

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

2nd SCD



PRINTED: 03/31/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2014
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NAME OF PROVIDER OR SUPPLIER  TRI-CITIES NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823
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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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F 000	INITIAL COMMENTS  A standard health survey was conducted on 02/18-20/14. Deficient practice was identified at "D" level.	F 000	Tri-Cities Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	Tri-Cities Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tri-Cities Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.  <b>ID Prefix Tag F431</b> The facility will continue to provide separately locked, permanently affixed compartments for storage of controlled drugs listed in the Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs	

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

TITLE

Administrative

(X6) DATE

4-3-14

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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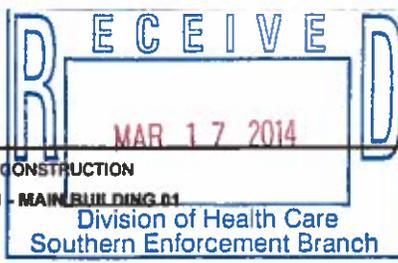
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/20/2014
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F 431	Continued From page 1  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure all controlled drugs were stored in a separate locked compartment. Observation of the medication room on the South Wing on 02/20/14, at 11:00 AM revealed two bottles of Lorazepam liquid (antianxiety medication), labeled as belonging to Resident A, stored with other noncontrolled drugs in the medication refrigerator which was unlocked.  The findings include:  Review of the facility's policy titled, "Medication Storage," which contained no date, revealed controlled substances would be stored under double lock.  Observation of the medication room on the South Wing on 02/20/14, at 11:00 AM revealed two bottles of Lorazepam liquid (antianxiety medication), labeled as belonging to Resident A, stored unlocked with other noncontrolled drugs in the medication refrigerator. The medication room door was locked.  Interview conducted with Licensed Practical Nurse (LPN) #1 on 02/20/14, at 11:05 AM, revealed she was required to keep the medication refrigerator locked at all times. The LPN stated she had just left the medication room and had forgotten to lock the refrigerator.  Interview conducted with the Director of Nursing	F 431	subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  On 2-20-2014 when the medication (lorazepam liquid) was discovered not to have been under two locks, the medication was checked to see if any was missing with the residents controlled narcotic count sheet and the medication was found to have been all there and the refrigerator was immediately locked upon notification from survey team that it was found not locked.  A 100% audit was done by the DON on 2-20-2014 checking for other possible scheduled medications that might not have been contained under two locks and no other medications were found out of compliance. The North side refrigerator held no narcotics in that refrigerator. On 3-28-2014 all Medication nurses and charge nurses including CMA's were in-serviced regarding controlled substances, proper label/storage of all medications/biologicals in medication rooms and how they are to be stored and that narcotics are to be contained under double locks and how the facility will monitor these areas. On 3-28-2014, the DON audited all medication rooms for		

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F 431	Continued From page 2 (DON) on 02/20/14, at 11:10 AM, revealed she monitored the medication rooms weekly to ensure the medication refrigerators and the medication room doors remained locked. The DON stated she had not identified any concerns with the medication refrigerators being unlocked.	F 431	<p>proper label/storage of all medications/biologicals stored by facility and no problems were identified.</p> <p>The charge nurses on South side will be responsible to check the refrigerator in South med room every two hours for two weeks then every four hours for two weeks then every six hours for two weeks then every shift for one month and thereafter with each narcotic count and they will document these checks on provided forms.</p> <p>The medication nurses, when counting narcotics for shift change, will be checking the medication rooms for proper label/storage of all medications/biologicals in both med rooms each shift for three months then daily thereafter and document on the provided forms.</p> <p>The ADON will check these forms weekly to assure that the staff passing medications are checking that the refrigerator containing narcotics is not found unlocked and all label/storage of drugs and biologicals are stored properly.</p> <p>Audit results will be forwarded to Administrative/Executive Committee for follow up as appropriate and to determine the frequency and/or need for continued monitoring.</p>	3-28-14	

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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: 1998</p> <p>SURVEY UNDER: 2000 Existing (using 2786S Short Form)</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (111)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Natural gas generator</p> <p>A life safety code survey was initiated and concluded on 02/20/14. 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.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000	<p>Tri-Cities Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.</p> <p>Tri-Cities Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tri-Cities Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p>	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeff Wilton</i>	TITLE Administrator	(X6) DATE 3-14-14
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NAME OF PROVIDER OR SUPPLIER  <b>TRI-CITIES NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823</b>	
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K 056	<p>Continued From page 1</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that the building sprinkler system was installed throughout the facility according to NFPA standards. This deficient practice affected three of six smoke compartments, staff, and approximately 26 residents. The facility has the capacity for 85 beds with a census of 70 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 02/20/14 at 10:40 AM, with the Director of Maintenance (DOM), a canopy at the South Rear entrance was observed to be over 4 feet in width and was not sprinkler protected. Canopies over 4 feet in width are required to be sprinkler protected unless they are made of non- or limited combustible material.</p> <p>An interview with the DOM on 02/20/14 at 10:40 AM revealed he was not aware if the canopy</p>	K 056	<p><b><u>ID Prefix Tag K 056</u></b></p> <p>The facility will continue to ensure that the building sprinkler system is installed throughout the facility according to NFPA standards.</p> <p>On 2-21-14, the facility placed an order with the awning company to have the three entrance canopies recovered with fire retardant materials.</p> <p>On 3-11-14, the awning company installed the new coverings with the fire retardant materials.</p> <p>The awning company provided the facility with a "Certificate of Flame Resistance" showing the materials used have been treated with a flame retardant chemical approved and registered by the State Fire Marshal.</p> <p>The facility will maintain the certification for inspection.</p>	3-11-14

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K 056	Continued From page 2 material was constructed of non- or limited combustible material.  During the survey two other canopies over 4 feet in width constructed of the same type of material were observed at the North entrance and Kitchen entrance of the facility.  The findings were revealed to the Administrator upon exit.  Reference: NFPA 13 (1999 Edition).  5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	<b><u>ID Prefix Tag K 066</u></b>  The facility will continue to ensure that smoking areas are maintained according to NFPA standards.  On 2-26-14, the facility ordered two steel self closing containers for use at the facility. One will be located in the resident smoking area in which to empty cigarette ashtrays in. The other will be utilized by the housekeeping department when they empty smoking receptacles at other locations in the facility courtyards and transport the ashes outside to be disposed of.  On 2-26-14, the facility also ordered six "Smokers Outpost" receptacles which are self contained units to deposit cigarette butts. These will be located in the inner courtyards for disposal of cigarettes.  The housekeeping supervisor will randomly monitor these areas for proper disposal of cigarettes.	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.	K 066		3-7-14

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K 066	<p>Continued From page 3</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoking areas according to NFPA standards. This deficient practice would affect four of six smoke compartments, staff, and approximately 49 residents. The facility has the capacity for 85 beds with a census of 70 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 02/20/14 at 10:30 AM with the Director of Maintenance (DOM), a smoking room inside the facility was observed not to have a metal self-closing container to empty cigarette ashtrays in as required. An interview with the DOM on 02/20/14 at 10:30 AM revealed he had tried to order metal self-closing containers but could not get the order approved. During the survey, additional observations of the smoking areas of two inner courtyards revealed no metal self-closing containers for disposal of cigarette ashtrays.</p> <p>The findings were revealed to the Administrator upon exit.</p>	K 066		
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