

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

PRINTED: 09/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2011
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NAME OF PROVIDER OR SUPPLIER MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066
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F 000	INITIAL COMMENTS An annual survey and an abbreviated survey (KY #15458, KY #16053, KY #16071 and KY #16562) were conducted on 09/06/11 through 09/09/11 and a Life Safety Code survey was conducted on 09/08/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal requirements with deficiencies cited at the highest S/S of an "F." KY #15458 was unsubstantiated with no deficiencies cited, KY #16053, KY #16071 and KY #16562 were substantiated with no deficiencies cited.	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food was prepared, distributed and served under sanitary conditions as evidenced by the staff handling the residents' food with their bare hands during the meal service on 09/06/11. The findings include: A review of the facility's policy and procedure	F 371	F 371 483.35(i) FOOD PROCURE STORE/PREPARE/SERVE - SANITARY It is the normal practice of Mills Health and Rehab Center to procure food from sources approved or considered satisfactory by federal, state or local authorities and store, prepare, distribute and serve food under sanitary conditions <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident #19, 20, 21, 22 and 23 were observed for symptoms of food borne illnesses. No residents were identified to have any symptoms as of 9/26/11 LPN #1 and ADON #1 have been re-educated on the proper handling of residents food by the DON on 9/09/11 CNA #1 has been re-educated on the proper handling of residents food by the ADON on 9/09/11 <u>How other residents who may have been affected by this practice were identified:</u> Residents receiving meal trays have the potential to be affected by the practice	10/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

[Signature] Administrator 10/03/11

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 371	<p>Continued From page 1</p> <p>"Serving Meal Trays" from Mosby's Textbook, Sixth Edition, revealed no information regarding handling of the residents' food with bare hands.</p> <p>Observations during the meal service, on 09/06/11, revealed three of the facility staff handled the residents' food with their bare hands. At 12:55 PM, Certified Nurse Aide (CNA) #1 touched Residents #19 and #20's rolls and cookies while setting up his/her meal trays. At 1:00 PM, Licensed Practical Nurse (LPN) #1 removed a sandwich from the wrapper and served it to Resident #21. At 1:15 PM, the Assistant Director of Nursing (ADON) removed a sandwich, cookies and rolls from the wrappers and served them to Residents #22 and #23.</p> <p>An interview with CNA#1, on 09/09/11 at 1:10 PM, revealed she got in a hurry to pass the lunch trays and "just did not think." She stated she was aware she should not touch the residents' food with her bare hands.</p> <p>An interview LPN #1, on 09/09/11 at 1:25 PM, revealed she "did not think." She stated she was trained not to handle the residents' food items with her bare hands.</p> <p>An interview with the ADON, on 09/09/11 at 1:40 PM, revealed she was aware she should not touch the residents' food with her bare hands but could not provide an explanation as to why she did so.</p> <p>An interview with the Dietary Manager (DM), on 09/09/11 at 1:35 PM, revealed kitchen staff were trained not to handle food items with their bare hands; however, she was not aware how the</p>	F 371	<p>F-371 (con't)</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All Staff responsible for distributing food will be re-educated on proper handling of food during meal services by the dietary manager, staff development nurse and DON by 10/12/11. In-servicing was initiated on 9/9/11. The dietary manager/registered dietician will be responsible to provide in-servicing for any employees who have not received the education by 10/12/11</p> <p>5 residents on each unit (approximately 11%) will be interviewed by the dietary manager to review proper handling of food during their meal service. Weekly X 4 weeks, then every 2 Weeks X 8 weeks then monthly X 6 Months.</p> <p><u>Monitoring Measures Implemented to Maintain Ongoing Compliance:</u></p> <p>The Dietary Manager, Registered Dietician and staff development nurse will conduct dining meal observations utilizing the revised dining observation tool 3 X a week X 4 weeks, then 2 X a week X 4 weeks, then 1 X per week X 4 weeks, then monthly ongoing.</p> <p>The results of the audits will be reported to the Administrator/DON and the facility's Quality Assessment and Assurance Committee.</p> <p>If any areas of concern are identified, the frequency and or number of the audits being conducted will be increased, or conversely, if no areas of concern are identified the number or frequency may be decreased.</p>		

