

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

PRINTED: 10/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/28/2015
NAME OF PROVIDER OR SUPPLIER OWENSBORO HEALTH MUHLENBERG COMMUNITY HOSPITAL LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 11/09/15, as alleged.	{F 000}			

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

TITLE

(X6) DATE

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185008	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/28/2015
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Name of Facility OWENSBORO HEALTH MUHLENBERG COMMUNITY HOSPITA	Street Address, City, State, Zip Code 440 HOPKINSVILLE ST. GREENVILLE, KY 42345
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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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0225</u> Reg. # <u>483.13(c)(1)(ii)-(iii), (c)(2) -</u> LSC _____	Correction Completed 10/13/2015	ID Prefix <u>F0279</u> Reg. # <u>483.20(d), 483.20(k)(1)</u> LSC _____	Correction Completed 10/13/2015	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 10/13/2015
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	Reviewed By <u>DH</u>	Date: <u>10/29/15</u>	Signature of Surveyor: <u>Deborah A. Gordon, RLS, OR</u>	Date: <u>10/29/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/25/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER OWENSBORO HEALTH MUHLENBERG COMMUNITY HOSPITAL LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported</p>	F 225	F225 - Deficiency 483.13(c)(1)(ii)-(iii), (c)(2) - (4). Please see attached Plan of Correction for Corrective Action, Identification of Other Residents, Measure to Ensure Will Not Recur, and Monitoring. Information detailed on pages 1 and 2.	10/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Becky Gagnier, LNHHA TITLE: Administrator (X6) DATE: 10/28/15

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

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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure an alleged violation was thoroughly investigated for one (1) resident, in the selected sample of ten (10) residents (Resident #10). On 09/16/15 at approximately 9:11 PM, Resident #10 was discovered missing. The resident left the facility through an exit door which did not have a functioning alarm, and was discovered near a loading dock behind the hospital. The facility failed to ensure a thorough investigation was completed related to the resident's elopement, as all staff members involved in the incident were not interviewed.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Abuse", with a revision date of 09/13, revealed the facility shall ensure that all alleged violations are reported immediately to the Administrator and to other officials in accordance with State law through established procedures. All alleged violations shall be thoroughly investigated and procedures shall be in place to prevent further abuse while the investigation is in progress.</p> <p>Review of the facility's policy entitled "Admission</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>Procedures", with an effective date of 09/13, revealed the facility will admit only those residents whose medical and nursing care needs can be met, with the objectives of the admission - to admit residents who can be adequately cared for by the facility.</p> <p>Closed record review revealed the facility admitted Resident #10, on 09/15/15 at 2:30 PM, with diagnoses to include Malaise and Fatigue, Non-Insulin Dependent Diabetes Mellitus, Prostate Cancer, Seasonal Allergies, Myocardial Infarction, Back Surgery with Placement of Rods and Cage, Delusional Disorder, Pain Psychotic Disorder, and Anxiety Disorder. Review of Resident #10's Admission Assessment, dated 09/15/15 at 2:30 PM, and review of the nursing notes at 4:46 PM, revealed the resident was alert and oriented X3 with a normal affect. Review of the five (5) day Minimum Data Set (MDS), dated 09/20/15, revealed the resident required supervision and limited assistance with activities of daily living (ADLs). There was no evidence a Brief Interview Mental Status (BIMs) was conducted on Resident #10. The resident was discharged home on 09/20/15.</p> <p>Record review revealed, on 09/15/15 at 6:53 PM, the resident stated he/she was going home, and would return tomorrow. He/she stated he/she could not spend another night at the facility and was going to call a lawyer. The resident then made a phone call to an unknown person.</p> <p>Review of the nursing notes, dated 09/15/15 at 7:00 PM, revealed Resident #10 wanted to leave the facility and go back home. The resident told the staff that the facility was not a prison, and he/she could leave if he/she wanted to leave.</p>	F 225			

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F 225	Continued From page 3 Review of the nursing notes, dated 09/16/15 at 4:39 PM, revealed Resident #10 wandered to his/her roommate's side of the room and went through some of his/her roommate's belongings. He/she was redirected by staff, and the resident turned off the sensor alarm and unplugged it. Continuation of the nursing notes revealed the resident was alert, confused, and wandered in to other residents' rooms. Review of the nursing notes, dated 09/16/15 at 6:00 PM and 6:45 PM, revealed Resident #10's niece was in the facility, and she approached staff with a concern that the resident was showing early signs of Dementia or Sundowners, with confusion and disorientation as a new behavior. Review of the nursing notes, dated 09/16/15 at 9:11 PM, revealed Resident #10 was discovered missing. Staff was called by Housekeeper #1 about a resident being near the loading dock behind the hospital. Review of the nursing notes revealed Resident #10 was very vocal and combative with facility staff, who called the physician and family, related to him/her leaving the facility through an exit door which did not have a functioning alarm. Review of the nursing notes, dated 09/17/15 at 6:31 AM, revealed Resident #10 was out of bed several times during the night, unable to hold his/her balance and unable to be redirected. He/she was easily agitated and refused personal care. Interview with Housekeeper #1 and Housekeeper #2, on 09/23/15 at 1:45 PM and 2:39 PM, respectively, revealed no one from management	F 225			

