be reported at monthly QAPI meeting. Findings will dictate the need for more audits or actions.</p> <p>4. Findings of the above stated audits will be discussed and reviewed in the QAPI (attended by Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Medical Director, Maintenance Director, Housekeeping Supervisor, Dietary manager, Activity Director, Sub-committees can be made up of any staff</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	
(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 323	<p>Continued From page 15</p> <p>to support the majority of their own weight, otherwise injury may occur.</p> <p>Review of the facility's Owner's Operator and Maintenance Manual for Patient Slings, not dated, revealed "to use only an approved manufacturer sling that is recommended by the individual's doctor, nurse or medical assistant for the comfort and safety of the individual being lifted."</p> <p>Interview with Director of Nursing (DON), on 12/02/15 at 1:50 PM; and, on 12/03/15 at 4:07 PM, revealed the facility did not have any specific policy in regards to assessing residents for assistive devices to include the use of mechanical lifts.</p> <p>1. Record review revealed the facility admitted Resident #1 on 01/22/13 with diagnoses of Muscle Weakness, Lack of Coordination, Abnormal Posture, Contracture to Left Knee, and Acute Osteomyelitis to Left Foot and Ankle.</p> <p>Review of Resident #1's Fall's Risk Screen, dated 06/08/15, revealed Resident #1 had an inability to walk or stand and required the assistance of two (2) staff with the use of a Hoyer Lift for transfers.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/08/15, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) Score of six (6), which indicated this resident was not interviewable. Further review of the MDS assessment revealed the resident required extensive assistance of two (2) staff for transfers. However, there was a note attached to the MDS that indicated the resident should have been coded as total dependence of two (2) staff for</p>	F 323	<p>member).meeting monthly for 3 months for further follow up, including more audits, more education or new interventions if concerns are identified.</p> <p>5. Completion date 01/11/2016</p>	4/11/16

