

**DIVISION OF HEALTH CARE  
PACKET PROCESS LIST**

FACILITY: Hillside Center CITY: Madisonville

LEVEL OF CARE: SUF/NF SURVEY DATE(S): 08/11-13/15

SURVEY TYPE: INITIAL  RELIC.  RECERT  REVISIT  OTHER

COMPLAINT # NA PRIORITY: 1  2  3  4

\*LIST ENTRANCE TIME/DATE IF OFF-HOURS SURVEY: NA (M E W H)

\*NURSE AIDE TRAINING PROGRAM: YES  NO

TEAM: P. Hubbert, R. Blankenship, J. Sullivan, T. Morgan

SECRETARY: \_\_\_\_\_

ACTION	INITIALS	DATE
Packet Completed: Deficiency(ies)? YES <input type="checkbox"/> NO <input type="checkbox"/>	<u>BH</u>	<u>8/24/15</u>
Life Safety Code Tags included YES <input type="checkbox"/> NO <input type="checkbox"/>	<u>OH</u>	<u>08/25/15</u>
RPM Review	<u>OH</u>	<u>08/25/15</u>
Packet to Secretary	<u>OH</u>	<u>08/25/15</u>
SoD to Facility	<u>OH</u>	<u>08/25/15</u>
PoC Received and Copy to Coordinator	<u>OH</u>	<u>09/10/15</u>
POC Acceptable: YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<u>OH</u>	<u>09/10/15</u>
Provider Notified: by <u>Hubbert</u> on <u>09/10/15</u>		
POC Returned to Facility	_____	_____
2nd POC Received and Copy to Coordinator	_____	_____
2nd POC Acceptable: YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____
Provider Notified: by _____ on _____		
Revisit Required: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<u>OH</u>	<u>08/25/15</u>
Revisit Completed: Deficiency(ies) YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____
Revisit SoD to Facility	_____	_____
PoC Received and Copy to Coordinator	_____	_____
PoC Acceptable: YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____
Provider Notified: by _____ on _____		
2nd Revisit Required: YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____
2nd Revisit Completed: Deficiency(ies) YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____
Packet Completed	_____	_____

Highest Scope/Severity "B" Opportunity to Correct or No Opportunity to Correct (OTC or NOTC) OTC

SQC .13 .15 .25 (X areas of SQC)----- (Complete form HCFA-673 if SQC identified)

RPM/C.O. notified of SQC \_\_\_\_\_ Doctors/Board Letters Mailed-Ann Notified of SQC \_\_\_\_\_

Citation Issued: TYPE A or TYPE B (Type A stamped & faxed to Attorney General's Office \_\_\_\_\_)

PoC Due 09/04/15 Latest PoC Date 09/10/15 Date to be Corrected: 09/27/15

IDR Requested \_\_\_\_\_ IDR Scheduled \_\_\_\_\_ IDR Held \_\_\_\_\_  
 Changes to SoD? YES  NO  IDR SoD/Notice \_\_\_\_\_ IDR PoC Due \_\_\_\_\_  
 IDR PoC Received \_\_\_\_\_ PoC Acceptable? YES  NO  Provider Notified: by \_\_\_\_\_ on \_\_\_\_\_  
 PACKET TO C.O. 09/23/15 PACKET TO R.O. \_\_\_\_\_ 462L faxed to C.O. \_\_\_\_\_  
 1539 faxed to C.O. \_\_\_\_\_

*See Qert 08/27/15*

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL  
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PPBT  
Facility ID: 100189

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>185012</b>	3. NAME AND ADDRESS OF FACILITY (L3) <b>HILLSIDE CENTER</b> (L4) <b>1500 PRIDE AVENUE</b> (L5) <b>MADISONVILLE, KY</b> (L6) <b>42431</b>	4. TYPE OF ACTION: <u>2</u> (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
2. STATE VENDOR OR MEDICAID NO. (L2) <b>7100001500</b>	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital    05 HHA    09 ESRD    13 PTIP    22 CLIA 02 SNF/NF/Dual    06 PRTF    10 NF    14 CORF 03 SNF/NF/Distinct    07 X-Ray    11 ICF/IID    15 ASC 04 SNF    08 OPT/SP    12 RHC    16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) <b>12/31</b>
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) <b>10/01/2006</b>	6. DATE OF SURVEY <b>08/13/2015</b> (L34)	
8. ACCREDITATION STATUS: <u>    </u> (L10) 0 Unaccredited    1 TJC 2 AOA    3 Other		