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F 225	Continued From page 4 had spoken with either of them about Resident #10 leaving the facility or being outside by the loading docks. Interview with Registered Nurse (RN) #5, on 09/24/15 at 9:42 AM, revealed she did not write a statement and did not have any other staff write statements related to Resident #10 eloping from the facility. Interview with the Administrator, on 09/24/15 at 5:40 PM, revealed she did not conduct a thorough investigation regarding Resident #10's elopement as there were no formal interviews from staff related to the incident.	F 225			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 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).	F 279	F279 - Deficiency 483.20(d), 483.20(k)(1). Please see attached Plan of Correction for Corrective Action, Identification of Other Residents, Measures to Ensure Will Not Recur, and Monitoring. Information detailed on pages 3 and 4.	10/14/15	

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F 279	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to develop a care plan that addressed the behavioral needs for one (1) resident upon admission to the facility, in the selected sample of ten (10) residents (Resident #10). Resident #10 was noted to have wandering tendencies and expressing a desire to go home prior to his/her elopement from the facility on 09/16/15.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Admitting a Resident to Long Term Care (LTC)", dated 09/13, revealed when a resident is admitted to the nursing unit, the LTC staff must record the following data in the nurse's notes or other appropriate places, as designated by the nursing policy, such as reason for admission, acute conditions, current vital signs, the condition of the resident upon admission (i.e., disoriented, weak, alert), completion of admission assessments, required forms and care planning, observe the general condition of the resident (i.e., rashes, etc.), as well as his or her reaction to the admission.</p> <p>Review of the facility's policy entitled "Assignment of Residents for Nursing Care", revised 09/13, revealed delivery of resident care shall be assigned to nursing personnel based on the resident's identified needs and the qualifications of the nursing staff. Charge Nurse assignments shall consist of supervision of the unit based on the task at hand and priority of resident needs.</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>Residents will have resident specific interventions on Meditech intervention screen to be completed as specified.</p> <p>Closed record review revealed the facility admitted Resident #10, on 09/15/15 at 2:30 PM, with diagnoses to include Malaise and Fatigue, Non-Insulin Dependent Diabetes Mellitus, Prostate Cancer, Seasonal Allergies, Myocardial Infarction, Back Surgery with Placement of Rods and Cage, Delusional Disorder, Pain Psychotic Disorder, and Anxiety Disorder. Review of Resident #10's Admission Assessment, dated 09/15/15 at 2:30 PM, and review of the nursing notes, dated 09/15/15 at 4:46 PM, revealed the resident was alert and oriented X3 with a normal affect. Review of the five (5) day Minimum Data Set (MDS), dated 09/20/15, revealed the resident required supervision and limited assistance with activities of daily living (ADLs). There was no evidence a Brief Interview Mental Status (BIMs) was conducted on Resident #10. The resident was discharged home on 09/20/15.</p> <p>Review of the LTC Pre-admission Form, undated, revealed Resident #10 did not have any behavior issues.</p> <p>Review of the nursing notes, dated 09/15/15, revealed Resident #10 was admitted to the facility at 2:30 PM. Record review revealed, on 09/15/15 at 6:53 PM, the resident stated he/she was going home, and would return tomorrow. Further review revealed he/she could not spend another night at the facility and was going to call a lawyer. The resident then made a phone call to an unknown person.</p> <p>Review of a Behavior Symptoms form and the</p>	F 279			

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F 279	<p>Continued From page 7</p> <p>nursing notes, dated 09/15/15 at 7:00 PM, revealed Resident #10 stated he/she was going home and became angry, stating the facility was not a prison and was calling family to come get him/her.</p> <p>Review of a Behavior Symptoms form, dated 09/16/15 at 2:30 PM and 10:00 PM, and 09/17/15 at 6:00 AM, revealed the resident had behaviors on and off during the shift. Further review revealed medication was given after non-drug approaches were attempted, with behaviors notated as "resident wandered outside, became combative upon attempt to return to the facility, and resident stated they were going to the graveyard to see his/her spouse. The resident was easily annoyed, fidgety/restless, and had trouble falling/staying asleep".</p> <p>Review of the nursing notes, dated 09/16/15 at 4:39 PM, revealed Resident #10 wandered to his/her roommate's side of the room and went through some of his/her roommate's belongings. He/she was redirected by staff, and the resident turned off his/her sensor alarm and unplugged it. Continuation of the nursing notes revealed the resident was alert, confused, and wandered in to other residents' rooms.</p> <p>Review of the nursing notes, dated 09/16/15 at 6:00 PM and 6:45 PM, revealed Resident #10's niece was in the facility, and she approached staff with a concern related to the resident showing early signs of Dementia or Sundowners, with confusion and disorientation as a new behavior.</p> <p>Review of the nursing notes, dated 09/17/15 at 6:31 AM, revealed Resident #10 was out of bed several times during the night, unable to hold</p>	F 279			

