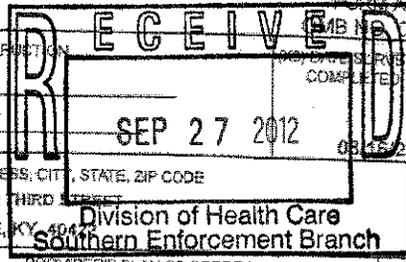


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2012  
FORM APPROVED  
OMB No. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		DATE OF SURVEY COMPLETED 08/16/2012
NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 842 NORTH THIRD STREET DANVILLE, KY 40417		
(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  A standard health survey was conducted on 08/14-16/12. Deficiencies were cited with the highest scope and severity at "E" level.	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A sink was observed to be clogged and not draining properly in the Reflections Unit and a door to a resident room on Unit 1 was sticking and could not be easily opened.  The findings include:  An interview conducted with the Maintenance Director on 08/16/12, at 5:10 PM, revealed the facility did not have a written maintenance policy. According to the Maintenance Director, it was the facility practice for staff to complete a maintenance request at the nurses' stations on the units for items in need of repair, and the maintenance staff collected the maintenance requests daily from the nurses' stations on each unit. Additional interview revealed Maintenance conducts rounds in the facility daily to identify items in need of repair.	F 253	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F253 The Danville Centre will continue to provide maintenance service necessary to maintain a sanitary and comfortable interior.  Maintenance Director immediately upon notification repaired the clogged sink in the Reflections unit. Maintenance Director also repaired the sticking door on Unit 1.  An audit was conducted on all resident rooms for any maintenance issues, including sinks and resident doors in the facility and any concerns were immediately repaired.  As a part of weekly environmental rounds Maintenance and/or Executive Director will randomly audit facility rooms for any maintenance issues including bathroom sinks to make sure they are draining properly and will randomly audit resident doors to ensure they are functioning properly.  The facility will utilize the Angel Care program to interview residents regarding any concerns they may have related to room repairs and maintenance. The Angel will also weekly audit resident rooms for any maintenance issues, including bathroom sinks and doors.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Quarah L. Wilson* TITLE: *Executive Director* DATE: *9/25/2012*

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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NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 542 NORTH THIRD STREET DANVILLE, KY 40422		
(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 253	Continued From page 1 Observations conducted during an environmental tour conducted on 08/16/12, at 9:15 AM, revealed the sink in resident room 28 was clogged and not draining properly. Additional observations conducted on 08/16/12, at 4:30 PM, revealed a door to resident room 5 was sticking and could not be easily opened.  An interview conducted with the Maintenance Director revealed a maintenance request had not been submitted for the sink or the door and the Maintenance Director had not identified the clogged sink or the sticking door during daily maintenance rounds.		F 253 The Staff Development Coordinator (SDC) or Maintenance Director will educate all staff on the process to complete a maintenance request for any maintenance issues identified in the facility from September 13, 2012 through September 17, 2012.  The Maintenance supervisor will bring any concerns identified to the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.		
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, the facility failed to ensure services were provided in accordance with the plan of care for one of twenty-one sampled residents (Resident #1). Resident #1's care plan directed staff to utilize mattress bolsters on the resident's bed to prevent falls; however, the bolsters were not in place on 08/14-15/12.  The findings include:		F 282  Completion date: September 30, 2012  F282 The Danville Centre will continue to provide quality care according to the resident's individual care plan.  A new mattress with bolsters was delivered by Recovery Care on August 15, 2012.  An audit was conducted on all beds and all mattresses to ensure the care plans and C.N.A. assignment sheets were being followed regarding the implementation of all devices.		

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F 282	<p>Continued From page 2</p> <p>A review of the facility's Accident and Supervision to Prevent Accident policy (dated 04/28/11) revealed preventative measures to prevent falls would be implemented and addressed in the resident's care plan.</p> <p>A review of the medical record revealed the facility admitted Resident #1 on 02/07/12, with diagnoses to include Osteoporosis, Pressure Ulcer, Dementia, Failure to Thrive, and Parkinson's Disease. A review of the quarterly (MDS) assessment (reference date 07/13/12) revealed the facility assessed the resident to require total assistance of staff for bed mobility and transfers. The facility also assessed the resident to have sustained one fall during the assessment reference period, on 07/13/12, with no injury identified.</p> <p>A review of the post fall evaluation dated 06/19/12, revealed Resident #1 sustained a fall from the bed at 5:50 PM on 06/19/12. The resident was assessed to have no injuries from the fall. The fall evaluation further revealed bolsters and fall mats were to be implemented to prevent further falls.</p> <p>A review of the comprehensive care plan dated 06/19/12, revealed the facility identified the resident's fall from the bed on 06/19/12, and developed interventions to place the resident on the "falling star" program, to utilize an air mattress with upper and lower bolsters, and to place fall mats on each side of the resident's bed.</p> <p>Resident #1 was observed on 08/14/12, at 12:00 PM, at 2:40 PM, at 3:50 PM, and at 7:00 PM, to be lying on the bed with an alternating pressure</p>	F 282	<p>The facility will audit 20% of the care plans per month until all care plans have been audited to ensure all items are in place and are on the care plans and they match the CNA assignment sheets. Upon 100% completion of that audit, random audits of 10% per month will be conducted to ensure ongoing compliance.</p> <p>As part of the Angel Care Program weekly rounds will be conducted by the angel care members and they will ensure all care planned items are in place for that resident. The round sheets will be turned into the Executive Director and/or DNS who will address any issues.</p> <p>The Staff Development Coordinator will conduct an all staff education on September 13 through September 17, 2012 to educate on following care plans and C.N.A. assignment sheets.</p> <p>The Executive Director will bring any concerns identified to the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further inventions or corrective actions will be implemented as necessary.</p> <p>Completion date: September 30, 2012</p>		

