

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OIOB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 100651A

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 185473		3. NAME AND ADDRESS OF FACILITY (L3) THOMSON-HOOD VETERANS CENTER		4. TYPE OF ACTION: <u>2</u> (L8)	
2. STATE VENDOR OR MEDICAID NO. (L2) 7100274320		(L4) 100 VETERANS DRIVE		1. Initial	
		(L5) WILMORE, KY		2. Recertification	
		(L6) 40390		3. Termination	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)		4. CHOW	
		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA		5. Validation	
6. DATE OF SURVEY 12/03/2015 (L34)		02 SNF/NF/Dual 06 PRPF 10 NF 14 CORF		6. Complaint	
8. ACCREDITATION STATUS: <u> </u> (L10)		03 SNF/NF/District 07 X-Ray 11 ICF/IID 15 ASC		7. On-Site Visit	
0 Unaccredited 1 TJC		04 SNF 08 OPT/SP 12 RHC 16 HOSPICE		8. Full Survey After Complaint	
2 AOA 3 Other				9. Other	
11. LTC PERIOD OF CERTIFICATION		10. THE FACILITY IS CERTIFIED AS:		FISCAL YEAR ENDING DATE: (L35)	
From (a):		A. In Compliance With		06/30	
To (b):		Program Requirements			
12. Total Facility Beds 285 (L18)		Compliance Based On:		And/Or Approved Waivers Of The Following Requirements:	
13. Total Certified Beds 285 (L17)		____ I. Acceptable POC		____ 2. Technical Personnel	
				____ 3. 24 Hour RN	
				____ 4. 7-Day RN (Rural SNF)	
				____ 5. Life Safety Code	
				____ 6. Scope of Services Limit	
				____ 7. Medical Director	
				____ 8. Patient Room Size	
				____ 9. Beds/Room	
		X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS
18 SNF	18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1): (L15)
	285				
(L37)	(L38)	(L39)	(L42)	(L43)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):					
A Recertification Survey was initiated on 12/01/15 and concluded on 12/03/15. Deficiencies were cited with the highest scope and severity of a "D". A Life Safety Code survey was initiated on 12/03/2015 and concluded on 12/03/2015. The facility was found not to be in compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The highest scope/severity is at a "D" level.					
17. SURVEYOR SIGNATURE			Date:	18. STATE SURVEY AGENCY APPROVAL	
			12/16/2015		
			(L19)	(L20)	

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572)	
X... 1. Facility is Eligible to Participate				2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)	
..... 2. Facility is not Eligible				3. Both of the Above :	
(L21)					
22. ORIGINAL DATE OF PARTICIPATION 02/28/2014 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS		26. TERMINATION ACTION: (L30)	
		A. Suspension of Admissions: (L44)		VOLUNTARY <u>00</u> INVOLUNTARY	
		B. Rescind Suspension Date: (L45)		01-Merger, Closure 05-Fail to Meet Health/Safety	
				02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement	
				03-Risk of Involuntary Termination OTHER	
				04-Other Reason for Withdrawal 07-Provider Status Change	
				00-Active	
28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. 15101 (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey

From: F1 To: F2
MM DD YY MM DD YY

Extended Survey

From: F3 To: F4
MM DD YY MM DD YY

Name of Facility THOMSON-HOOD VETERANS CENTER		Provider Number 185473	Fiscal Year Ending: F5 06 30 18 MM DD YY	
Street Address 100 VETERANS DRIVE	City WILMORE	County JESSAMINE	State KY	Zip Code 40390
Telephone Number: F6 859-858-2814		State/County Code: F7		State/Region Code: F8

A. F9

- 01 Skilled Nursing Facility (SNF) - Medicare Participation
- 02 Nursing Facility (NF) - Medicaid Participation
- 03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes No

If yes, indicate Hospital Provider Number: F11

Ownership: F12

For Profit

- 01 Individual
- 02 Partnership
- 03 Corporation

NonProfit

- 04 Church Related
- 05 Nonprofit Corporation
- 06 Other Nonprofit

Government

- 07 State
- 08 County
- 09 City
- 10 City/County
- 11 Hospital District
- 12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes No

Name of Multi-Facility Organization: F14

COMMONWEALTH OF KENTUCKY DEPARTMENT OF VETERANS AFFAIRS

Dedicated Special Care Units (show number of beds for all that apply)

- | | |
|---|---|
| F15 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AIDS | F16 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Alzheimer's Disease |
| F17 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dialysis | F18 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Disabled Children/Young Adults |
| F19 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Head Trauma | F20 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospice |
| F21 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Huntington's Disease | F22 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ventilator/Respiratory Care |
| F23 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other Specialized Rehabilitation | |

- | | | | |
|---|-----|---|--|
| Does the facility currently have an organized residents group? | F24 | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| Does the facility currently have an organized group of family members of residents? | F25 | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| Does the facility conduct experimental research? | F26 | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| Is the facility part of a continuing care retirement community (CCRC)? | F27 | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: F28 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hours waived per week: F29 _____
Waiver of 24 hr licensed nursing requirement.	Date: F30 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hours waived per week: F31 _____
	MM DD YY	