11. LTC PERIOD OF CERTIFICATION From (a): To (b):	10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: <u>X</u> 1. Acceptable POC  B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A1*</b> (L12)	And/Or Approved Waivers Of The Following Requirements: <u>    </u> 2. Technical Personnel <u>    </u> 6. Scope of Services Limit <u>    </u> 3. 24 Hour RN <u>    </u> 7. Medical Director <u>    </u> 4. 7-Day RN (Rural SNF) <u>    </u> 8. Patient Room Size <u>    </u> 5. Life Safety Code <u>    </u> 9. Beds/Room
12. Total Facility Beds <b>71</b> (L18)		
13. Total Certified Beds <b>71</b> (L17)		

14. LTC CERTIFIED BED BREAKDOWN  18 SNF    18/19 SNF    19 SNF    ICF    IID  <b>71</b> (L37)    (L38)    (L39)    (L42)    (L43)	15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1): <b>YES</b> (L15)
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16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):  
**See Attached Remarks**

17. SURVEYOR SIGNATURE  <i>Barbara Huddleston RN, NRP</i> <b>09/23/2015</b> (L19)	18. STATE SURVEY AGENCY APPROVAL  _____ (L20)
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u>    </u> 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above: <u>    </u>
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22. ORIGINAL DATE OF PARTICIPATION <b>04/30/1970</b> (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)	26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure    05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement    06-Fail to Meet Agreement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal <u>OTHER</u> 07-Provider Status Change 00-Active
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		

28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. <b>00160</b> (L31)	30. REMARKS
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31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	DETERMINATION APPROVAL
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MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL  
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PPBT

Facility ID: 100189

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C&T REMARKS - CMS 1539 FORMSTATE AGENCY REMARKS

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Carol Britt - Hillside Center (Carol.Britt@genesishcc.com)

A standard health survey was conducted on 08/11-13/15, and a standard LSC survey was conducted on 08/12/15. Deficiencies were identified with the highest S/S being an 'B'.

SoDs were issued 08/25/15, and an acceptable PoC was received 09/10/15.

Recertification is recommended based on an acceptable PoC with the facility deemed to be in substantial compliance on 09/01/15, as alleged. An on-site revisit was determined not to be necessary. Compliant with Title VI.

FACILITY NAME: Hillside Center  
 SURVEY DATE: 08/11-13/15

List all of the facility's SNF/NF (Title 18/19) beds in each room by room number in numerical order and indicate how many beds are in each room:

<u>Room</u>	<u># BEDS</u>	<u>Room</u>	<u># BEDS</u>	<u>Room</u>	<u># BEDS</u>	<u>Room</u>	<u># BEDS</u>
100	2	200	1	300	2	400	2
101	2	201	1	301	2	401	2
102	2	202	2	302	2	402	2
103	2	203	1		6	403	2
104	2	204	1			406	2
105	2	205	1			407	2
106	2	206	2			408	2
107	2	207	2			409	1
108	2	208	2			410	2
109	2	209	2			411	2
	<u>20</u>		<u>15</u>			412	1
						413	2
						414	2
						415	2
						416	2
						<u>417</u>	<u>71</u>
						Total SNF/NF beds	
						<u>2</u>	
						30	

List all of the facility's NF (Title 19 only) beds in each room by room number in numerical order and indicate how many beds are in each room:

0  
 Total NF only beds

**List all of the facility's SNF (Title 18 only) beds in each room by room number in numerical order and indicate how many beds are in each room:**

0

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**Total SNF Only Beds**

**List all of the facility's LICENSURE ONLY beds in each room by room number in numerical order and indicate how many beds are in each room:**

0

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**Total Licensure Only Beds**

**List all of the facility's PC beds in each room by room number in numerical order and indicate how many beds are in each room:**

0  
**Total PC Beds**

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

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey

From: F1 08 00 05 To: F2 08 03 15  
MM DD YY MM DD YY

Extended Survey

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

Name of Facility Hillside Center		Provider Number 18-5012		Fiscal Year Ending: F5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> MM DD YY	
Street Address 1500 PRIDE AVE.		City Madisonville	County Hopkins	State KY	Zip Code 42431
Telephone Number: F6 270.821.1813		State/County Code: F7 18/530		State/Region Code: F8 18/201	