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F 282	<p>Continued From page 3</p> <p>relief mattress. Fall mats were observed on each side of the bed. On 8/15/12, at 8:52 AM, at 10:00 AM, and at 1:05 PM, the resident was again observed to be lying on the bed with fall mats in place. However, based on the observations conducted on 08/14/12 and 08/15/12, facility staff failed to ensure bolsters were utilized for Resident #1.</p> <p>Interview with Certified Nurse Aide (CNA) #2 on 08/15/12, at 4:20 PM, revealed CNA #2 routinely provided care for Resident #1 and knew the bolsters were to be utilized for the resident to prevent falls. CNA #2 stated she did not report the bolsters were not on the resident's mattress to the nurse after a different mattress had been placed on the resident's bed.</p> <p>Interview with the Unit Manager (UM) on 08/15/12, at 4:15 PM, revealed she did not know the mattress had been changed and no one had reported to her the bolsters were not in place on the resident's bed. The UM stated she made daily rounds to ensure care plan interventions were in place, but had failed to identify the bolsters were not in use for Resident #1 in accordance with the resident's plan of care.</p> <p>Interview conducted with the Director of Nurses (DON) on 08/15/12, at 3:00 PM, revealed the bolsters had been implemented for Resident #1 after the resident sustained a fall on 08/18/12. However, the DON stated the mattress had been changed on 08/06/12, and the bolsters should have been placed on the new mattress. The DON stated she was not aware the bolsters had not been placed on the new mattress.</p>	F 282			

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F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to provide appropriate treatment and services to maintain/restore as much bladder function as possible for one of twenty-one sampled residents (Resident #8). Resident # 6 was assessed to be occasionally incontinent of bladder on 11/25/11. A quarterly assessment on 07/03/12, revealed the resident was assessed to be always incontinent. However, there was no evidence the facility had assessed Resident #6 to identify causative factors of the decline in the resident's bladder function in an attempt to restore as much bladder function as possible.</p> <p>The findings include: A review of the facility's Bladder Status Evaluation Policy, dated 04/28/11, revealed the facility was to identify the resident's continence status upon admission/readmission, annually, and/or if a change in continence status occurs. According to</p>	F 315	<p>F315 The Danville Centre will continue to provide quality care by ensuring appropriate treatment and services to maintain, restore as much bladder function as possible. A 3-day voiding pattern was completed on resident #6 and resident was placed on a scheduled toileting program and resident was referred to therapy for the UI Rehab. program. An audit was completed by MDS coordinators to identify any resident who declined in incontinence. Residents identified in the audit will be placed on a 3 day voiding pattern and the IDT will review and determine the correct bladder program. During quarterly assessments by the MDS office any residents identified with increased incontinence will notify the DNS and/or Unit Managers of decline to implement 3 day voiding pattern. The Staff Development Coordinator will conduct an all staff education on September 13 through September 17, 2012 to educate on the completion of the 3 day voiding.</p>		

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F 315	<p>Continued From page 5</p> <p>the policy, a licensed nurse was to obtain historical information related to urinary incontinence including voiding patterns, medication review, fluid intake patterns, cognitive status, pertinent diagnoses which could affect urinary function, and environmental factors. In addition, a baseline voiding record was to be obtained for three days to assess for a pattern of voiding. The type of incontinence was to be determined following the assessment and a treatment/retraining intervention was to be tailored to the resident's needs. There was no indication in the policy regarding the specific staff member responsible to develop/implement/communicate the interventions addressing a resident's incontinence.</p> <p>A review of the medical record revealed Resident #6 was admitted to the facility on 11/18/11, with diagnoses including status-post Fractured Right Humerus, End Stage Renal Disease, Anemia, Hypertension, and Depression. A review of the Minimum Data Set (MDS) admission assessment with an assessment reference date of 11/25/11, revealed Resident #6 was occasionally incontinent with no toileting program or trial in progress. A quarterly MDS assessment with an assessment reference date of 07/03/12, revealed the resident was assessed to be always incontinent. There was no evidence a urinary toileting program/trial was in place for Resident #6 in an attempt to restore the resident's bladder function as much as possible.</p> <p>Observations of Resident #6 throughout the survey revealed the resident was alert, oriented, and able to make her needs known. An interview</p>	F 315	<p>The MDS Coordinator will notify the Director of Nursing any concerns regarding incontinence. The Director of Nursing will bring any concerns identified to the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary</p> <p>Completion date: September 30, 2012</p>		