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 16</p> <p>transfers because he/she was non weight bearing. Further record review revealed there was no documented evidence Resident #1 was assessed for the safe use of the Hoyer or Sit to Stand lift.</p> <p>Review of Resident #1's Comprehensive Care Plan for "Alteration in Physical Mobility", and "Risk for Falls", dated 02/04/13 and last revised 10/10/15, revealed to transfer with two (2) assist and the use of a Hoyer Lift.</p> <p>Review of Resident #1's August 2015 Daily Nursing Assistant Care Plan revealed Resident #1 was a two (2) assist for transfers with the use of a Hoyer Lift.</p> <p>Review of a Nursing Note, dated 08/09/15 at 11:15 AM, revealed Registered Nurse (RN) #7 documented Resident #1 was in a sit to stand lift (weight bearing) in the shower room with two (2) assist when the resident's knees began to give and his/her hands let go of the hand grips and the resident began to slip from the lift pad. Staff was unable to get the wheelchair under the resident in time and the resident slipped out of the lift pad landing on the floor on his/her left side but did not hit his/her head. Further review revealed Resident #1 was crying and in severe pain. Staff did not move the resident due to a possible fracture. The Emergency Medical Services (EMS) was called for transport. Staff notified the Advanced Practice Registered Nurse (APRN) of the fall and the clinical situation; an order was received to send the resident to the Emergency Room (ER) for evaluation and treatment. The Power of Attorney (POA) was notified and a report was called to the ER. EMS arrived and Resident #1 was transferred to a back board and</p>	F 323		2/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 17</p> <p>up on the stretcher, where the resident's right leg was noted to be several inches shorter than the left leg. Resident #1 continued to cry in severe pain.</p> <p>Review of Resident #1's Hospital Discharge Summary, dated 08/14/15, revealed the resident was admitted to the hospital on 08/09/15 and discharged on 08/14/15. Further review revealed Resident #1 was diagnosed with a Supracondylar Fracture of the left distal femur (left hip fracture) and received a surgical procedure during the hospital stay of an "Open Reduction and Internal Fixation of the Femur".</p> <p>Review of the Advanced Registered Nurse Practitioner's Note, dated 08/18/15, revealed on 08/14/15, Resident #1 returned from the hospital with orders for physical and occupational therapy to evaluate and treat for rehabilitation after the left femur fracture status post surgical repair.</p> <p>Interview with Certified Nursing Assistant (CNA) #13, on 12/02/15 at 2:08 PM, revealed he was by himself attempting to transfer Resident #1 to the commode in the shower room with a sit to stand lift when Resident #1 fell on 08/09/15. He stated he was unsure if he had looked at the Daily Nursing Assistant Care Plan to see that Resident #1 was to have two (2) staff for transfers, but he had been trained to use the Daily Nursing Assistant Care Plan in orientation. CNA #1 stated in hindsight he should have had another staff to assist him prior to attempting a sit to stand lift transfer for Resident #1. He stated he had used the wrong lift pad as he had used a lift pad that was to be used with the Hoyer lift and not with the sit to stand lift. He stated he did not know there was difference in the slings. CNA #13 stated he</p>	F 323		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 18</p> <p>did not recall receiving any hands on training related to the use of the lifts during orientation, but he had received verbal training related to the lifts.</p> <p>Interview (Post Survey) with the Mechanical Lift Manufacturer Representative, on 12/11/15 at 9:45 AM, revealed the Hoyer lift sling should not be used with the sit to stand lift because a Hoyer lift sling would not be secure and hold the resident appropriately in a standing position. She stated if a Hoyer lift sling was used with a sit to stand lift the risk for a resident to slip out of the sling and sustain an injury would be very probable.</p> <p>Interview with Registered Nurse (RN) #7, on 12/02/15 at 3:04 PM, revealed she was walking in to the shower room looking for a CNA to assist a resident on the unit when she observed Resident #1 falling to the floor out of the sit to stand lift. She stated CNA #13 was assisting Resident #1 with a transfer using the sit to stand lift by himself without any other staff present and it was not safe or appropriate for one (1) staff to ever use a mechanical lift by themselves for a resident transfer. She further stated any CNA who had been through CNA classes and training should have known that this was an unsafe practice and they should have known it was not safe to do a transfer with use of a mechanical lift alone. During further interview, RN #7 stated if there had been two (2) staff assisting Resident #1 there may not have been an injury or as significant of an injury. RN #7 stated a CNA was responsible for knowing what the Daily Nursing Assistant Care Plan said in regards to the resident's care needs. She stated her Nurse's Note dated 08/09/15 at 11:15 AM, was in error because she charted there were two (2) staff assisting Resident #1 at</p>	F 323		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 19</p> <p>the time of Resident #1's fall on 08/09/15. RN #7 stated CNA #13 was transferring Resident #1 with the sit to stand lift without the assistance of any other staff.</p> <p>Interview with the Director of Nursing (DON), on 12/02/15 at 1:50 PM, revealed she expected the Interdisciplinary Care Plan and the Daily Nursing Assistant Care Plan to be followed by the nursing staff as both of these care plans called for Resident #1 to have two (2) staff for transfers. She stated she expected all staff to be sure at least two (2) staff was in place for all mechanical lift transfers and it was unacceptable for less than that to be in place for any mechanical lift transfers. She also stated Resident #1 potentially could have not been injured or injured as severely if two (2) staff had been present at the time of Resident #1's fall instead of just one (1) staff. The DON stated the reason CNA #13 transferred Resident #1 with a sit to stand lift instead of the Hoyer lift was because the sit to stand lift was being used on a trial basis to see if this would be helpful for toileting Resident #1. When asked how the staff would have known to use the sit to stand lift without it being on the plan of care, the DON stated staff knew through "word of mouth" that they were using this on a trial basis. The DON was unable to recall how long the sit to stand lift had been used on a trial basis. She further stated the facility had no process or protocol in place to assess residents for the appropriate and safe use of mechanical lifts.</p> <p>2. Record review revealed Resident #14 was admitted to the facility on 12/21/11 with diagnoses which included End Stage Neurodegenerative Disease, and Upper and Lower Extremity Contractures. Review of a Quarterly MDS</p>	F 323		4/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 20</p> <p>Assessment, dated 09/30/15, revealed the facility assessed Resident #14's cognition as severely impaired. Further review of the resident's Activity of Daily Living (ADL) Assistance status revealed the resident required total dependence of two (2) plus persons for transfers. Further record review revealed there was no documented evidence an assistive device assessment was completed related to the use of the Hoyer Lift for transfers for Resident #14.</p> <p>Review of Resident #14's Quarterly Fall's Risk Screen, dated 09/30/15, revealed the resident was at risk due to problems with mobility, inability to stand or walk, requires assistance with transfers, poor positioning, leaning, slumping, and sliding. Further review revealed the interventions put in place related to the screen included a Pommel Cushion to his/her reclined geri-chair, Hoyer lift for transfers and when putting the resident to bed, and a mattress with upper and lower roll guards.</p> <p>Review of Resident #14's Comprehensive Care Plan for Self Care Deficit, dated 01/04/12, revealed an intervention for a Hoyer lift and two (2) assist for transfers. Further review revealed a Comprehensive Care Plan for Risk for Falls and Injury with an intervention to use Hoyer lift and two (2) assist for transfers; utilize the large sling with Hoyer lift; and, to follow standards of care.</p> <p>Review of Resident #14's Daily Nursing Assistant Care Plan, dated December 2015, revealed interventions to use a Hoyer (mechanical) lift for transfers with the assist of two (2) persons, staff to use caution when lifting the resident, and ensure proper placement of the resident's arms and legs while utilizing the mechanical lift siling</p>	F 323		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 21 that fits under the resident during transfer.</p> <p>Review of a Nursing Note, dated 11/20/15 at 6:41 PM, revealed when CNA #3 and CNA #12 were attempting to transfer Resident #14 using a Hoyer mechanical lift, the lift tipped causing the resident to slide out of the lift pad onto the floor landing on his/her left hip, then hitting his/her head on the floor. The resident was transferred to a local hospital Emergency Room for evaluation and treatment related to a fall with a head injury.</p> <p>Review of the Emergency Room Report, dated 11/20/15, revealed Resident #14 was dropped three (3) feet from a mechanical lift, which resulted in neck and head trauma along with a three (3) centimeter (cm) laceration to the left side of his/her head requiring seven (7) staples to close the wound. Further review of the Emergency Room Report revealed the resident required Dilaudid (pain medication) one (1) milligram (mg) for pain during the examination. The resident was returned back to the facility with orders for neuro-checks to be completed every two (2) hours for twenty-four (24) hours and wound care.</p> <p>Interview with CNA #12, on 12/03/15 at 3:17 PM, revealed she was transferring Resident #14 from a reclined geri-chair with the Hoyer (mechanical) lift and during the transfer when the resident was in mid air the lift tipped and slid over causing the resident to fall out of the sling. She stated when she started to work in June 2015 she did not receive any formal training in the mechanical lift. She stated she was educated on what type of pad to use with what type of lift and also received hands on training on the use of the sit to stand lift in August 2015. She stated she received hands</p>	F 323		1/11/16	