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F 279	<p>Continued From page 8</p> <p>his/her balance and unable to be redirected. He/she was easily agitated and refused personal care.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 09/24/15 at 1:58 PM, revealed he was informed by staff that Resident #10 was missing a few minutes before 8:00 PM on 09/16/15. Housekeeping had called around 8:00 PM and notified the staff that Resident #10 was outside by the loading dock. Resident #10 was combative and increasingly verbal. LPN #3 stated he did not know if the resident had behaviors prior to this incident. He stated he did not hear any alarms going off prior to the resident's elopement, and to his knowledge, it was working properly. LPN #3 did not have any knowledge of the alarms being checked daily by anyone. He revealed he did not check it, and was not aware of any log related to alarm checks. LPN #3 revealed he did not know anything about Resident #10's care plans, or if the resident had unplugged the alarms. He stated a care plan should be initiated if a resident is exit seeking, has behaviors, is confused or combative.</p> <p>Interview with Registered Nurse (RN) #5, on 09/24/15 at 9:42 AM, revealed, on 09/15/15 during shift report, a Certified Nurse Aide (CNA) reported Resident #10 had stated he/she was not going to stay at the facility. RN #5 further stated she went to the resident's room and he/she informed her that the facility was not a prison, and he/she could leave whenever he/she wanted to. The resident was agitated the remainder of the night, and she called a family member to tell him/her about the resident being upset and the desire to leave. RN #5 further revealed if Resident #10 were to unplug the alarms, it should</p>	F 279			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 9 be on his/her care plan. She stated she did not look to see if the resident was care planned for safety or behaviors, and staff who admitted the resident usually took care of it. Review of Resident #10's care plans revealed care plans for wandering, agitation, anxiousness, combativeness, and confusion were not initiated until 09/17/15, after the exit seeking behaviors, comment, and the elopement. Interview with the Administrator, on 09/24/15 at 5:40 PM, revealed a care plan should have been developed for Resident #10 related to exit seeking behaviors and comments; however, a care plan was not developed for wandering and behaviors until after the incident.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision for one (1) resident, in the selected sample of ten (10) residents (Resident #10), who voiced his/her intent to leave the facility prior to exiting the facility on 09/16/15, without staff's	F 323	F323 - Deficiency 483.25(h). Please see attached Plan of Correction for Corrective Action, Identification of Other Residents, Measures to Ensure Will Not Recur, and Monitoring. Detailed information on pages 5 and 6.	10/14/15