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes No

11/17 - 11/30/15

FACILITY STAFFING

	Tag Number	A			B				C				D			
		Services Provided			Full-Time Staff (hours)				Part-Time Staff (hours)				Contract (hours)			
		1	2	3												
Administration	F33				1	4	5	6								
Physician Services	F34	Y	N	N												
Medical Director	F35						4	4								
Other Physician	F36															
Physician Extender	F37	Y	N	N		1	2	0								
Nursing Services	F38	Y	N	N												
RN Director of Nurses	F39						5	1								
Nurses with Admin. Duties	F40				1	3	5	8								
Registered Nurses	F41				1	0	8	9		3	6					
Licensed Practical/ Licensed Vocational Nurses	F42				2	4	2	5		6	5		2	9	3	
Certified Nurse Aides	F43				5	3	3	9		1	4	7	1	8	1	1
Nurse Aides in Training	F44					5	6	1								
Medication Aides/Technicians	F45					6	6	5								
Pharmacists	F46	Y	N	N											2	6
Dietary Services	F47	Y	N	N												
Dietitian	F48					1	6	1								
Food Service Workers	F49				3	6	9	5							7	6
Therapeutic Services	F50															
Occupational Therapists	F51	Y	N	N											6	7
Occupational Therapy Assistants	F52												1	2	7	
Occupational Therapy Aides	F53												4	7		
Physical Therapists	F54	Y	N	N									8	0		
Physical Therapists Assistants	F55												2	9		
Physical Therapy Aides	F56												5	1		
Speech/Language Pathologist	F57	Y	N	N									9	7		
Therapeutic Recreation Specialist	F58	Y	N	N			3	4								
Qualified Activities Professional	F59	Y	N	N				0								
Other Activities Staff	F60	Y	N	N		5	7	6								
Qualified Social Workers	F61	Y	N	N		2	9	0								
Other Social Services	F62	N	N	N												
Dentists	F63	Y	N	N											8	
Podiatrists	F64	Y	N	N											0	
Mental Health Services	F65	Y	N	N											0	
Vocational Services	F66	N	N	N												
Clinical Laboratory Services	F67	Y	N	N												
Diagnostic X-ray Services	F68	Y	N	Y												
Administration & Storage of Blood	F69	N	N	N												
Housekeeping Services	F70	Y	N	N	3	6	9	6								
Other Security, Dental Aides, Sunshine Aide, Warehouse	F71				1	2	2	5								

error AL

Name of Person Completing Form	Amy Lambert	Time	13:10
Signature	<i>Amy Lambert</i>	Date	12/1/15

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No. <u>185473</u>	Medicare F75 9	Medicaid F76 84	Other F77 145	Total Residents F78 238
ADL	Independent	Assist of One or Two Staff		Dependent
Bathing	F79 7	F80 128		F81 103
Dressing	F82 37	F83 131		F84 70
Transferring	F85 59	F86 111		F87 68
Toilet Use	F88 47	F89 116		F90 75
Eating	F91 141	F92 70		F93 27

A. Bowel/Bladder Status

- F94 23 With indwelling or external catheter
- F95 Of the total number of residents with catheters, how many were present on admission 12?
- F96 141 Occasionally or frequently incontinent of bladder
- F97 131 Occasionally or frequently incontinent of bowel
- F98 0 On urinary toileting program
- F99 0 On bowel toileting program

B. Mobility

- F100 1 Bedfast all or most of time
- F101 179 In a chair all or most of time
- F102 29 Independently ambulatory
- F103 29 Ambulation with assistance or assistive device
- F104 0 Physically restrained
- F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0?
- F106 75 With contractures
- F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 55?

C. Mental Status

F108-114 - indicate the number of residents with:

- F108 0 Intellectual and/or developmental disability
- F109 133 Documented signs and symptoms of depression
- F110 121 Documented psychiatric diagnosis (exclude dementias and depression)
- F111 162 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease
- F112 92 Behavioral healthcare needs
- F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 73?
- F114 5 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 - indicate the number of residents with:

- F115 5 Pressure ulcers (exclude Stage 1)
- F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 2?
- F117 231 Receiving preventive skin care
- F118 2 Rashes

E. Special Care

F119-132 - indicate the number of residents receiving:

- F119 11 Hospice care
- F120 0 Radiation therapy
- F121 0 Chemotherapy
- F122 2 Dialysis
- F123 0 Intravenous therapy, IV nutrition, and/or blood transfusion
- F124 24 Respiratory treatment
- F125 0 Tracheostomy care
- F126 3 Ostomy care

- F127 0 Suctioning
- F128 65 Injections (exclude vitamin B12 injections)
- F129 3 Tube feedings
- F130 115 Mechanically altered diets including pureed and all chopped food (not only meat)
- F131 47 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD
- F132 21 Assistive devices while eating

F. Medications

F133-139 - indicate the number of residents receiving:

- F133 164 Any psychoactive medication
- F134 57 Antipsychotic medications
- F135 45 Anli anxiety medications
- F136 152 Antidepressant medications
- F137 5 Hypnotic medications
- F138 14 Antibiotics
- F139 135 On pain management program

G. Other

- F140 11 With unplanned significant weight loss/gain
- F141 0 Who do not communicate in the dominant language of the facility (include those who use American sign language)
- F142 2 Who use non-oral communication devices
- F143 141 With advance directives
- F144 183 Received influenza immunization
- F145 220 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
	RN ADON	12/4/15

TO BE COMPLETED BY SURVEY TEAM

- F146 Was ombudsman notified prior to survey? Yes No
- F147 Was ombudsman present during any portion of the survey? Yes No
- F148 Medication error rate 0 %