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

- |                   |                          |                   |                      |
|-------------------|--------------------------|-------------------|----------------------|
| <b>For Profit</b> | <b>NonProfit</b>         | <b>Government</b> |                      |
| 01 Individual     | 04 Church Related        | 07 State          | 10 City/County       |
| 02 Partnership    | 05 Nonprofit Corporation | 08 County         | 11 Hospital District |
| 03 Corporation    | 06 Other Nonprofit       | 09 City           | 12 Federal           |

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

Name of Multi-Facility Organization: F14

Genesis Healthcare

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

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

- Does the facility currently have an organized residents group? F24 Yes  No
- Does the facility currently have an organized group of family members of residents? F25 Yes  No
- Does the facility conduct experimental research? F26 Yes  No
- Is the facility part of a continuing care retirement community (CCRC)? F27 Yes  No

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    Hours waived per week: F29 \_\_\_\_\_  
 Waiver of 24 hr licensed nursing requirement. Date: F30    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

bh/RS

### 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	X	X	X		291						0			0	
Physician Services	F34	Y	N	N	X	X	X	X	X	X	X	X	X	X	X	X
Medical Director	F35	X	X	X								0			0	
Other Physician	F36	X	X	X								0			0	
Physician Extender	F37	Y	N	N								0			0	
Nursing Services	F38	Y	N	N	X	X	X	X	X	X	X	X	X	X	X	X
RN Director of Nurses	F39	X	X	X		80						0			0	
Nurses with Admin. Duties	F40	X	X	X		178						0			0	
Registered Nurses	F41	X	X	X		145			220						0	
Licensed Practical/ Licensed Vocational Nurses	F42	X	X	X		529			47						0	
Certified Nurse Aides	F43	X	X	X								0			0	
Nurse Aides in Training	F44	X	X	X		1305			156						0	
Medication Aides/Technicians	F45	X	X	X								0			0	
Pharmacists	F46	Y	N	N								0			0	
Dietary Services	F47	Y	N	N	X	X	X	X	X	X	X	X	X	X	X	X
Dietitian	F48	X	X	X		24						0			0	
Food Service Workers	F49	X	X	X		286			138						0	
Therapeutic Services	F50	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Occupational Therapists	F51	Y	N	N					22						0	
Occupational Therapy Assistants	F52	X	X	X		107			40						0	
Occupational Therapy Aides	F53	X	X	X								0			0	
Physical Therapists	F54	Y	N	N					13						0	
Physical Therapists Assistants	F55	X	X	X		80			67						0	
Physical Therapy Aides	F56	X	X	X								0			0	
Speech/Language Pathologist	F57	Y	N	N		76						0			0	
Therapeutic Recreation Specialist	F58	Y	N	N								0			0	
Qualified Activities Professional	F59	Y	N	N		88						0			0	
Other Activities Staff	F60	Y	N	N					40						0	
Qualified Social Workers	F61	Y	N	N								0			0	
Other Social Services	F62	Y	N	N		48						0			0	
Dentists	F63	N	N	Y								0			0	
Podiatrists	F64	Y	N	N								0			0	
Mental Health Services	F65	Y	N	N								0			0	
Vocational Services	F66	N	N	N	X	X	X	X	X	X	X	X	X	X	X	X
Clinical Laboratory Services	F67	Y	N	N	X	X	X	X	X	X	X	X	X	X	X	X
Diagnostic X-ray Services	F68	Y	N	Y	X	X	X	X	X	X	X	X	X	X	X	X
Administration & Storage of Blood	F69	N	N	Y	X	X	X	X	X	X	X	X	X	X	X	X
Housekeeping Services	F70	Y	N	N		509			30						0	
Other	F71	X	X	X								10			0	

Name of Person Completing Form <i>CAROL BRITT</i>	Time <i>2:00 PM</i>
Signature <i>Carol Britt</i>	Date <i>8/12/15</i>

**RESIDENT CENSUS AND CONDITIONS OF RESIDENTS**

Provider No. 185012	Medicare F75 8	Medicaid F76 43	Other F77 3	Total Residents F78 54
<b>ADL</b>	<b>Independent</b>	<b>Assist of One or Two Staff</b>		<b>Dependent</b>
Bathing	F79 2	F80 28		F81 24
Dressing	F82 3	F83 39		F84 12
Transferring	F85 12	F86 31		F87 11
Toilet Use	F88 11	F89 25		F90 18
Eating	F91 38	F92 8		F93 8