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F 323	<p>Continued From page 10 knowledge.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Incident and Accident Reporting", revised 09/13, revealed an incident is any event that disrupts or occurs outside of normal procedure. A detailed investigation will be completed as outlined in the policy "Abuse Investigations".</p> <p>Review of the facility's policy entitled "Admission Procedures", with an effective date of 09/13, revealed the facility will admit only those residents whose medical and nursing care needs can be met, with the objectives of the admission - to admit residents who can be adequately cared for by the facility.</p> <p>Review of facility documentation, dated 09/23/15, provided by the Administrator, revealed she was unable to provide policies to address supervision, monitoring the resident, behaviors, or security.</p> <p>Closed record review revealed the facility admitted Resident #10, on 09/15/15 at 2:30 PM, with diagnoses to include Malaise and Fatigue, Non-Insulin Dependent Diabetes Mellitus, Prostate Cancer, Seasonal Allergies, Myocardial Infarction, Back Surgery with Placement of Rods and Cage, Delusional Disorder, Pain Psychotic Disorder, and Anxiety Disorder. Review of Resident #10's Admission Assessment, dated 09/15/15, revealed the resident was alert and oriented X3 with a normal affect. Review of the five (5) day Minimum Data Set (MDS), dated 09/20/15, revealed the resident required supervision and limited assistance with activities of daily living (ADLs). There was no evidence a</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>Brief Interview Mental Status (BIMs) was conducted on Resident #10. The resident was discharged home on 09/20/15.</p> <p>Review of the Long Term Care (LTC) Pre-admission Form, undated, revealed Resident #10 did not have any behavior issues.</p> <p>Record review revealed, on 09/15/15 at 6:53 PM, the resident stated he/she was going home, and would return tomorrow. Further review revealed the resident stated he/she could not spend another night at the facility and was going to call a lawyer. Additional review revealed the resident then made a phone call to an unknown person.</p> <p>Review of a Behavior Symptoms form, dated 09/15/15 at 7:00 PM, revealed Resident #10 became angry, stating the facility was not a prison, and wanted to call his/her family. Additional review of the nursing notes, dated 09/15/15 at 7:00 PM, revealed Resident #10 wanted to leave the facility and go back home. The resident told the staff the facility was not a prison, and he/she could leave if he/she wanted to leave.</p> <p>Review of an assessment, dated 09/16/15 at 11:24 AM, completed by Social Worker #1, revealed Resident #10 was alert with confusion at times. Further review revealed he/she displayed confusion the previous evening, and during the interview, became confused and frustrated trying to recall what he/she wanted to say.</p> <p>Review of the nursing notes, dated 09/16/15 at 4:39 PM, revealed Resident #10 wandered to his/her roommate's side of the room and went through some of his/her roommate's belongings.</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>Further review revealed he/she was redirected by staff, and the resident turned off the sensor alarm and unplugged it. Continuation of the nursing notes revealed the resident was alert, confused, and wandered in to other residents' rooms.</p> <p>Review of the nursing notes, dated 09/16/15 at 6:00 PM and 6:45 PM, revealed Resident #10's niece was in the facility, and she approached staff with a concern about the resident showing early signs of Dementia or Sundowners, with confusion and disorientation as a new behavior.</p> <p>Review of the nursing notes, dated 09/16/15 at 9:11 PM, revealed Resident #10 was discovered missing. Staff was called by Housekeeper #1 about a resident being near the loading dock behind the hospital. Review of the nursing notes revealed Resident #10 was very vocal and combative with facility staff, who called the physician and family, related to him/her leaving the facility through an exit door, which did not have a functioning alarm.</p> <p>Review of a summary of the incident, provided by the facility, revealed Resident #10 was last seen in the facility, on 09/16/15 at 7:45 PM, and subsequently discovered to be missing. Housekeeping called the floor at approximately 8:10 PM and notified them of Resident #10's location, outside the facility by the loading docks. The alarm at the back door was determined not to be working appropriately at the time of the resident's exit.</p> <p>Interview with Certified Nurse Aide (CNA) #6, on 09/24/15 at 2:58 PM, revealed the last time she observed Resident #10 was between 7:30 PM and 8:00 PM in his/her room. The resident was</p>	F 323		

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F 323	<p>Continued From page 13</p> <p>getting up and down out of the chair, causing his/her personal alarm to go off. CNA #6 stated afterward, she gathered supplies, and vital signs were done. She stated she came out of a room with another CNA and they did not see Resident #10 in the hall. CNA #6 stated she opened the exit door and called down the stairwell, but no one answered. She stated the door alarm did not sound when she opened the door. CNA #6 revealed Resident #10 was located by Housekeeping, who revealed the resident was outside the facility.</p> <p>Interview with Housekeeper #1, on 09/23/15 at 1:45 PM, revealed he was emptying trash in a dumpster behind the hospital when he visualized an open back door, and Resident #10 walked out the door with his/her walker. Housekeeper #1 revealed Resident #10 stated his/her family called and he/she needed to leave. Housekeeper #1 stated he told the resident there was a busy street, and it was not safe. He called the LTC unit and discovered they were missing a resident, so he stayed with the resident until LTC staff arrived. Housekeeper #1 revealed Resident #10 was combative, trying to go to the road.</p> <p>Interview with Housekeeper #2, on 09/23/15 at 2:39 PM, revealed he was behind the hospital by the dumpster, and observed Resident #10 coming out the back door with a walker, wearing pajamas, and told the Housekeeper he/she was going to the graveyard because it was his/her spouse's birthday. Housekeeper #2 stated he explained to the resident about the busy road and they needed to go in and call his/her family; however, Resident #10 was not cooperative. Housekeeper #2 revealed he notified the LTC unit that Resident #10 was discovered outside the</p>	F 323			

