

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

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|--|---|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186172 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 10/01/2015 |
| NAME OF PROVIDER OR SUPPLIER WILLIAMSON ARH | | STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503 | | |
| (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 | F 000 | | |
| F 226 SS=E | <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of employee personnel files, and review of the facility's policy, it was determined the facility failed to develop written policies that prohibit mistreatment, neglect, and abuse of residents. Review of the facility's abuse policy revealed the policy did not outline procedures to ensure the Kentucky Caregiver Misconduct Registry was checked to ensure staff hired did not have a history of abuse.</p> <p>The findings include: Review of Kentucky Revised Statute 209.032 revealed the Caregiver Misconduct Registry allowed vulnerable adult service providers and individuals to query as to whether a validated substantiated finding of adult abuse, neglect, or exploitation had been entered against an individual who was a prospective employee, volunteer of the provider, or an individual seeking employment in a direct caregiving role.</p> | F 226 | <p>F226</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/1/2015 during the state survey it was identified that screening of all individuals on the KY Caregiver Misconduct Registry was not being performed on new hires as directed by KRS 209.032. A full criminal background check, license check for licensed individuals and nurse aide abuse registry check was performed on all employees but, a Kentucky Caregiver Misconduct Registry check had not been performed. A corrected process was put into effect with Human Resources with the next hire date of 10/12/2015 to include a check of all new hires on the Kentucky Caregiver Misconduct Registry and on 11/2/15 a check of all employees hired since July 1, 2014 was completed (see attachment #1). The Abuse policy was updated to include the information regarding the Kentucky Caregiver Misconduct Registry 10/16/2015 (see attachment #2).</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents would be at risk of being exposed to individual not screened on the Kentucky Caregiver Misconduct Registry and through this deficient process. All new hires starting with the next hire date of 10/12/2015 will be screened on the registry and all new hires from July 1, 2014 to current were screened to ensure none were listed on the Kentucky Caregiver Misconduct Registry. The screen was added in the human resources new employee check off list to ensure check is done with each new employee (see attachment #1). The process change was made to ensure that all new hires will be checked to ensure there were no incidents of misconduct on file against any individuals considered for employment and a retroactive search was performed to ensure no one hired since July 1, 2014 was on the registry (none were noted to be listed on the registry that were hired from July 1, 2014 completed on 11/2/2015). If an individual is found on the registry they would be found not eligible for hire at that time. The Human resource manager was provided with the information concerning the tag and provided with information concerning proper process to access and utilize the Kentucky Caregiver Misconduct Registry. Kentucky Caregiver Misconduct registry checks will be a part of pre employment screening process along with Abuse Registry and criminal background checks.</p> <p>3. What Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. A process change was made to include the Kentucky Caregiver Misconduct Registry checks on all new hires with the start the next official hire date of 10/12/2015 and all new hires from July 1, 2014 to current. A check off sheet (see attachment #1) will be performed with each new hire for ARH Tug Valley to ensure that no potential new hires were listed on the Kentucky Caregiver Misconduct Registry. This will be done in addition to all other checks including criminal background check, nurse aide abuse registry and licensure checks as applicable. Revisions were made to include the Kentucky Caregiver Misconduct Registry checks as a part of the Abuse Policy updated on 10/16/2015 (see attachment #2).</p> | 11/03/2015 |