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

PRINTED: 12/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 22</p> <p>on training after this incident in November 2015 on the Hoyer lift. She stated the ADON did the training on the sit to stand lift in August 2015; and, the nurses on the floor did the training on the Hoyer lift in November 2015.</p> <p>Interview with CNA #3, on 12/03/15 at 3:15 PM, and on 12/07/15 at 3:11 PM (Post Survey), revealed the ADON completed her orientation and verbally told her about the mechanical lift and described the pads to use; but she did not do any type of demonstration using the lift. She stated when she started working on the units, one (1) of the other CNAs showed her how to use the lift. She stated the ADON only talked to her about each thing on the skills check list during the orientation process and did not demonstrate anything or ask her to complete a return demonstration on any skill. CNA #3 stated she did not know what caused the lift to tilt over. She stated she was at the side of the resident during the transfer and could not see the position of the lift from where she was standing. She stated after the incident, the DON had her and the other CNA demonstrate what they were doing at the time of the fall and CNA #12 did not have the base of the lift spread out completely. She stated after the demonstration, the DON explained the proper use of the lift and thought that could have caused the lift to tip over.</p> <p>Interview with RN #5, on 12/03/15 at 11:22 AM and 11:30 AM, revealed she expected all nursing staff to utilize a minimum of at least two (2) staff for all mechanical lift transfers and it was also the facility's expectations for mechanical lift transfers to have at least two (2) staff present. She stated all nursing staff was responsible for knowing what the residents' care plans state. She revealed one</p>	F 323		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	Continued From page 23 part of her nursing responsibilities was to assess the resident in the restorative program as well as help with the assessment of the assistive devices. She stated the facility did not have a formal process to complete the assessments; they do not involve physical therapy in the assessment process; and, she did not think the facility had a policy related to the assessment for the use of mechanical lifts of any kind. She further revealed each nurse could assess and determine what was best for the resident at the time to determine the type of lift to use, as well as document on the resident's plan of care. She stated if a resident was weight bearing at all, a sit to stand lift could be used, but if a resident was not weight bearing a Hoyer Lift should be used. She stated it was "not set in stone" what size sling the resident required and the tag on the sling only details the size of the sling, there was nothing documented about weight on the tag. RN #5 further stated the facility should have something documented to use as a guidance related to the appropriate size sling required for each resident but they do not. She revealed she was the RN who completed the post fall investigations and believed the cause for Resident #1's fall on 08/09/15 was due to only one (1) staff being present for the transfer with the use of the mechanical sit to stand lift. She stated during the investigation it was determined CNA #13 used the wrong lift sling, as he had used the lift sling that was to be used for the Hoyer Lift and not the sit to stand lift sling. Further interview revealed it was possible the use of the wrong sling also contributed to the fall. RN #5 stated on 08/09/15 after Resident #1's fall, she took pictures of which slings were to be used with which mechanical lifts and the pictures were attached to each Hoyer Lift and the sit to stand lift, that way staff knew which lift sling went with	F 323		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 24</p> <p>which mechanical lift. She revealed the facility had not completed the fall's investigation for Resident #14. RN #5 stated they had not decided on the root cause of the fall, but part of the investigation determined that the legs of the lift were not properly spread out and it tipped over. She stated if that happened during the transfer of the resident it could have caused the lift to tip over.</p> <p>Interview with ADON, on 12/02/15 at 12:20 PM and on 12/03/15 at 4:30 PM, revealed the facility did not have any type of assessment that was used for determining what type of mechanical lift was appropriate for what resident. She stated she expected all CNAs to do what they were taught in orientation; which was to review and follow the Daily Nursing Assistant Care Plan during each shift they work as this explained what type of care and assistance the residents required. She stated she was responsible for the CNA training regarding mechanical lifts during their general orientation to the facility. She stated there was nothing during that training that explained how to determine what lift was to be used for what resident. The ADON stated she verbally discussed the use of the mechanical lifts, but there was no hands on training with lifts until the CNAs do their orientation on the floor with other aides.</p> <p>Interview with the DON, on 12/03/15 at 4:10 PM, revealed the Assistant Director of Nursing (ADON) was responsible for the skills check list for all staff during their orientation process. She stated after orientation the CNAs were assigned to work with another employee for a least one (1) week of training and then Administration followed up with them after a few days of working on the</p>	F 323		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 25</p> <p>floor to see if they had any questions. She revealed after the initial skills check off no one monitored them to ensure they were using the equipment properly. She stated she reviewed Resident #14's incident report and had both the CNAs (CNA #3 and CNA #12) re-enact the exact thing they did during the transfer and noticed CNA #12 did not open the Hoyer lift legs during the transfer demonstration. She stated she explained to both staff members that they have to open the base of the lift legs wide prior to transfer to prevent the lift from tipping over. The DON stated after Resident #1's fall in August 2015 all staff was provided a demonstration of the use of the lifts and were required to perform a return demonstration, but there was no documentation of the training presented at that time.</p> <p>Prior to the exit conference, the DON provided documentation of the training. Review of the documentation revealed sign in sheets, dated 08/09/15 and 08/10/15 that documented staff were educated on the proper use of a Hoyer Lift and a Sit to Stand Lift with a demonstration also provided along with a return demonstration by staff; however, interview with RN #9, on 12/11/15 at 2:51 PM, revealed she provided some of the facility's lift training on 08/09/15 and 08/10/15 in regards to the proper use of a Hoyer lift and the proper use of a sit to stand lift. She stated this training covered how to properly use the Hoyer and sit to stand lifts, what lift slings go with what lift, how to place a sling on someone, how to hook a sling to the lift and that two (2) staff have to be present anytime a lift is being used for a resident. RN #9 stated that not all of the staff performed a return demonstration to show that they knew how to correctly use the lift. She stated, staff that felt like they already knew how to use the lifts did not</p>	F 323		1/11/16	