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F 323	<p>Continued From page 14 facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 09/24/15 at 1:58 PM, revealed he was informed by staff that Resident #10 was missing a few minutes before 8:00 PM on 09/16/15. Housekeeping had called around 8:00 PM and notified the staff that Resident #10 was outside by the loading dock. Resident #10 was combative and increasingly verbal. LPN #3 stated he did not know if the resident had behaviors prior to this incident. He stated he did not hear any alarms going off prior to the resident's elopement, and to his knowledge, it was working properly. LPN #3 did not have any knowledge of the alarms being checked daily by anyone. He revealed he did not check it and was not aware of any log related to alarm checks. LPN #3 revealed he did not know anything about Resident #10's care plans, or if the resident had unplugged the alarms. He stated a care plan should be initiated if a resident is exit seeking, has behaviors, is confused or combative.</p> <p>Review of a Behavior Symptoms form, dated 09/16/15 at 2:30 PM and 10:00 PM, and 09/17/15 at 6:00 AM, revealed the resident had behaviors on and off during the shift. Medication was given after non-drug approaches were attempted, with behaviors notated as "resident wandered outside, became combative upon return to the facility, and resident stated he/she was going to the graveyard to see his/her spouse. The resident was easily annoyed, fidgety/restless, and had trouble falling/staying asleep".</p> <p>Review of Resident #10's record revealed care plans for wandering, agitation, anxiousness, combativeness, and confusion were not initiated</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>until 09/17/15, after the exit seeking behaviors, his/her comment, and the elopement on 09/16/15.</p> <p>Interview with Registered Nurse (RN) #5, on 09/24/15 at 9:42 AM, revealed, on 09/15/15 during shift report, a CNA reported Resident #10 had stated he/she was not going to stay at the facility. RN #5 further stated she went to the resident's room and he/she informed her that the facility was not a prison, and he/she could leave whenever he/she wanted to. The resident was agitated the remainder of the night, and she called a family member to tell him/her about the resident being upset and the desire to leave. RN #5 further revealed if Resident #10 were to unplug the alarms, it should be on his/her care plan. She stated she did not look to see if the resident was care planned for safety or behaviors, and staff who admitted the resident usually took care of it. Further interview with RN #5 revealed the alarms were supposed to be on all the doors; however, the alarms were not working on the door where the resident exited. The alarm was off and staff did not know he/she exited the facility. RN #5 further stated the alarms were supposed to be turned on to alert the staff.</p> <p>Review of documentation provided by the Administrator, dated 09/24/15, revealed a wandering or elopement assessment was not completed on Resident #10 upon admission or following the elopement incident.</p> <p>Interview with the Administrator, on 09/24/15 at 5:40 PM and 6:40 PM, revealed a care plan should have been developed for Resident #10 related to exit seeking behaviors and comments;</p>	F 323			

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F 323	Continued From page 16 however, a care plan was not developed for wandering and behaviors until after the incident. The Administrator revealed she knew the potential problem related to the door alarm system not functioning properly, and at this time, there was no log to record the functioning of the door alarm system.	F 323			

F 225 Investigate/Report

1. Corrective action accomplished for Resident # 10

- a. The LTC Administrator was able to verify that Resident # 10 was discharged from the Facility prior to the completion of a thorough investigation of the resident's elopement
- b. The LTC Administrator verified that this discharge was requested by the family (See attachments 1, 2 & 3)
- c. In order to correct the deficient practice of an incomplete investigation, the LTC Administrator reviewed and/or updated the following policies:
 - "Abuse" (attachment # 4) – policy was reviewed to assure that the procedure identifies all allegations shall be thoroughly investigated (section IX)
 - "Admission Procedures" (attachment #5) – policy was reviewed to assure that residents will be admitted as long as their nursing and medical needs can be met adequately by the Facility (section #5)
 - "Incident/Accident Reporting" (attachment #6) – policy was reviewed to assure that any incident is thoroughly investigated (section 3.2) and revised to assure that guidelines are established for the completion of the BIMS (section 3.2.1)
 - "Abuse Investigations" (attachment #7) – policy was reviewed to address who is designated to provide a complete and thorough investigation (section 3.2); define what the investigation shall include and who shall be interviewed (section 4); specific guidelines to follow when conducting interviews (section 5); and revised to assure that guidelines are established for the completion of the BIMS (section 4.5.1)

2. Identification of Other Residents in the Facility

- a. The Director of Nursing and/or designee completed an assessment on all residents in the Facility – "Risk of Elopement/Wandering Review" (attachment #8)
- b. The Director of Staff Development added a section to the "Bedrail/Fall Assessment" to enquire about a history of elopement or to indicate if family voices any concerns indicating the resident may have wandering tendencies or try to leave (Attachment #9); answer of "yes" requires interventions:
 - Notify administrator and/or Director of Nursing
 - Provide 15-30 minute checks with resident
 - When necessary provide individual sitter until appropriate arrangements can be made for safety of the resident

3. Measures in place to ensure deficient practice will not recur

- a. The LTC Administrator and Director of Nursing completely reviewed and/or updated the following policies:
 - "Abuse" (attachment # 4) – policy was reviewed to assure that the procedure identifies all allegations shall be thoroughly investigated (Section IX)
 - "Admission Procedures" (attachment #5) – policy was reviewed to assure that residents will be admitted as long as their nursing and medical needs can be met adequately by the Facility (statement #5)
 - "Incident/Accident Reporting" (attachment #6) – policy was reviewed to assure that any incident is thoroughly investigated (section 3.2) and revised to assure that guidelines are established for the completion of the BIMS (section 3.2.1)