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NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422	
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F 315	Continued From page 6 conducted with Resident #6 on 08/16/12, revealed the resident had worn incontinence pads for "quite a while." The resident further stated staff responded promptly when he/she activated the call light.  An interview with State Registered Nurse Aide (SRNA) #3 on 08/16/12, at 11:15 AM, revealed SRNA #3 believed the resident's incontinence had slightly improved recently.  An interview with Licensed Practical Nurse (LPN) #2 on 08/15/12, at 2:30 PM, revealed LPN #2 had completed the quarterly MDS assessment dated 07/03/12. LPN # 2 stated she had e-mailed the Director of Nursing (DON) to notify her of the change in Resident #6's continence status when the assessment was completed. LPN #2 further stated she was unable to locate a copy of the e-mail, that she "must have deleted it."  An interview with the DON on 08/16/12, at 11:20 AM, revealed no further assessment was conducted for Resident #6 because the DON was unaware of the change in continence status for the resident. According to the DON, LPN #2 should have communicated the change in status to the DON so further assessment could have been done. The DON stated LPN #2 failed to inform the DON of the change in continence status for Resident #6 so no additional assessment was done.	F 315		
F 332 SS=D	463.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 332	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the medication error rate was not, and did not exceed, five percent. Observation of a medication pass revealed staff failed to administer three of forty-four medications in accordance with physician's orders. As a result of the medication errors, it was determined the facility had a medication error rate of six percent. Resident #2 was to receive Depakote 125 milligrams, and Depakote 250 milligrams was prepared for administration. Unsampled Resident A was ordered to have Haldol 2.5 milligrams and the dose was omitted. Unsampled Resident B was ordered to have Calcium Gluconate 2 milligrams, and Calcium Gluconate 2.5 milligrams was administered.  The findings include:  A review of the facility policy titled Medication Administration, dated 08/31/11, revealed the licensed nurses or certified personnel were required to read the medication administration record (MAR) and compare the MAR with the label on the medication to ensure the right medication and strength, and administered to the right resident.  1. Observation of medication administration for Resident #2 conducted on 08/15/12, at 2:00 PM, revealed Licensed Practical Nurse (LPN) #1 prepared 250 milligrams (mg) of Depakote for administration to Resident #2.	F 332	F332 The Danville Centre will continue to provide quality care by ensuring we are free of medication errors.  The order for Depakote 250 mg. was discontinued and the medication was pulled from the medication cart and destroyed.  The Haldol for Resident A was ordered by the MD and started on August 16, 2012.  MD was called and order was received for potassium gluconate 2.5 mg for Resident B. On 8/17/2012 labs were obtained and potassium was within therapeutic range.  The Unit Managers will audit the medication carts to ensure that the medication that is ordered is actually the medication in the cart. Any concerns identified will be corrected immediately.  Monthly the Director of Nursing will randomly audit the medication carts to ensure that the medication that is ordered is actually the medication in the cart. Any concerns identified will be corrected immediately.		

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F 332	Continued From page 8  However, a review of the Medication Administration Record (MAR) and the physician's order for Resident #2 revealed the resident was to receive 125 mg of Depakote three times daily.  An interview conducted with Licensed Practical Nurse (LPN) #1 on 08/15/12, at 2:00 PM, revealed the LPN had reviewed the Medication Administration Record (MAR) for Resident #2 and prepared the dosage of medication in accordance with the directions on the label of the medication bottle located in the resident's drawer of the medication cart. LPN #1 was not aware the resident's medication had been changed by the physician or that the dosage on the MAR did not match the dosage on the medication label on the medication bottle. Additional interview revealed LPN #1 did not know why the old bottle of Depakote had not been removed from the cart when the resident's medication dose had changed.  2. A review of the medical record for Resident A revealed a physician's order for Haldol 2.5 mg to be administered three times daily. However, observation of medication administration for Resident A on 08/15/12, at 1:50 PM, revealed LPN #3 failed to administer the 2.5 mg of Haldol to Resident A as prescribed by the physician.  An interview conducted with LPN #3 on 08/16/12, at 13:55 PM, revealed the Haldol was not administered to Resident A because the order had been "yellowed out" on the MAR and the LPN thought the medication had been discontinued.  An interview conducted with Registered Nurse	F 332	The Staff Development Coordinator will in-service all licensed nursing staff on medication pass techniques including checking the medication against the MAR to ensure the correct medication and dosage is being given on September 13 through September 17, 2012. Also an educational video on preventing medication errors will be viewed as part of this training.  The Director of Nursing will bring any concerns identified to the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary  Completion date: September 30, 2012		