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

PRINTED: 12/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	<p>Continued From page 26</p> <p>have to do a return demonstration if they chose not to, as it was not made mandatory for all staff to do a return demonstration to be sure the staff in fact knew how to correctly utilize a mechanical lift.</p> <p>3. Interview with the DON, on 12/03/15 at 4:03 PM, revealed the facility has no specific policy on the storage of aerosol cans and cleaning products.</p> <p>During Initial Tour on 12/01/15 at 9:37 AM and further observation at 3:25 PM, revealed an aerosol can of Aqua Net hair spray, more than half full, on a counter in the room of Unsampled Resident D.</p> <p>Review of the Aqua Net hair spray label revealed, " Danger-flammable, avoid heat, fire, flame or smoking while spraying and until hair is fully dry. Avoid spraying in eyes. Do not ingest. Keep out of reach of children, contents under pressure, do not puncture or incinerate, do not store at temperatures above 120 degrees Fahrenheit, use only as directed, intentional misuse by deliberately concentrating and inhaling contents can be harmful or fatal."</p> <p>During Initial Tour on 12/01/15 at 9:41 AM and further observation at 3:28 PM, revealed a full spray bottle of Lysol bathroom cleaner in Unsampled Resident E's bathroom, on the side of the tub.</p> <p>Review of the Material Safety Data Sheet for Lysol bathroom cleaner revealed, "health injuries are not known or expected under normal use and could be slightly irritating to the skin."</p>	F 323		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 323	Continued From page 27 Interview with Certified Medication Technician (CMT) #1, on 12/03/15 at 9:18 AM, revealed that there should be no aerosol cans or cleaning products in residents' rooms because they could be flammable and cause injury to the resident. Interview with Registered Nurse (RN) #3, on 12/03/15 at 9:30 AM, revealed there should be no aerosol cans of any kind in resident's rooms because they were flammable and no cleaning products should be in residents' bathrooms because they could be harmful to the residents. Interview with the DON, on 12/03/15 at 4:03 PM, revealed aerosols and cleaners could be flammable and harmful to the residents and should not be kept in residents' rooms.	F 323			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure	F 328	<u>F 328</u> 1. Resident #13's Oxygen "E" tank was changed to a full tank and nasal cannula was properly placed by Charge nurse on 12/2/15 and 12/3/15. 2. Director of Nursing/ Assistant Director of Nursing audited on 12/22/2015 residents with Oxygen orders to ensure proper tubing placement and adequate oxygen is administered as ordered. No other concerns were identified. 3. Licensed staff, Certified Medicine Tech and Certified Nurses Aide will be in-serviced on the protocol of proper placement of Oxygen tubing and usage of oxygen "E" tanks by the oxygen company, RecoverCare on 12/23/2015. Charge nurses will be responsible for monitoring Oxygen usage and tubing placement every shift. The Director of	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 328	<p>Continued From page 28</p> <p>residents received proper care and treatment for oxygen (O2) administration for one (1) of nineteen (19) sampled residents (Resident #13).</p> <p>Observations on 12/02/15 at 8:00 AM; and, on 12/03/15 at 9:30 AM, revealed Resident #13 was in his/her wheelchair with an Oxygen "E" cylinder tank to the back of his/her wheelchair and the tank was on empty. On the second observation, on 12/03/15 at 9:30 AM, Resident #13's nasal cannula was off to the side of his/ her nose and the resident's O2 saturation was 81% (normal 90% to 100%).</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Oxygen Administration", not dated, revealed to turn on oxygen per MD (doctor) order and check the mask, tank, humidifying jar, etc. (when in use), to be sure they are in good working order and are securely fastened.</p> <p>Record review revealed the facility admitted Resident #13, on 03/17/15 with diagnoses which included Dysphagia, Cerebrovascular Accident, Hypertension, Chronic Kidney Disease (Stage III), and Anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/30/15, revealed the facility assessed Resident #13's cognition as severely impaired with a Brief Interview of Mental Status (BIMS) score of three (3) indicating he/she was not interviewable.</p> <p>Review of the Comprehensive Care Plan, dated 05/20/15, for "Alteration in Respiratory status related to recent Upper Respiratory Infection, wheezing, and moist lung sounds", last revised 11/2015, revealed to administer O2 at two (2)</p>	F 328	<p>Nursing/Assistant Director of Nursing will make 100% weekly inspections/audits for four weeks then monthly for three months to ensure "E" tanks are working and have tubing properly placed on the resident. Findings will dictate further action, including more audits and or education.</p> <p>4. Director of Nursing/Assistant Director of Nursing will track and trend the above audits and bring results to monthly QAPI meeting (attendees are Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, and Medical Director) for recommendations and follow-up.</p> <p>5. Completion date: 1/11/2016</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 328	<p>Continued From page 29</p> <p>liters per minute (LPM) via a nasal cannula.</p> <p>Review of the Physician's Order, dated 09/07/15, revealed an order for O2 at 2 LPM related to decreased O2 saturations.</p> <p>Review of O2 Saturation Monitoring Logs, dated 11/01/15 through 12/03/15, revealed O2 saturations were in the mid to upper nineties (90s) (Normal range: 90% to 100%).</p> <p>Observation during a breakfast meal, on 12/02/15 at 8:00 AM, revealed Resident #13 had an oxygen "E" cylinder tank to the back of his/her wheelchair and the tank was empty. Additional observation, on 12/03/15 at 9:30 AM, revealed Resident #13 was sitting in the front lobby with an "E" tank on the back of the wheelchair and it was empty. Observations revealed the resident's nasal cannula was off to the side of his/her nose. Licensed Practical Nurse (LPN) #1 checked the resident's O2 saturation on 12/03/15 and it was eighty-one percent (81%).</p> <p>Interview (post survey) with Certified Nurse Aide (CNA) #16, on 12/10/15 at 9:00 AM, revealed when she got Resident #13 ready for breakfast on 12/02/15, she asked the Charge Nurse if she thought there was enough O2 in the "E" tank to last throughout the breakfast meal and she was told the tank had enough O2 in it to last. She stated that on 12/03/15, when the tank was observed empty again at approximately 9:30 AM, she had gotten the resident up that morning and as before, there was O2 in the tank.</p> <p>Interview with Certified Nursing Assistant (CNA) #14, on 12/03/15 at 10:45 AM, revealed anyone could check the O2 tanks to ensure they were</p>	F 328		4/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 328	Continued From page 30 functioning properly. Interview with LPN #4, on 12/03/15 at 11:03 AM, revealed if a resident had an order and was care planned for O2, it should be on and functioning properly. Interview with LPN #1, on 12/03/15 at 10:17 AM, revealed she expected if a resident had an order for the O2 to be continuous, then it should be on per the Physician's Order and per the care plan. Additional interview revealed anyone (CNAs and Licensed Nurses) may check the "E" tanks to ensure they were functioning properly and had O2 in them. Interview with Registered Nurse (RN) #3, on 12/03/15 at 10:23 AM, revealed if a resident had an order and care plan for O2, then it would be expected for the resident to have it accessible and wearing it. Interview with the Director of Nursing (DON), on 12/03/15 at 1:30 PM, revealed she expected the care plan to be followed. Post survey interview, on 12/09/15 at 2:40 PM, revealed it was the licensed nurses responsibility to ensure the "E" tanks were functioning properly when placed on the resident.	F 328		4/11/16	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced	F 332	F332 1. The attending physician and family were notified by Director of Nursing, of the medication variances for resident A. The physician orders have been clarified and medications are being administered as ordered. Resident was observed throughout the day with no adverse reactions noted. The Certified Medication Aide (CMA) has received counseling by Director of Nursing on 12/1/15 on proper procedure to follow including immediate notification of the licensed nurse upon identifying any discrepancy on a medication administration record.		