- "Abuse Investigations" (attachment #7) – policy was reviewed to address who is designated to provide a complete and thorough investigation (section 3.2); define what the investigation shall include and who shall be interviewed (section 4); specific guidelines to follow when conducting interviews (section 5); and revised to assure that guidelines are established for the completion of the BIMS (section 4.5.1)
 - The Director of Nursing reviewed and adopted a tool from MED-Pass to use in assessing all residents in the Facility – "Risk of Elopement/Wandering Review" (attachment #8); (see instructions on "side one" for completion guidelines)
- c. The Director of Staff Development added a section to the "Bedrail/Fall Assessment" to enquire about a history of elopement or to indicate if family voices any concerns indicating the resident may have wandering tendencies or try to leave (attachment #9); answer of "yes" requires interventions:
- Notify administrator and/or Director of Nursing
 - Provide 15-30 minute checks with resident
 - When necessary provide individual sitter until appropriate arrangements can be made for safety of the resident
- d. The Director of Staff Development provided staff education to all Long Term Care staff including Administrative staff, RN, LPN, and CNA to review all measures in place to ensure this deficient practice does not recur (attachment #10 & 11)
- d.1. This education was provided face-to-face in an In-service setting
4. Monitoring actions to ensure that corrective actions are followed and the deficient practice does not recur
- a. The Director of Nursing or designee will complete a 100% audit of all new admissions through review of the "Admission to-do checklist" – this was reviewed and revised to include the "Risk of Elopement/Wandering Review" (attachment #12)
 - b. The LTC Administrator and/or the Director of Nursing will complete a 100% audit of the "Allegation of Abuse Checklist" – this was reviewed and revised to include identification of all individuals to be reviewed during the investigation (attachment #13)
 - c. The Director of Nursing or designee will complete a 100% audit of all residents identified at risk for wandering or elopement through review of the "Wandering/Elopement Risk Procedure" checklist – this was developed to include information related to completion of the Elopement/wandering Review and the BIMS interview (attachment #14)
 - d. All audits will be filed in the Director of Nursing office
5. Date of completion 10/14/15

F 279 Develop Comprehensive Care Plans

1. Corrective action accomplished for Resident #10

- a. The LTC Administrator was able to verify that a care plan was developed for Resident #10 to address behavior/wandering issues (attachment #15)
- b. The LTC Administrator was able to verify that this was not addressed timely
- c. In order to correct the deficient practice of not assuring the development of an appropriate care plan, the LTC Administrator and the Director of Nursing reviewed and/or updated the following policies:
 - "Admitting a Resident to LTC" (attachment #16) – policy was reviewed to assure that nurse's notes and assessments upon admission reflect all appropriate data (section #1)
 - "Assignment of Residents for Nursing Care" (attachment #17) – policy was reviewed to assure that all identified resident needs are assigned appropriately with specific interventions (sections 1 & 3)
 - "Wandering, Unsafe Resident" (attachment #18) – policy was reviewed and revised to assure that guidelines are present for appropriate development of a specific care plan; completion of BIMS; documentation (sections I (2); II; VI)
 - "Care Plans – Preliminary" (attachment #19) – policy was reviewed and updated to include development of a care plan following an incident/accident (section 3)
 - "Care Plans Comprehensive" (attachment # 20) – policy was reviewed to assure the development of a comprehensive care plan

2. Identification of other residents in the Facility

- a. The Director of Nursing and/or designee completed an assessment on all residents in the Facility – "Risk of Elopement/Wandering Review" (attachment #8)
 - 2 residents were identified at risk (attachments #21 & 22)
 - Appropriate care plans were developed (attachments #23 & 24)
- b. The Director of Staff Development added a section to the "Bedrail/Fall Assessment" to enquire about a history of elopement or to indicate if family voices any concerns indicating the resident may have wandering tendencies or try to leave (Attachment #9); answer of "yes" requires interventions:
 - Notify administrator and/or Director of Nursing
 - Provide 15-30 minute checks with resident
 - When necessary provide individual sitter until appropriate arrangements can be made for safety of the resident

3. Measures in place to ensure deficient practice will not recur

- a. The LTC Administrator and the Director of Nursing reviewed and/or updated the following policies:
 - "Admitting a Resident to LTC" (attachment #16) – policy was reviewed to assure that nurse's notes and assessments upon admission reflect all appropriate data (section #1)
 - "Assignment of Residents for Nursing Care" (attachment #17) – policy was reviewed to assure that all identified resident needs are assigned appropriately with specific interventions (sections 1 & 3)

- "Wandering, Unsafe Resident" (attachment #18) – policy was reviewed and revised to assure that guidelines are present for appropriate development of a specific care plan; completion of BIMS; documentation (sections I (2); II; VI)
 - "Care Plans – Preliminary" (attachment #19) – policy was reviewed and updated to include development of a care plan following an incident/accident (section 3)
 - "Care Plans Comprehensive" (attachment # 20) – policy was reviewed to assure the development of a comprehensive care plan
- b. The Director of Staff Development provided staff education to all Long Term Care staff including Administrative staff, RN, LPN, and CNA to review all measures in place to ensure this deficient practice does not recur (attachments #10 & 11)
- b.1. This education was provided face-to-face in an In-service setting
4. Monitoring actions to ensure that corrective actions are followed and the deficient practice does not recur
- a. The Director of Nursing or designee will complete a 100% audit of all new admissions through review of the "Admission to-do checklist" – this was reviewed and revised to include the "Risk of Elopement/Wandering Review (attachment #12)
 - b. The Director of Nursing or designee will complete a 100% audit of all residents identified at risk for wandering or elopement through review of the "Wandering/Elopement Risk Procedure" checklist – this was developed to include information related to completion of the Elopement/wandering Review and the BIMS interview (attachment #14)
 - c. All audits will be filed in the Director of Nursing office
5. Date of completion 10/14/15