<b>A. Bowel/Bladder Status</b>		<b>B. Mobility</b>	
F94	<u>3</u> With indwelling or external catheter	F100	<u>5</u> Bedfast all or most of time
F95	Of the total number of residents with catheters, how many were present on admission <u>3</u> ?	F101	<u>42</u> In a chair all or most of time
F96	<u>30</u> Occasionally or frequently incontinent of bladder	F102	<u>4</u> Independently ambulatory
F97	<u>26</u> Occasionally or frequently incontinent of bowel	F103	<u>3</u> Ambulation with assistance or assistive device
F98	<u>8</u> On urinary toileting program	F104	<u>1</u> Physically restrained
F99	<u>6</u> On bowel toileting program	F105	Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints <u>0</u> ?
		F106	<u>6</u> With contractures
		F107	Of the total number of residents with contractures, how many had a contracture(s) on admission <u>4</u> ?

<b>C. Mental Status</b>		<b>D. Skin Integrity</b>	
<b>F108-114 - indicate the number of residents with:</b>		<b>F115-118 - indicate the number of residents with:</b>	
F108	<u>2</u> Intellectual and/or developmental disability	F115	<u>2</u> Pressure ulcers (exclude Stage 1)
F109	<u>40</u> Documented signs and symptoms of depression	F116	Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission <u>1</u> ?
F110	<u>20</u> Documented psychiatric diagnosis (exclude dementias and depression)	F117	<u>27</u> Receiving preventive skin care
F111	<u>29</u> 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	F118	<u>2</u> Rashes
F112	<u>12</u> Behavioral healthcare needs		
F113	Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them <u>12</u> ?		
F114	<u>0</u> Receiving health rehabilitative services for MI and/or ID/DD		

**E. Special Care**

F119-132 - indicate the number of residents receiving:

F119 1 Hospice care  
 F120 0 Radiation therapy  
 F121 0 Chemotherapy  
 F122 3 Dialysis  
 F123 1 Intravenous therapy, IV nutrition, and/or blood transfusion  
 F124 15 Respiratory treatment  
 F125 0 Tracheostomy care  
 F126 1 Ostomy care

F127 0 Suctioning  
 F128 17 Injections (exclude vitamin B12 injections)  
 F129 2 Tube feedings  
 F130 20 Mechanically altered diets including pureed and all chopped food (not only meat)  
 F131 31 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD  
 F132 8 Assistive devices while eating

**F. Medications**

F133-139 - indicate the number of residents receiving:

F133 42 Any psychoactive medication  
 F134 21 Antipsychotic medications  
 F135 17 Antianxiety medications  
 F136 34 Antidepressant medications  
 F137 2 Hypnotic medications  
 F138 3 Antibiotics  
 F139 31 On pain management program

**G. Other**

F140 7 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 0 Who use non-oral communication devices  
 F143 30 With advance directives  
 F144 38 Received influenza immunization  
 F145 38 Received pneumococcal vaccine

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

Signature of Person Completing the Form 	Title RN/DON	Date 8/11/2015
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**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 \_\_\_%



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

PRINTED: 09/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R 09/10/2015
NAME OF PROVIDER OR SUPPLIER  HILLSIDE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 09/01/15, 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 185012	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/10/2015
Name of Facility HILLSIDE CENTER	Street Address, City, State, Zip Code 1500 PRIDE AVENUE MADISONVILLE, KY 42431	

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).