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 332	<p>Continued From page 31</p> <p>by: Based on observation, interview, record review and review of the facility's policy and procedure and Specialized Long Term Care Nursing Drug Handbook, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent (%) or greater. Observation of a medication pass, revealed thirty-three (33) opportunities with two (2) errors which resulted in a six percent (6%) medication error rate.</p> <p>Unsampled Resident A was ordered Glipzide (Antidiabetic Agent) 10 milligrams (mgs) every day before meals and Metformin (Antidiabetic Agent) 1000 mg twice a day with meals; and, both medications were administered approximately two (2) hours after the meal.</p> <p>The findings include:</p> <p>1. Review of the facility's policy and procedure, titled "Preparation and General Guidelines", revised 12/18/12, revealed medications are administered within sixty (60) minutes of scheduled time, except before or after a meal orders, which are administered (based on mealtimes). Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration by the facility. Furthermore, special consideration for medications given that are required to be administered with regard to food intake shall be administered per manufacturer's guidelines.</p> <p>Review of the manufacturer's guidelines, retrieved from the facility's "Specialized Long Term Care Nursing Drug Handbook", not dated, revealed all oral doses of Glipzide and Metformin</p>	F 332	<p>2. Medication administration records have been reviewed by a licensed nurse for all current residents. Any discrepancies have been addressed as needed.</p> <p>3. The Consultant Pharmacist will monitor for accuracy of physician orders and scheduling of medication administration records during monthly chart reviews and observations. Any discrepancies will be corrected immediately. Each Licensed Nurse and Certified Medication Aide was educated on 12/23/15 and 12/24/15 regarding proper medication administration by Pharmacy RN. The protocol for completing the monthly process of checking physician orders with the medication records has been reviewed and reeducated all licensed nurses by Director of Nursing. The Director of Nursing or Consultant Pharmacist will conduct medication pass observations monthly on alternating halls so that all hallways are audited quarterly.</p>	4/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 332	<p>Continued From page 32</p> <p>should be administered with a meal. Twice daily dosing should be administered with the morning and evening meals.</p> <p>Record review revealed the facility admitted Unsampld Resident A, on 01/02/14, with diagnoses which included Type II Diabetes Mellitus. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 10/02/15, revealed the facility assessed Unsampld Resident A's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of nine (9) indicating the resident was capable of making daily decisions.</p> <p>Review of the Physician's Orders originally dated 11/25/14, revealed to administer Glipizide 10 mg, one (1) tablet every day and an order originally dated 01/02/14 to administer Metformin 1000 mg, one (1) tablet twice daily with food.</p> <p>Review of the November 2015 Medication Administration Record (MAR), revealed the resident was to be administered Glipizide 10 mg, and Metformin 1000 mg at 9:00 AM.</p> <p>Observation of a medication pass, on 12/01/15 at 10:00 AM, revealed Certified Medication Technician (CMT) #3 administered Unsampld Resident A's medications which included Glipizide 10 mg and Metformin 1000 mgs. Interview with CMT #3 revealed breakfast had been served to Unsampld Resident A at approximately 8:15 AM.</p> <p>Interview with CMT #3, on 10/02/15 at 11:10 AM, revealed the Glipizide and Metformin had always been given per the MAR at 9:00 AM and not with the resident's meals since she had been passing medications at the facility. She stated she knew</p>	F 332	<p>4. The Director of Nursing Services and Consultant Pharmacist will track and trend their reviews and report results to the QAPI (attendees are Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, and Medical Director) monthly for three months or until the committee determines compliance has been sustained.</p> <p>5. Completion date:1/11/2016</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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)	(X6) COMPLETION DATE	
F 332	<p>Continued From page 33</p> <p>the medications should have been given per pharmacy guidelines, but in order to be given per the guidelines, the times on the MAR for medication administration would have to be at meal time and not all medications should be scheduled at 9:00 AM.</p> <p>Interview with CMT #1, on 12/03/15 at 10:45 AM, revealed medications required to be given thirty (30) minutes before a meal or with a meal should be given that way and if for some reason they could not be given, then the Charge Nurse should be informed to notify the physician for guidance on when to give the medications.</p> <p>Interviews on 12/03/15 with Registered Nurse (RN) #3 at 10:27 AM, and RN #4 at 10:30 AM, revealed they expected a medication that was ordered to be administered with meals and/or thirty (30) minutes before a meal, to be given as ordered.</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 3:55 PM, revealed she expected the Physician's Orders to be followed for administering medications of any kind. She stated the MARs were sent from the pharmacy and the medication pass times were printed on them; however, they should have been modified to ensure the medications were given per pharmacy recommendations.</p> <p>Further interview (Post Survey) with the DON, on 12/10/15 at 8:58 AM, revealed the Licensed Nurses working the floor were responsible to ensure the new MARs were reconciled with the previous month's MARs to ensure the times were specific to the medication guidelines.</p>	F 332		1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 490 F 490 SS=G	Continued From page 34 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Administrator Job Description, it was determined the Administration of the facility failed to ensure that the facility's resources were utilized effectively and efficiently to provide the required care and services for two (2) of nineteen (19) sampled residents (Resident #1 and Resident #14). The Administrator failed to develop and implement policies and procedures to assess residents to ensure facility staff provided the necessary supervision and appropriate assistive lift devices to ensure safe transfers. In addition, the Administrator failed to ensure staff was fully trained and competent with the use of the lifts. These failures resulted in Resident #1 sustaining a hip fracture, requiring hospitalization and surgery, after the use of a sit to stand lift, with the wrong sling, and without the required assistance of two (2) staff members; and, Resident #14 sustaining a head laceration which required seven (7) staples, after staff failed to ensure the Hoyer lift was used correctly during the transfer. There was no documentation either resident was assessed for the use of the lifts. Refer to F282,	F 490 F 490	F490 1 The Signature Care Consultant educated the following management staff; Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, and MDS coordinator, on the Care plan policy and procedure, Mechanical Lift Policy and Procedure, Lift Competencies, Resident Rights Policy and Procedure, Quality of Care Delivery, Professional Standards, and QAPI on 12/28/2015. This training was completed face to face in order to facilitate discussion and Questions. 2. Residents who require the use of a mechanical lift were re-assessed by Therapy with only one new recommendation for transfer status at this time. Residents' who require the use of a mechanical lift, Care plans and CNA Care plans were reviewed on 12/23/2015 by interdisciplinary team to ensure that care plan interventions were	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 490	Continued From page 35 and F323. The findings include: Review of the Administrator's Job Description, revised 12/2011, revealed the Administrator was responsible to lead and direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives. Further review revealed under "Essential Duties & Responsibilities", the Administrator was responsible for Management duties to include the training and developing of staff; the Quality Assurance (QA) program; and to consult with department managers concerning the operation in their departments to assist in eliminating/correcting problem areas, and/or improvement of services. 1. The facility care planned Resident #1 for the use of a Hoyer lift with two (2) staff assist. However on 08/09/15, Certified Nurse Aide (CNA) #13 transferred Resident #1 with a sit to stand lift and without the assistance of another staff member. In addition, he used a Hoyer lift sling with the sit to stand lift. There was no evidence Resident #1 had been assessed for the use of the sit to stand lift or Hoyer lift and no evidence CNA #13 had received any hands on training on the use of the lifts. Resident #1 fell to the floor and sustained a hip fracture which required surgical repair. 2. The facility care planned Resident #14 to be transferred with a Hoyer lift by two (2) staff. On 11/20/15, CNA #3 and CNA #12 transferred	F 490	appropriate. Observation of transfer audits will be done for all staff that use Hoyer lift completed by DON/ADON/Restorative RN/Charge Nurses by 1/8/2016 to ensure care plan interventions were followed in regards to appropriate number of assists with use of mechanical lifts. The Director of Nursing and Assistant Director of Nursing audited residents with Oxygen orders to ensure proper tubing placement and to ensure adequate oxygen is administered as ordered. No other concerns were identified. Respiratory in-service was held on 12/3/15 and on 12/8/15 by Recover Care, our oxygen company and all licensed nurses educated on proper use of E cylinders and following MD orders pertaining to Oxygen administration. In-service scheduled for 12/23/15 by RecoverCare to educate CNAs/CMTs on identifying low or empty E cylinders and reporting protocols. 3. Formal in-service education was completed by Signature loss control manager, for	1/11/16	