F 323 Free of Accidents Hazards/Supervision/Devices

1. Corrective action accomplished for Resident #10

- a. The LTC Administrator was able to verify that adequate supervision and alarm devices were not in place prior to the discharge of Resident #10.
- b. The Director of Plant Operations ordered a part to repair the alarm system (attachment #25)
- c. The Director of Plant Operations or designee repaired the alarm system (attachment #26)
- d. In order to correct the deficient practice with inadequate supervision and safety alarm system, the LTC Administrator and Director of Nursing reviewed, updated or wrote the following policies:
 - "Incident/Accident Reporting" (Attachment #6) – policy was reviewed to assure that any incident is thoroughly investigated (section 3.2) and revised to assure that guidelines are established for the completion of the BIMS (section 3.2.1)
 - "Abuse" (attachment # 4) – policy was reviewed to assure that the procedure identifies all allegations shall be thoroughly investigated (Section IX)
 - "Admission Procedures" (Attachment #5) – policy was reviewed to assure that residents will be admitted as long as their nursing and medical needs can be met adequately by the Facility (section #5)
 - "Care Plans – Preliminary" (attachment #19) – policy was reviewed and updated to include development of a care plan following an incident/accident (section 3)
 - "Care Plans Comprehensive" (attachment # 20) – policy was reviewed to assure the development of a comprehensive care plan
 - "Supervision/Monitoring of the Resident with Behaviors" (attachment # 27) – policy was developed to outline detailed monitoring needed to assure safety of the resident (Identification – section #2) and include guidelines for the door alarm system (Door Alarm Checks – section #1)

2. Identification of other residents in the Facility

- a. The LTC Administrator was able to identify that all residents in the facility had the potential to be affected by this deficient practice
- b. The Director of Nursing and/or designee completed an assessment on all residents in the Facility – "Risk of Elopement/Wandering Review" (Attachment #8)
 - 2 residents were identified at risk (attachments #21 & 22)
 - Appropriate care plans were developed (attachments #23 & 24)
- c. The Director of Staff Development added a section to the "Bedrail/Fall Assessment" to enquire about a history of elopement or to indicate if family voices any concerns indicating the resident may have wandering tendencies or try to leave (Attachment #9); answer of "yes" requires interventions:
 - Notify administrator and/or Director of Nursing
 - Provide 15-30 minute checks with resident
 - When necessary provide individual sitter until appropriate arrangements can be made for safety of the resident

3. Measures in place to ensure deficient practice will not recur

- a. The LTC Administrator and Director of Nursing reviewed, updated or wrote the following policies:
 - “Incident/Accident Reporting” (Attachment #6) – policy was reviewed to assure that any incident is thoroughly investigated (section 3.2) and revised to assure that guidelines are established for the completion of the BIMS (section 3.2.1)
 - “Abuse” (attachment # 4) – policy was reviewed to assure that the procedure identifies all allegations shall be thoroughly investigated (Section IX)
 - “Admission Procedures” (Attachment #5) – policy was reviewed to assure that residents will be admitted as long as their nursing and medical needs can be met adequately by the Facility (section #5)
 - “Care Plans – Preliminary” (attachment #19) – policy was reviewed and updated to include development of a care plan following an incident/accident (section 3)
 - “Care Plans Comprehensive” (attachment # 20) – policy was reviewed to assure the development of a comprehensive care plan
 - “Supervision/Monitoring of the Resident with Behaviors” (attachment # 27) – policy was developed to outline detailed monitoring needed to assure safety of the resident (Identification – section #2) and include guidelines for the door alarm system (Door Alarm Checks – section #1)
 - b. The Director of Plant Operations ordered a part to repair the alarm system (attachment #25)
 - c. The Director of Plant Operations or designee repaired the alarm system (attachment #26)
 - d. The Director of Nursing developed a “Alarm Log Sheet” to document correct functioning of the alarm system by the charge nurse each shift (attachment #28)
 - e. The Director of Staff Development provided staff education to all Long Term Care staff including Administrative staff, RN, LPN, and CNA to review all measures in place to ensure this deficient practice does not recur (attachments #10 & 11)
 - e.1. This education was provided face-to-face in an In-service setting
 - f. All OHMCH employees were instructed via email related to the alarm system for LTC (attachment #29)
4. Monitoring actions to ensure that corrective actions are followed and the deficient practice does not recur
- a. The Director of Nursing or designee will complete an audit of the “Alarm Log Sheet” weekly
 - b. All audits will be filed in the Director of Nursing office
5. Date of completion 10/14/15