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F 371	Continued From page 2 nursing staff were trained. An interview with the Dietician, on 09/09/11 at 2:10 PM, revealed the staff were trained not to handle food with their bare hands; however, she did not observe the staff as they handled the residents' food during the lunch meal. An interview with Director of Nursing (DON), on 09/09/11 at 11:00 AM, revealed she expected the staff to handle food appropriately while setting up meal trays or assisting the residents with their meals. She stated the staff were trained prior to being certified or licensed and should be aware of proper food handling.	F 371			

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NAME OF PROVIDER OR SUPPLIER MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70 (a) BUILDING: 01 PLAN APPROVAL: 1976 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (000) Unprotected SMOKE COMPARTMENTS: Six (6) smoke compartments. COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II Natural Gas Generator. A life safety code survey was initiated and concluded on 09/08/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 10/03/11
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K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested 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 observation and interview, the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected one (1) of six (6) smoke compartments. The facility is licensed for ninety-eight (98) beds and the census the day of the survey was eighty-seven (87).</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 09/08/11, at 12:05 PM, with the Maintenance Supervisor corrosion was noted on the two (2) sprinkler heads in the vestibule of the front entrance. Not maintaining sprinkler heads can decrease their ability to react as intended.</p> <p>Interview with the Maintenance Supervisor on 07/26/11, at 1:15 PM, revealed she thought the sprinkler company would replace them if it was required.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper</p>	K 062	<p>K 062</p> <p>It is the normal practice of Mills Health and Rehab Center to maintain the sprinkler system in proper working order.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p>No residents were identified in this deficiency. The sprinkler company was notified on 9/8/11 and replaced the 2 identified sprinklers on 9/29/11</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Residents present in the identified smoke compartment have the potential to be affected by this practice.</p> <p><u>Measures implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The maintenance supervisor was re-educated on 9/28/11 on proper sprinkler system maintenance and logging of inspections by the Administrator. A complete inspection of the sprinkler system was conducted by Premier Fire Protection, Inc. on 9/9/11</p> <p><u>Monitoring Measures Implemented to Maintain Ongoing Compliance:</u></p> <p>The administrator will audit the sprinkler inspection log quarterly</p>	10/14/11

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K 062	<p>Continued From page 2</p> <p>orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Based on record review and interview, it was determined the facility failed to ensure the sprinkler system was maintained, according to NFPA standards. The deficiency had the potential to affect approximately Ninety-Eight (98) residents, staff, and residents.</p> <p>The findings include:</p> <p>Based on Interview and Review of the facility's sprinkler maintenance inspection logs revealed no documented evidence of an internal pipe inspection for the dry pipe sprinkler system. The observation was confirmed by the Maintenance Director.</p> <p>Interview on 09/08/11 at 2:45 PM, with the Maintenance Director, revealed she was unable to located the documentation of the last internal pipe inspection for the dry pipe sprinkler system.</p> <p>Reference: NFPA 25 (1998 edition) 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined</p>	K 062			

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K 062	Continued From page 3 internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.	K 062	
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect Six (6) of Six (6) smoke compartments, all residents, staff and visitors. The facility is licensed for Ninety-Eight (98) beds; the census on the day of the survey was Eighty-Seven (87).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code Survey on 09/08/11 between 11:45 AM and 2:30 PM, with the Maintenance Supervisor, revealed Clean Linen Carts stored and not in use in East Long Hall, East Short Hall, West Long Hall and West Short Hall. The items observed in the corridors</p>	K 072	<p>K 072</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>Residents residing in the facility have the potential to be affected by the practice</p> <p><u>Measures implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All staff re-educated on proper linen storage on 9/28/11 by the Director of Nursing. Administrator/designee will be responsible to arrange education for any staff unable to attend by 10/12/11 Linen carts were removed from the hallway by the maintenance department on 9/30/11 All linens are stored in a linen closet on each unit as of 9/30/11</p> <p>10/14/11</p>

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K 072	<p>Continued From page 4 .</p> <p>were stored and not in use for a period of more than thirty (30) minutes. Means of egress must be kept clear at all times in case of fire or other emergency.</p> <p>Interview with the Maintenance Supervisor, confirmed the items located in the corridors and indicated that they were moved every thirty minutes.</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>K 072 (con't)</p> <p><u>Monitoring Measures Implemented to Maintain Ongoing Compliance:</u></p> <p>Administrator or supervising staff will monitor hall ways during routine rounds to verify presence of no linen cart storage in hallways. It will be conducted 5 X a week X 3 months. Results will be reported to the facility Quality Assurance committee.</p>	