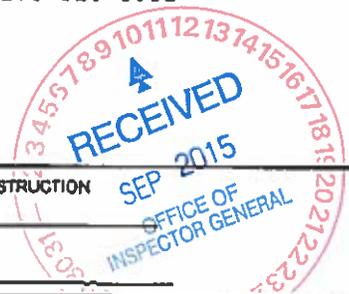
(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0160</u> Reg. # <u>483.10(c)(6)</u> LSC _____	Correction Completed 09/01/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ 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 _____ State Agency	Reviewed By <u>IOH</u>	Date: <u>09/10/15</u>	Signature of Surveyor: <u>Deborah C. Henderson, NCF, OR</u>	Date: <u>09/10/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/13/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/13/2015
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NAME OF PROVIDER OR SUPPLIER  HILLSIDE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431
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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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<p>F 000 INITIAL COMMENTS</p> <p>A Recertification Survey was conducted on 08/11/15 through 08/13/15 a deficiency cited at the highest scope and severity of an "B".</p> <p>F 160 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH SS=B</p>	<p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility policy, it was determined the facility failed to ensure residents, who had money in Resident Accounts, had their money transferred to the resident's estate within thirty (30) days after the death of the resident, for four (4) residents of five (5) unsampled residents (Residents A, B, C and D).</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Resident Funds", last revised 04/15/15, revealed the withdrawals upon the death of a resident and disbursement of monies would be done in accordance with State regulations. Once the withdrawal transaction was posted to the resident's account, disbursements must have been made.</p> <p>1. Unsampled Resident A expired on 02/12/15</p>	<p>F 000</p> <p>F 160</p>	<p>"This Plan of Correction is prepared and submitted as required by law. Hillside Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, or conclusions that form the basis for the alleged deficiency.</p> <p>F160 On 08/13/15 the Regional Quality Assurance Manager reviewed the resident accounts for residents A, B, C, D and determined that the accounts had been closed.</p> <p>All residents of the facility have the potential to be affected including residents with personal funds deposited with the facility. On 08/24/15 an audit was conducted by the Business Office Manager to ensure that any resident who had money in resident accounts had their money transferred to the resident's estate within 30 days after the death of the resident. None were noted.</p> <p>The Business Office Manager was re-educated by the Regional Quality Assurance Manager on 08/18/15 on ensuring personal funds deposited in resident accounts will be transferred to the resident's estate within thirty (30) days after the death of a resident.</p>	<p></p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carol Britt, Administrator</i>	TITLE	(X6) DATE 08/28/15
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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.

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

PRINTED: 08/25/2015  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/13/2015
NAME OF PROVIDER OR SUPPLIER  HILLSIDE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 PRIDE AVENUE MADISONVILLE, KY 42431		
(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 160	<p>Continued From page 1</p> <p>and the account was not closed until 03/24/15.</p> <p>2. Unsampled Resident B expired on 01/31/15 and the account was not closed until 07/31/15.</p> <p>3. Unsampled Resident C expired on 12/24/14 and the account was not closed until 03/24/15.</p> <p>4. Unsampled Resident D expired on 10/31/14 and the account was not closed until 12/03/14.</p> <p>Interview with the staff in charge of Accounts Payable, on 08/13/15 at 5:20 PM, revealed she was aware the account needed to be closed within thirty (30) days, but was unsure why this had not occurred as the Business Office Manager (BOM) was on vacation.</p> <p>Review of the report concerning the Resident Accounts was faxed to the State Agency on 08/18/15 and review revealed Resident A's funds were "overlooked" as that account was "seldom used." Resident B's account involved the suspension of the SSI checks when the resident was admitted and the account would not transfer over to Medicaid and a new application had to be filed with Medicaid. Resident C's late disbursement was realized in an audit completed by the facility and disbursed that day. However, this was 80 days after the death of the resident. Resident D's account was closed late due to poor communications with the Social Security Office.</p> <p>Interview with the Administrator, on 08/13/15 at 5:25 PM, revealed the Administrator was not typically involved in the management of Resident Accounts.</p>	F 160	<p>The Administrator will review the resident account upon the death of a resident with a personal fund deposited with the facility, to ensure the facility conveys within 30 days, the resident's funds, and an accounting of those funds to the individual or probate jurisdiction administering the resident's estate weekly for four weeks then as determined by the monthly Quality Performance Committee with corrective action upon discovery. The Administrator will report findings of these audits to the monthly Quality Improvement Committee which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Food Services Director, Payroll/Benefits Designee, Business office Manager, Nurse Practice Educator, and Maintenance Director for any additional follow up and/or inservicing needs until the issue is resolved and randomly thereafter.</p> <p>Completion date</p>	09/01/15

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207, or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 185012	Provider/Supplier Name HILLSIDE CENTER
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Type of Survey (select all that apply)

I	D			
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- A Complaint Investigation
- B Dumping Investigation
- C Federal Monitoring
- D Follow-up Visit
- M Other
- E Initial Certification
- F Inspection of Care
- G Validation
- H Life Safety Code
- I Recertification
- J Sanctions/Hearing
- K State License
- L CHOW

Extent of Survey (select all that apply)

A	F			
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- A Routine/Standard Survey (all providers/suppliers)
- B Extended Survey (HHA or Long Term Care Facility)
- C Partial Extended Survey (HHA)
- D Other Survey