F490

1/11/16

Licensed Staff and CNAs on 12/28/2015 on proper usage of Hoyer lifts including proper sling, how many assists should be used and following the care plan interventions for each resident's care needs in regards to assists with transfers. Charge Nurses will be responsible for monitoring Oxygen usage and tubing placement every shift. Audits are being done by Director of Nursing each shift during resident's wake hours. These audits include checking accuracy of Resident Care Plans and CNA Care plans, observation of transfers with residents to ensure appropriate number of assists are used and appropriate implementation of care plan interventions, usage of mechanical lift is appropriate, ensuring adequate oxygen is being administered by following Physician order and Plan of Care with use of E Cylinders. The Administrator or DON will review these audits weekly X4 weeks then monthly X3 months. Care plans will be reviewed and updated as needed in the

F490

1/11/16

Clinical meeting by the Interdisciplinary Team. The Director of Nursing/charge nurse will audit 10% of Residents who require mechanical lifts for transfers and 100% of Residents who require Oxygen Administration. Findings will determine if more audits are needed.

4. Administrative oversight of the facility will be completed by the Signature Care Consultant, VP of Operations, and/or Clinical Compliance Specialist weekly for 4 weeks, then monthly until resolved. The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing, safety and quality of care, as well as an effective plan to identify concerns and implement a plan of correction to involve all staff of the facility. Corporate Administrative oversight of the QAPI meeting will be completed by the Vice President of Operations, the Signature Care consultant and/or the

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 490	Continued From page 38 Resident #14 using a Hoyer lift and the lift tipped causing the resident to slide out of the lift pad onto the floor landing on his/her left hip, then hitting his/her head on the floor. Resident #14 sustained neck and head trauma along with a three (3) centimeter (cm) laceration to the left side of his/her head requiring seven (7) staples. It was determined the staff failed to ensure the lift legs were opened during the transfer which caused the lift to tip over. There was no evidence Resident #14 had been assessed for the use of the Hoyer lift and no evidence the facility had been monitoring staff to ensure the training with staff in August 2015 was effective. Interview with the Administrator, on 12/03/15 at 5:15 PM, revealed there had not been a formal training on use of the lifts since 2010 and it was expected that the CNAs learned this skill during their CNA training with another CNA on the floor. He stated he had nothing in place to ensure the staff were competent with the use of the lifts after they had completed their orientation. In addition, he stated there was no policy and procedures related to assessing for the use of the lift.	F 490	clinical compliance consultant weekly for 4 weeks then monthly for 3 months and then quarterly until compliance has been sustained. Findings of the above stated audits will be discussed and reviewed in the QAPI meeting monthly for 3 months for further recommendations and follow-up as indicated. Completion date: 1/11/2016	1/11/16	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	F514 1. Resident #11's care plan has been updated by the Interdisciplinary team on 12/3/2015 to ensure it reflects the resident's current code status. 2. On 12/2/2015, the Interdisciplinary team reviewed current residents' charts and ensured appropriate care plans in place regarding resident code status. All concerns found were corrected at that time. 3. The systemic changes put in place to prevent reoccurrence in the facility is Director of		