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

TITLE

(X6) DATE

Sonya D Wasserman RN, BSN, DON, NHA

10/20/2015

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 30 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 226 | Continued From page 1 Review of the facility's Abuse policy (not dated) revealed employees would be screened for a history of abuse, neglect, mistreatment, or exploitation of an adult or child; however, the policy failed to outline procedures to ensure the Kentucky Caregiver Misconduct Registry was checked. Review of personnel files for Employees #1, #2, #3, #4, and #5 revealed no documented evidence the employees were queried on the Kentucky Caregiver Misconduct Registry. Interview with the Administrator on 10/01/15 at 3:29 PM revealed the Kentucky Caregiver Misconduct Registry checks should have been available in the personnel files. The administrator stated, "We dropped the ball on this." | F 226 | F226 Continued 4. How the facility plans to monitor its performance to ensure that solutions are sustained. A process change was made to include the Kentucky Caregiver Misconduct Registry checks on all new hires as of 10/12/2015 with this being the most recent hire date post survey and all new hires since July 1, 2014 was completed on 11/2/2015. A check off sheet (see attachment #1) will be performed with each new hire to ensure that no potential new hires are listed on the Kentucky Caregiver Misconduct Registry. This will be done in addition to all other checks including criminal background check, nurse aide abuse registry and licensure checks as applicable. Human Resources will perform the Kentucky Caregiver Misconduct Registry check and include on the pre screening tool for all new hires and keep a completed check off sheet for each new employee. A log will be kept of all new employees screened on the Kentucky Caregiver Misconduct Registry. This check will be reviewed every 2 weeks by the Human Resource Manger and Administrator of SNF to ensure that all new employees have been screened. This check will be performed every 2 weeks with Human Resources with a biweekly hiring schedule. The log will be monitored for compliance and reported out quarterly with QI meetings to evaluate effectiveness and to assess the need for implementation of changes. | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide care in accordance with the Comprehensive Plan of Care for one (1) of ten (10) sampled residents (Resident #1). Resident #1's Comprehensive Care Plan contained interventions for an indwelling urinary catheter that included "to secure the Foley catheter tubing to leg to prevent irritation." | F 282 | F282 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/1/2015 during state survey it was noted that resident #1 had a Foley Catheter in use to promote wound healing of pressure ulcer to his coccyx. This resident was noted to be care planned for Foley catheter to be secured. It was noted that the residents catheter was not secured as care planned. The resident's catheter was secured immediately after discovery of the deficient practice on 10/1/2012. Resident #1 is bedridden and unable to ambulate. The resident requires total care for all ADL's. The defective practice was noted, identified and corrected for resident #1 on 10/1/2015. Staff was in serviced related to need for securing Foley catheters to prevent trauma or dislodgment along with reminder to always follow the plan of care (see attachment #3). A new tracking sheet (see attachment #4) was implemented to include the tracking of Foley catheters secured to be performed with each shift. A order for Foley catheter / cath secure was added to admission orders (see attachment #5). | 10/20/2015 | |

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| F 282 | <p>Continued From page 2</p> <p>However, observations on 09/30/15 revealed the urinary catheter tubing was not secured.</p> <p>The findings include:</p> <p>Interview with the Administrator on 10/01/15 at 3:15 PM revealed the facility did not have a policy related to following a resident's plan of care.</p> <p>Review of Resident #1's medical record revealed the facility admitted Resident #1 on 08/28/15 with diagnoses of Traumatic Brain Injury with Craniotomy, Cerebral Septic Emboli, Unstageable Decubitus Hydrocephalus, and Chronic Respiratory Failure. Review of the admission Minimum Data Set (MDS) assessment dated 09/09/15 revealed Resident #1 required the use of an indwelling urinary catheter. Review of the comprehensive care plan dated 09/17/15 revealed catheter care was required daily on each shift and as needed and the catheter tubing was required to be secured.</p> <p>Observations of Resident #1 on 09/30/15 at 03:55 PM during catheter care revealed Resident #1's catheter was attached to a bedside drainage bag; however, the tubing was not secured.</p> <p>Interview with the MDS Coordinator on 10/01/15 at 4:07 PM revealed she was responsible for developing the care plans and updating the care plans as needed. Further interview revealed she also performed random rounds weekly with staff to ensure care plan interventions were being followed. Additional interview revealed the catheter should have been anchored.</p> <p>Interview with the Administrator on 10/01/15 at 3:00 PM revealed the charge nurses were</p> | F 282 | <p>F282 Continued</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents requiring a Foley catheter can be at risk from this deficient practice found on 10/1/2015. Resident #1 was found to have a Foley catheter and the catheter was found to not be secured in a manner to prevent trauma or dislodgement. A inservice was provided to staff on 10/16/2015 (see attachment #3) concerning use of Foley Catheter /cath secures to prevent trauma and dislodgement. The inservice also included a reminder to always follow the plan of care when caring for the residents. A new flow sheet was implemented to ensure that Foley catheters are secured on each shift (see attachment # 4) . All residents were reviewed that had catheters at time of survey for at total of 3 (including resident #1) with all noted to have their Foley Catheters secured as of 10/1/2015. The MDS coordinator will keep a log of all residents requiring a catheter to monitor the practice of securing Foley catheters.</p> <p>3. What Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. An inservice was provided to staff on 10/16/2015 (see attachment #3) concerning use of Foley Catheter /cath secures to prevent trauma and dislodgement. The inservice also included instruction to always follow the plan of care when caring for the residents. A new flow sheet was implemented to ensure that Foley catheters are secured on each shift (see attachment # 4) . Daily rounds by nursing will also include checks to ensure Foley catheters are secured as care planned to prevent trauma and dislodgement. All residents were reviewed that had catheters at time of survey for at total of 3 (including resident #1) with all noted to have their Foley catheters secured as of 10/1/2015. The MDS coordinator will keep a log of all residents requiring a catheter to monitor the practice of securing Foley catheters.</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained. A new flow sheet was implemented to ensure that Foley catheters are secured on each shift (see attachment # 4) . The MDS coordinator will keep a log of all residents requiring a catheter to monitor the practice of securing Foley catheters. Weekly checks of all residents requiring a foley catheter will be performed by the MDS coordinator, or Administrator in her absence , on residents included on the log to ensure all residents that require a Foley catheter have the catheter secured as care planned. A PI monitor will be put in place to monitor the effectiveness of the process changes and to re evaluate any need for additional measures to implemented to insure that the care plan is followed and Foley catheters are secured as care planned. A PI monitor will be reported out with quarterly PI meeting for discussion and implementations for improvements as needed.</p> | | |