*F offsite/Paper*

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 18332			0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....	1.00	Total RO Supervisory Review Hours.....	0.00
Total SA Clerical/Data Entry Hours....	1.00	Total RO Clerical/Data Entry Hours.....	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No



**DIVISION OF HEALTH CARE  
PACKET PROCESS LIST**

FACILITY: Hillside Center CITY: Madisonville

LEVEL OF CARE: SNF/NF Provider/Licensed Number \_\_\_\_\_ SURVEY DATE(S): \_\_\_\_\_

SURVEY TYPE: INITIAL RELIC. RECERT. REVISIT OTHER LSC

COMPLAINT # \_\_\_\_\_ PRIORITY: 1 2 3 4

\*LIST TIME/DATE IF OFF-HOURS SURVEY: \_\_\_\_\_ (M E W H)

TEAM: Robert Welch SECRETARY: \_\_\_\_\_

*See Out 08/27/15*

ACTION	INITIALS	DATE	Date in ACO
Packet completed: Deficiency(ies)? YES <u>NO</u>	<u>RW/DAH</u>	<u>08/17/15</u>	
RPM Review	<u>OH</u>	<u>08/25/15</u>	
Packet to Secretary	<u>OH</u>	<u>08/25/15</u>	
SoD to Facility	<u>OH</u>	<u>08/25/15</u>	<u>08/25/15</u>
PoC Received/Copy to Coordinator/Admin Sign Off			
POC Acceptable: YES NO			
Provider notified by _____ on _____			
POC Returned to Facility			
2 <sup>nd</sup> POC Received/Copy to Coordinator/Admin Sign Off			
2 <sup>nd</sup> POC Acceptable: YES NO			
Provider notified by _____ on _____			
Revisit Required: YES <u>NO</u>	<u>OH</u>	<u>08/25/15</u>	
Revisit Completed: Deficiency (ies) YES NO			
Revisit SoD to Facility			
PoC Received/Copy to Coordinator/Admin Sign Off			
PoC Acceptable: YES NO			
Provider notified by _____ on _____			
2 <sup>nd</sup> Revisit Required: YES NO			
2 <sup>nd</sup> Revisit Completed: Deficiency(ies) YES NO			

Packet Completed

Highest Scope/Severity \_\_\_\_\_ Opportunity to Correct or No Opportunity to Correct (OTC or NOTC) \_\_\_\_\_

SQC .13 .15 .25 (X area of SWC) \_\_\_\_\_ (Complete from CMS-673 if SQC identified)

RPM/CO notified of SQC \_\_\_\_\_ Doctors/Board Letters Mailed \_\_\_\_\_

If Citation Issued: TYPE A OR TYPE B Date Issued: \_\_\_\_\_

POC Due \_\_\_\_\_ Latest POC Date \_\_\_\_\_ Date to be Corrected: \_\_\_\_\_

1<sup>st</sup> Revisit Due \_\_\_\_\_ 2<sup>nd</sup> Revisit Due \_\_\_\_\_

IDR Requested \_\_\_\_\_ IDR Scheduled/Notice \_\_\_\_\_ IDR Held \_\_\_\_\_

Changes to SoD? YES NO IDR SoD/Notice \_\_\_\_\_ IDR PoC Due \_\_\_\_\_

IDR PoC Received \_\_\_\_\_ PoC Acceptable? YES NO

PACKET TO C.O. 09/23/15 PACKET TO R.O. \_\_\_\_\_

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

PRINTED: 08/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2015
NAME OF PROVIDER OR SUPPLIER  HILLSIDE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431	
(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>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1969.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1969 with 0 smoke detectors and 99 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1969 and upgraded in 2009.</p> <p>GENERATOR: Type II generator installed in 2009. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 08/12/15. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-one (71) beds with a census of fifty-four (54) on the day of the survey.</p>	K 000		

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

TITLE

(X6) DATE

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Provider/Supplier Number 185012	Provider/Supplier Name HILLSIDE CENTER
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Type of Survey (select all that apply)

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- A Complaint Investigation
- B Dumping Investigation
- C Federal Monitoring
- D Follow-up Visit
- M Other
- E Initial Certification
- F Inspection of Care
- G Validation
- H Life Safety Code
- I Recertification
- J Sanctions/Hearing
- K State License
- L CHOW

Extent of Survey (select all that apply)