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 37</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to ensure the medical record was accurately maintained for one (1) of nineteen (19) sampled residents (Resident #11). The facility failed to accurately and consistently document the resident's code status in the medical record.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Designation of Resuscitation Status," dated 06/01/09, revealed a resident's resuscitation status will be documented in his/her medical record on a "Designation of Resuscitation Status Form". This form must be completed and placed in the chart and prior designations that such resident may have brought with him/her will not suffice. All designations will be reviewed periodically during the resident stay and may be amended by the resident or the resident's health care surrogate. Any amendment must be in writing and will be documented in the resident's chart. The attending physician will be notified in writing of the resident's designation and acknowledgement of this will be documented. A copy of the designation form will be provided to the physician. The policy also stated a "Do Not Resuscitate" (DNR) order from the physician was not required for a facility to honor a DNR designation, by a</p>	F 514	<p>Nursing and/or Assistant Director of Nursing in-serviced all Licensed nurses on 1/8/16 in the policy and procedure of updating the resident plan of care. This training will also be included in new hire orientation done by ADON. Also, the Director of Nursing/assistant Director of Nursing will be responsible for reviewing the 24 hour shift reports and the condition change forms at the morning meeting. During this review, the Director of Nursing/Assistant Director of Nursing will ensure the care plans are updated as needed and code status in place, by auditing 10% of resident's care plans weekly for four weeks, then monthly for three months or until compliance has been sustained.</p> <p>4. The Interdisciplinary team will track and trend results and review monthly at QAPI (attendees are Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, and Medical Director) meeting.</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 38</p> <p>resident. The procedure included to label the chart as a Full Code Status or a DNR, by affixing a sticker to the inside of the resident's chart; and, if the resident was a DNR, a red dot would be added to the spine of the chart. A facility "DNR Master List" was to be maintained at the front of the Medication Administration Record (MAR), the Treatment Administration Records (TAR), and at each nurse's station.</p> <p>Record review revealed the facility admitted Resident #11 on 02/28/14 with diagnoses which included Osteoarthritis, Acute and Chronic Renal Failure and Chronic Heart Failure.</p> <p>Review of Resident #11's October, November and December 2015 Physician's Orders; the December 2015 MAR and TAR; and, the "DNR Residents' List", last updated 11/11/15, revealed the resident was listed as a "Full Code."</p> <p>Review of Resident #11's "Kentucky Emergency Medical Services DNR Order" and the "Resuscitation Designation Form," revealed the Power of Attorney (POA) had signed the forms to request for the resident not to be resuscitated, on 05/27/15. The physician's part of the "Resuscitation Designation Form" had not been signed and the "Kentucky Emergency Medical Services DNR Order" had not been notarized. In addition, the spine of the chart had a red, circular sticker and a DNR sticker, inside the front of the chart, which indicated the resident had a DNR status.</p> <p>Review of the Comprehensive Care Plan revealed no documented evidence of the resident's code status on the comprehensive care plan, dated 03/11/14.</p>	F 514	<p>The audits will continue on a weekly basis until the time the QAPI committee determines they can be decreased in frequency.</p> <p>5. Completion Date: 1/11/2016</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(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 39	F 514			
F 520 SS=G	<p>Interview with Licensed Practical Nurse (LPN) #1, on 12/03/15 at 11:20 AM, revealed after looking at Resident #11's records, the resident was listed as a DNR on the chart back and inside cover and as a full code on the MARs, TARs, "DNR Residents List" and Physician's Orders. LPN #1 stated there was inconsistency within the chart and she would talk with the physician and clarify the order.</p> <p>Interview with the Director of Nursing (DON), on 12/03/15 at 4:00 PM, revealed in a code situation, the code status was to have been determined by the sticker on the chart ("DNR" for Resident #11) and on the DNR List (Full Code for Resident #11) which was kept at each nurse's station. The DON stated the status was to have been monitored monthly, during the monthly order checks. She stated the Physician's Orders should have been reviewed by comparing them with the previous months' MARs, TARs and previous Physician's Orders. The DON stated she was unsure why there were conflicting code status determinations in the chart.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment</p>	F 520	<p>F520</p> <p>1 The Signature Care Consultant educated the following management staff; Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, and MDS coordinator, on the Care plan policy and procedure, Mechanical Lift Policy and Procedure, Lift Competencies, Resident Rights Policy and Procedure, Quality of Care Delivery, Professional Standards, and QAPI on 12/28/2015. This training was completed face to face in order to facilitate discussion and Questions.</p> <p>2. Residents who require the use of a mechanical lift were re-assessed by Therapy with only one new recommendation for transfer status at this time. Residents' who require the use of a mechanical lift, Care plans and CNA Care plans were reviewed on 12/23/2015 by interdisciplinary team to ensure that care plan interventions were</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 40</p> <p>and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to have an effective Quality Assurance (QA) Committee that was structured to identify quality issues with the potential for negatively affecting resident care. The facility identified staff was not adequately trained to operate assistive transfer devices, resulting in falls for two (2) residents (Residents #1 and #14.) The QA committee failed to evaluate the root causes of the falls and implement an action plan to ensure resident safety during transfers, and to prevent further falls.</p> <p>Resident #1 fell from a sit-to-stand lift device on 08/09/15, while being transferred in the shower room by one staff member, Certified Nurse Aide (CNA) #13. CNA #13 used the Hoyer lift sling instead of the sit to stand lift sling to conduct the transfer. The resident sustained a hip fracture and had to be sent to the hospital for surgical</p>	F 520	<p>appropriate. Observation of transfer audits will be done for all staff that use Hoyer lift completed by DON/ADON/Restorative RN/Charge Nurses by 1/8/2016 to ensure care plan interventions were followed in regards to appropriate number of assists with use of mechanical lifts. The Director of Nursing and Assistant Director of Nursing audited residents with Oxygen orders to ensure proper tubing placement and to ensure adequate oxygen is administered as ordered. No other concerns were identified. Respiratory in-service was held on 12/3/15 and on 12/8/15 by Recover Care, our oxygen company and all licensed nurses educated on proper use of E cylinders and following MD orders pertaining to Oxygen administration. In-service scheduled for 12/23/15 by RecoverCare to educate CNAs/CMTs on identifying low or empty E cylinders and reporting protocols.</p> <p>3. Formal in-service education was completed by Signature loss control manager, for</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 41</p> <p>repair of the hip. There was no evidence the QA Committee reviewed the incident and ensured all staff was competent to safely operate the assistive devices and failed to implement a plan to monitor the safe use of the devices. Another resident (Resident #14) sustained a fall from a lift device on 11/20/15. The staff failed to ensure the lift legs were spread apart during the transfer and the lift tipped over. Resident #14 sustained a head laceration that required seven (7) staples. Refer to F282 and F323</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, titled "Quality Assessment and Assurance" dated 05/01/08, revealed the purpose of the QA Committee was "To establish guidelines regarding the quality assessment and assurance program within each facility". According to the policy, the QA Committee's action plan may be implemented in a variety of ways which may include but was not limited to:</p> <p>Staff training Procedure training Monitoring and feedback mechanisms Processes to revise plans that are not achieving or sustaining desired outcomes.</p> <p>Interview with the Administrator and Director of Nursing (DON), on 12/03/15 at 4:40 PM, revealed he facilitated the Quality Assurance (QA) meeting to ensure all problem areas were being monitored on an ongoing basis. The QA Committee consisted of the Administrator, Medical Director, DON, Assistant DON, Dietary Manager, Housekeeping/Laundry Supervisor, Activity Director, Social Services Director, and Admission</p>	F 520	<p>Licensed Staff and CNAs on 12/28/2015 on proper usage of Hoyer lifts including proper sling, how many assists should be used and following the care plan interventions for each resident's care needs in regards to assists with transfers. Charge Nurses will be responsible for monitoring Oxygen usage and tubing placement every shift. Audits are being done by Director of Nursing each shift during resident's wake hours. These audits include checking accuracy of Resident Care Plans and CNA Care plans, observation of transfers with residents to ensure appropriate number of assists are used and appropriate implementation of care plan interventions, usage of mechanical lift is appropriate, ensuring adequate oxygen is being administered by following Physician order and Plan of Care with use of E Cylinders. The Administrator or DON will review these audits weekly X4 weeks then monthly X3 months. Care plans will be reviewed and updated as needed in the Clinical meeting by the Interdisciplinary Team. The</p>	1/11/16	