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| F 282 | Continued From page 3 responsible to ensure staff was following residents' care plans. She further stated no problems had been identified concerning staff not following care plans. | F 282 | | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure appropriate treatment and services were provided to prevent possible injury/trauma of the urinary tract for one (1) of ten (10) sampled residents (Resident #1). Facility staff failed to ensure the urinary catheter was secured for Resident #1. The findings include: Review of the "Foley Catheter" policy (dated March 2009) revealed the catheter should be properly secured after insertion to prevent movement, disconnection, and/or trauma to the urethral area. | F 315 | F315 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 10/1/2015 during state survey it was noted that resident #1 had a Foley Catheter in use to promote wound healing of pressure ulcer to his coccyx. It was noted that the residents catheter was not secured to prevent trauma or dislodgement. The resident's catheter was secured after discovery of the deficient practice on 10/1/2012. Resident #1 is bedridden and unable to ambulate. The resident requires total care for all ADL's. The defective practice was noted, identified and corrected for resident #1 on 10/1/2015. Staff was in serviced related to need for securing Foley catheters to prevent trauma or dislodgment (see attachment #3). A new tracking sheet (see attachment #4) was implemented to include the tracking of Foley catheters secured to be performed with each shift. A order for Foley catheter / cath secure was added to admission orders (see attachment #5). 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents requiring a Foley catheter can be at risk from this deficient practice found on 10/1/2015. Resident #1 was found to have a Foley catheter and the catheter was found to not be secured in a manner to prevent trauma or dislodgement. A inservice was provided to staff on 10/16/2015 (see attachment #3) concerning use of Foley Catheter /cath secures to prevent trauma and dislodgement. A new flow sheet was implemented to ensure that Foley catheters are secured on each shift (see attachment # 4) . All residents were reviewed that had catheters at time of survey for at total of 3 (including resident #1) with all noted to have their Foley Catheters secured as of 10/1/2015. The MDS coordinator will keep a log of all residents requiring a catheter to monitor the practice of securing Foley catheters. 3. What Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. An inservice was provided to staff on 10/16/2015 (see attachment #3) concerning use of Foley Catheter /cath secures to prevent trauma and dislodgement. A new flow sheet was implemented to ensure that Foley catheters are secured on each shift (see attachment # 4) . Daily rounds by nursing will also include checks to ensure Foley catheters are secured to prevent trauma and dislodgement. All residents were reviewed that had catheters at time of survey for at total of 3 (including resident #1) with all noted to have their Foley Catheters secured as of 10/1/2015. The MDS coordinator will keep a log of all residents requiring a catheter to monitor the practice of securing Foley catheters. | 10/20/2015 | |