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 11/09/2015
NAME OF PROVIDER OR SUPPLIER OWENSBORO HEALTH MUHLENBERG COMMUNITY HOSPITAL LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 11/09/15, as alleged.	{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

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185008	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 11/9/2015
Name of Facility OWENSBORO HEALTH MUHLENBERG COMMUNITY HOSPITA		Street Address, City, State, Zip Code 440 HOPKINSVILLE ST. GREENVILLE, KY 42345

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0081	Correction Completed 11/09/2015	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 _____	Reviewed By <i>OH</i>	Date: <i>10/29/15</i>	Signature of Surveyor: <i>Richard O. Henderson, RPH, CR</i>	Date: <i>10/29/15</i>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/23/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185008	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2015
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NAME OF PROVIDER OR SUPPLIER OWENSBORO HEALTH MUHLENBERG COMMUNITY HOSPITAL LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1966.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (222).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, and upgraded in 1984 with 191 smoke detectors and 14 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1998.</p> <p>GENERATOR: Type I generator installed in 1984. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 09/23/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty-five (45) beds with a census of thirty-three (33) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Becky Higgins, LNH#17</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/14/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186008	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2015
NAME OF PROVIDER OR SUPPLIER OWENSBORO HEALTH MUHLENBERG COMMUNITY HOSPITAL LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
(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 Fire).	K 000		
K 061 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire sprinkler system was maintained as required by National Fire Protection Association (NFPA) standards. This deficient practice affected six (6) of six (6) smoke compartments, staff, and all the residents. The facility has the capacity for 45 beds with a census of 38 on the day of the survey.</p> <p>The findings include:</p> <p>Observation and interview, on 09/23/15 at 10:00 AM, with the Director of Maintenance revealed a valve in an outside pit which controls water flow to the facility's sprinkler system was observed not to be electronically supervised as required. This device alerts staff, by way of an alarm inside the facility, in case the water flow to the facility's sprinkler system is turned off.</p> <p>Interview with the Director of Maintenance, on 09/23/15 at 10:00 AM, revealed he was not aware</p>	K 061	K061 - Deficiency NFPA 101. Please see attached Plan of Correction for Corrective Action, Identification of all to be Affected, Measures to Ensure Does Not Continue, and Monitoring. Detailed information on page 7.	11/09/15

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NAME OF PROVIDER OR SUPPLIER OWENBORO HEALTH MUHLENBERG COMMUNITY HOSPITAL LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
(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 061	<p>Continued From page 2 the valve was required to be electronically supervised.</p> <p>The findings were revealed to the Administrator upon exit on 09/23/15.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>3-8.3.3.3.2* If a valve is installed in the connection between an alarm-initiating device intended to signal activation of a fire suppression system and the fire suppression system, the valve shall be supervised in accordance with the requirements of Chapter 2.</p> <p>A-3-8.3.3.3.2</p>	K 061		

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NAME OF PROVIDER OR SUPPLIER OWENSBORO HEALTH MUHLENBERG COMMUNITY HOSPITAL LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 440 HOPKINSVILLE ST. GREENVILLE, KY 42345	
(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 061	Continued From page 3 Sealing or locking such a valve in the open position, or removing the handle from the valve, does not meet the intent of the supervision requirement.	K 061		

K 061 Required automatic sprinkler systems have valves supervised

1. Corrective action taken

- a. The Director of Plant Operations verified that he failed to assure the building fire sprinkler system was maintained as required by National Fire Protection Association (NFPA) standards
- b. The Director of Plant Operations by observation verified that the valve in an outside pit which controls water flow to the facilities sprinkler system was not electronically supervised as required
- c. The Director of Plant Operations contacted sprinkler service provider and electrical contractor for quotations to install a Post Indicator Valve (PIV) Attachments #30 & 31
- d. OHMCH/LTC Administration approved the Capital Equipment Request to have the PIV installed and tested (attachment #32)

2. Identification of all to be affected

- a. The Director of Plant Operations verified that this deficiency has the potential to affect all residents in the facility

3. Measures in place to ensure deficient practice does not continue

- a. The Director of Plant Operations contacted sprinkler service provider and electrical contractor for quotations to install a Post Indicator Valve (PIV) Attachments #30 & 31
- b. OHMCH/LTC Administration approved the Capital Equipment Request to have the PIV installed and tested (attachment #32)

4. Monitoring actions to ensure compliance

- a. The Director of Plant Operations will ensure the proper monitoring of the sprinkler water shut off valve through required quarterly inspections performed by Pennyrite Fire Safety (attachment #33)
- b. Documentation will be filed in the Engineering office

5. Date of completion 11/9/15