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

PRINTED: 12/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 42</p> <p>Coordinator. The Administrator stated the Director of Nursing (DON) was responsible for tracking and trending areas which included, but was not limited to, Urinary Tract Infections, Falls, Pressure Ulcers, and any other areas of concern.</p> <p>Further interview with the Administrator and DON, on 12/03/15 at 5:15 PM, revealed there had not been a training on the use of the lifts since 2010 and it was expected the CNAs learned this skill during their CNA training. They stated they had nothing in place to ensure staff were competent with the use of the lifts after their orientation. They revealed there was an inservice of the CNAs, after the first fall on 08/09/15, to ensure all staff was aware of the need to utilize two (2) staff for all transfers with the lift devices, however, repeat demonstrations were not completed by all staff and no process was put in place to monitor to ensure the staff were now using the lifts correctly.</p>	F 520	<p>Director of Nursing/charge nurse will audit 10% of Residents who require mechanical lifts for transfers and 100% of Residents who require Oxygen Administration. Findings will determine if more audits/education is needed. A QAPI meeting will be held 12/28/15 with a Clinical Compliance Specialist and/or a Signature Care Consultant in attendance.</p> <p>4. Findings of the above stated audits will be discussed and reviewed in the QAPI (attendees are Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, Activity Director, Dietary Manager, and Medical Director) meeting monthly for 3 months or until compliance sustained with recommendations and follow-up as indicated.</p> <p>Completion date: 1/11/2016</p>	1/11/16	

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

PRINTED: 02/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 02/04/2016
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS An Onsite Revisit to the 12/03/15 Life Safety Code Survey was completed on 02/04/16 and determined the facility was in compliance on 01/11/16.	{K 000}			

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

TITLE

(X6) DATE

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 185275	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 2/4/2016	Y3
NAME OF FACILITY SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # <u>NFPA 101</u> LSC <u>K0144</u>	Correction Completed 01/11/2016	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) <u>DH</u>	DATE <u>02/10/16</u>	SIGNATURE OF SURVEYOR <u>Shelley Singleton LSC/10/Her...</u>	DATE <u>02/10/16</u>
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/3/2015

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO

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

PRINTED: 12/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1968 and 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III unprotected</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2009, with 16 smoke detectors and 129 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1978.</p> <p>GENERATOR: Type II generator installed in 2007. Fuel source is Diesel.</p> <p>A Standard Life Safety Code Survey was conducted on 12/03/15. The facility was found to not be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred ten (110) beds with a census of ninety (90) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000	<p>This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Signature Healthcare of Hartford Rehab and Wellness Center does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> 	1/11/16

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

TITLE

(X6) DATE

Jeffrey Barber

ADMINISTRATOR

1/7/16

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.

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

PRINTED: 12/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at a Scope and Severity of a "F".	K 000	<u>F144</u> 1. On 12/22/2015, Generator technician from generator company, did in-service with Maintenance Director, regarding monthly manual testing on generator.	1/11/16
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on generator testing record review and interview, it was determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility has the capacity for one hundred and ten (110) beds with a census of ninety (90) on the day of the survey. The findings include: Review of Maintenance Records revealed there was no documented evidence that monthly manual generator transfer switch testing was	K 144	2. On 12/22/2015, Regional plant operations manager educated maintenance director, on documentation of monthly testing of generator. 3. Maintenance Director will exercise the generator under load for 30 minutes each month starting on 12/22/2015 and document findings on generator log form each month. 4. Maintenance Director will document monthly manual test of generator exercise under load for 30 minutes on generator log form addressing any concerns identified at that time. The findings will be reported monthly in the Quality Assurance Performance Improvement meeting for 4 months for tracking and trending purposes with follow up action taken, including to determine if monitoring needs to continue. 5. Completion date 1/11/2016	

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

PRINTED: 12/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HARTFORD REHAB & WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	
(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 144	Continued From page 2 being completed. Interview with the Director of Maintenance, at the generator transfer switch panel, on 12/03/15 at 10:15 AM, revealed he was not aware he should be manually testing the generator transfer switch at the generator transfer switch panel on a monthly basis as required. This type of testing helps ensure the generator transfer switch is operating as intended. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 12/03/15. Reference: NFPA 110 1999 edition 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		1/11/16