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- A Routine/Standard Survey (all providers/suppliers)
- B Extended Survey (HHA or Long Term Care Facility)
- C Partial Extended Survey (HHA)
- D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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Team Leader ID								
1. 30055	08/12/2015	08/12/2015	0.50	0.00	4.00	0.00	4.00	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours.....	1.25	Total RO Supervisory Review Hours.....	0.00
Total SA Clerical/Data Entry Hours.....	1.50	Total RO Clerical/Data Entry Hours.....	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

Division of Health Care  
P.O. Box 2200 / 2400 Russellville Road  
Hopkinsville, Kentucky 42240  
Phone: (270) 889-6052  
Fax: (270) 889-6089  
<http://chfs.ky.ov/os/oig>

**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

September 23, 2015

**via EMAIL: Carol Britt - Hillside Center (Carol.Britt@genesishcc.com)**

Ms. Carol Britt, Administrator  
Hillside Center  
1500 Pride Avenue  
Madisonville, KY 42431

Dear Ms. Britt:

Thank you for submitting your proposed plan of correction regarding the deficiencies noted during the survey completed on August 13, 2015.

We are accepting your allegation of compliance and presume that substantial compliance was achieved by September 1, 2015, as alleged in your plan of correction. Therefore, we are not recommending the remedies referred to in the initial notice dated August 25, 2015, to the Centers for Medicare and Medicaid Services Regional Office at this time. Based on implementation of your plan of correction, we will recommend that your nursing facility be relicensed and recertified for continued participation in the Title XVIII/XIX programs contingent upon approval from the appropriate agencies.

Your cooperation is appreciated. If you should have questions regarding this information, please contact our office.

Sincerely,

  
Kathy Perry, RN, BSM, MA  
Regional Program Manager

KDP/BH:lef



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF INSPECTOR GENERAL**

**Steven L. Beshear**  
Governor

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**Audrey Tayse Haynes**  
Secretary

**Maryellen B. Mynear**  
Inspector General

August 25, 2015

**via EMAIL: Carol Britt - Hillside Center (Carol.Britt@genesishcc.com)**

Ms. Carol Britt, Administrator  
Hillside Center  
1500 Pride Avenue  
Madisonville, KY 42431

Dear Ms. Britt:

On August 13, 2015, a standard Health and Life Safety Code recertification survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was in substantial compliance with the participation requirements. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby corrections are required **(B)**.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

**Plan of Correction (POC)**

A POC for the deficiencies must be submitted no later than **ten (10) days from receipt of this letter**. Failure to submit an acceptable POC may result in a recommendation that remedies be imposed immediately upon notification requirements being met. Your POC, as fully implemented, will serve as your allegation of compliance.

**Your POC must:**

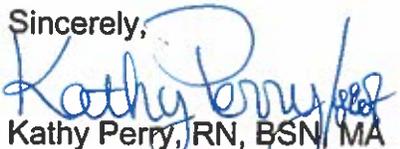
- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date', include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed Forms CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes substandard quality of care or immediate jeopardy. You are required to send your request in writing to **IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621.** Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute and provide a detailed basis for the dispute. Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies.** A request for informal dispute resolution shall not delay an enforcement action.

If you should have questions regarding this information, please contact our office.

Sincerely,

  
Kathy Perry, RN, BSN, MA  
Regional Program Manager

KDP/BH:lef

Enclosure



DEPARTMENT FOR MEDICAID SERVICES  
NURSE AIDE TRAINING & COMPETENCY EVALUATION  
PROGRAM SITE REVIEW

Please make available the following information:

- \_\_\_\_\_ Notice of Program Approval
- \_\_\_\_\_ Current Approval Program Application

Records of the Following:

- \_\_\_\_\_ Program Coordinator
- \_\_\_\_\_ All Primary Instructors
- \_\_\_\_\_ Any Guest Lecturers
- \_\_\_\_\_ ★ Two Trainees for OIG's Review. I review all records of the last two classes taught.
- \_\_\_\_\_ Program Policy Manual
- \_\_\_\_\_ Documentation of Ongoing Program Evaluations
- \_\_\_\_\_ Any communications regarding general administration of the program
- \_\_\_\_\_ File of program/class schedules
- \_\_\_\_\_ File of any program changes
- \_\_\_\_\_ File of any program complaints
- \_\_\_\_\_ File of Program Completions
- \_\_\_\_\_ Statistics on Pass/Fail for State Administered Competency Evaluation Program