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| F 315 | <p>Continued From page 4</p> <p>Review of the medical record revealed the facility admitted Resident #1 on 08/28/15 with diagnoses of Traumatic Brain Injury with Craniotomy, Cerebral Septic Emboli, and Unstageable Decubitus. Review of the admission Minimum Data Set (MDS) assessment dated 09/09/15 revealed the facility assessed Resident #1 to require the use of an indwelling urinary catheter due to an unstageable pressure ulcer. Review of the comprehensive care plan dated 09/17/15 revealed the facility addressed the use of the urinary catheter with interventions that included providing catheter care each shift and as needed and to secure the catheter and tubing appropriately.</p> <p>Catheter care was observed to be performed by facility staff for Resident #1 on 09/30/15 at 3:55 PM. The catheter was attached to a bedside drainage bag; however, the tubing was not secured to the resident's leg.</p> <p>Interviews conducted with Certified Nurse Aides (CNAs) #1 and #2 on 09/30/15 at 4:05 PM revealed the CNAs had been trained to anchor/secure the catheter tubing to the resident's leg to prevent pulling/trauma to the resident. However, both CNAs stated the tubing was not usually secured for residents who required urinary catheters.</p> <p>The Director of Nursing (DON) confirmed in an interview conducted on 10/01/15 at 3:05 PM that the urinary catheter tubing should be secured to the resident's leg with tape or secure device to prevent pulling and/or possible injury to the resident. The DON stated random rounds were made at least weekly to ensure resident care needs were provided; however, the DON stated</p> | F 315 | <p>F315 Continued</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>A new flow sheet was implemented to ensure that Foley catheters are secured on each shift (see attachment # 4). The MDS coordinator will keep a log of all residents requiring a catheter to monitor the practice of securing Foley catheters. Weekly checks will be performed on by the MDS coordinator, or Administrator in her absence, on residents included on the log to ensure all residents that require a Foley catheter have the catheter secured to prevent trauma or injury. A PI monitor will be put in place to monitor the effectiveness of the process changes and to re evaluate any need to additional measure to implemented to insure that all Foley catheters are secured to prevent trauma or injury to the residents. PI monitor will be reported out with quarterly PI meeting for discussion for improvements as needed.</p> | | |

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| F 315 | Continued From page 5 she had not checked residents to ensure the catheter tubing was secured appropriately "in a while." | F 315 | | |

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| K 000 | INITIAL COMMENTS Building: 01 Plan Approval: 1985 Survey under: NFPA 101 (2000 Edition) Facility type: SNF/NF Type of structure: Type I (332) Protected Smoke Compartments: Three Fire Alarm: Complete Fire alarm System Sprinkler System: Complete Sprinkler System (Wet) Generator: Type I Diesel and Type I Natural Gas. Natural Gas was original and Diesel was installed in 1996. A life safety code survey using 2786-S (Short Form) was initiated and concluded on 09/30/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. The facility is licensed for thirty-five (35) beds with the census being twenty-five (25) on the day of the survey. Deficiencies were identified during this survey at "F" level. | K 000 | | |
| K 062 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested | K 062 | K 062 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 9/30/2015 during life safety code inspection, it was noted that automatic sprinklers gauges has not been replaced or recalibrated since 3/17/2010. They are required to be replaced or tested at least every 5 years. Upon discovery of this deficient practice SimplexGrinnell contractor) was notified and all 8 gauges were replaced on 10/1/2015 before end of survey (see attachment #6) | 10/2/2015 |

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| NAME OF PROVIDER OR SUPPLIER WILLIAMSON ARH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 260 HOSPITAL DRIVE SOUTH WILLIAMSON, KY 41503 | | |
| (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 062 | <p>Continued From page 1</p> <p>periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure automatic sprinkler systems were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, thirty-five (35) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Record review of the automatic sprinkler inspection records on 09/30/15 at 1:31 PM, with Maintenance Staff, revealed the last time the gauges were replaced or recalibrated occurred on 03/17/10. Interview with Maintenance Staff revealed the gauges should have been replaced or recalibrated and Maintenance Staff was unsure why the outside contractor had not replaced or recalibrated the gauges as required.</p> <p>The Director of Nursing acknowledged the findings during the exit conference.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-3.2* Gauges. Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced.</p> | K 062 | <p>K062 Continued</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be impacted by this deficient practice. On 9/30/2015 during life safety code inspection, it was noted that automatic sprinklers gauges has not been replaced or recalibrated since 3/17/2010. They are required to be replaced or tested at least every 5 years. Upon discovery of this deficient practice SimplexGrinnell (contractor) was notified and all 8 gauges were replaced on 10/1/2015 before end of survey (see attachment #6)</p> <p>3. What Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 10/1/2015 all 8 gauges were replaced by SimplexGrinnell (see attachment #6) to bring automatic sprinkler system in compliance. The review of the gauges was added to the preventive maintenance program speed sheet with reminders to notify SimplexGrinnell of need for routine checks 2 months prior to expiring on 10/1/2020 and as needed for repair and general maintenance needed.</p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained. The review of the gauges was added to the preventive maintenance program speed sheet with reminders to notify SimplexGrinnell of need for routine checks 2 months prior to expiring on 10/1/2020 and as needed for repair and general maintenance as needed. The Maintenance supervisor will monitor the preventive maintenance program speed sheet and notify SimplexGrinnell as needed for inspection/repairs and maintenance to ensure that checks are done at minimum of every 5 years for the gauges for automatic sprinklers.</p> | | |