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F 332	Continued From page 9 (RN) #3 on 08/16/12, at 2:00 PM, revealed prior to the start of the Medication Pass on 08/16/12, at 2:00 PM, the RN had accidentally "yellowed out" the Haldol order on the MAR when the physician had discontinued another medication.  3. Observation of medication administration for Resident B on 08/16/12, at 9:00 AM, revealed LPN #3 administered 2.5 milliequivalents (meq) of Potassium Gluconate orally to the resident.  A review of the physician's orders for Resident B dated 08/01/12, revealed the resident was to receive 2 meq of Potassium Gluconate orally every day.  An interview conducted with LPN #3 on 08/16/12, at 9:05 AM, revealed she became "nervous" during the medication administration observation and failed to check the dosage of the Potassium Gluconate for Resident B as required.	F 332			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334	F334 The POA of resident #9 was contacted by the Unit Manager on 8/15/2012. POA refused the influenza and pneumococcal immunization at that time.  An audit was completed on 8/15/2012 on all residents in the facility for documentation of TB, influenza and pneumococcal. The hospitals and MD's were contacted for those residents without documentation of these immunizations. POA's were notified and permission and/or refusal was obtained immunizations were administered accordingly.		

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NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
(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 334	<p>Continued From page 10 immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p>	F 334	<p>The Director of Nursing educated the Unit Managers on 8/16/2012 the process to verify immunization records upon admission.</p> <p>DNS will verify documentation of refusal or administration of immunizations within 1 week of a new admission. Any concerns will be addressed immediately.</p> <p>The Director of Nursing will bring these audits to the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.</p> <p>Completion date: September 30, 2012</p>		

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NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
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F 334	<p>Continued From page 11</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility policy, the facility failed to ensure a pneumococcal vaccine was provided for one of twenty-one sampled residents (Resident #9). The facility provided vaccine education to Resident #9's legal representative; however, there was no evidence the facility provided the resident's legal representative an opportunity to consent to/refuse the vaccine for the resident.</p> <p>The findings include: A review of the immunization policy (dated 04/28/11) revealed the influenza and pneumococcal vaccine would be provided unless the vaccine was medically contraindicated, refused, or the resident had previously been vaccinated. The policy noted education would be provided to the resident or the resident's legal representative and staff would document the information in the resident's medical record. In addition, the policy noted the administration, the refusal of, or medical contraindication to the vaccine(s) would also be documented in the resident's medical record.</p>	F 334			

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NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 542 NORTH THIRD STREET DANVILLE, KY 40422		
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F 334	<p>Continued From page 12</p> <p>Review of the medical record revealed the facility admitted Resident #9 on 09/05/11, with diagnoses to include Osteoporosis, Hypertension, Alzheimer's Disease, Peripheral Vascular Disease, and Anemia.</p> <p>A review of the Vaccine Information Sheet Acknowledgement form revealed education regarding the risks and benefits of the influenza and pneumococcal vaccines had been provided to the resident's legal representative on 09/05/11, when the resident was admitted to the facility. However, there was no documentation the legal representative had refused or consented to the administration of the pneumococcal vaccine for Resident #9.</p> <p>Review of the immunization record for Resident #9 revealed no documentation the pneumococcal vaccine had been administered to the resident.</p> <p>Interview conducted with the Admissions Coordinator on 08/15/12, at 3:50 PM, revealed she was responsible to provide the education of the risks/benefits of the vaccines to the resident's legal representative when a resident was admitted to the facility. The Admissions Coordinator stated she was not responsible to obtain consent/refusal of the vaccines from the resident's legal representative.</p> <p>interview conducted with Unit Manager (UM) #2 on 08/15/12, at 4:05 PM, revealed the UM was responsible to obtain consent/refusal of the vaccine and document the information in the nurse's notes when the resident was admitted to the facility. The UM stated if indicated, the</p>	F 334			

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F 334	Continued From page 13 vaccine should be administered and documented in the resident's immunization record. The UM stated she was not the UM at the time of Resident #9's admission to the facility and reported the former UM was no longer at the facility and could not be contacted for interview.  Interview with the DON on 08/15/12, at 5:20 PM, revealed the nurses were responsible to talk with the resident's legal representative regarding consent/refusal of the vaccines and to document the information in the resident's medical record. The DON stated the facility did not have a system to monitor the consent/refusals and to ensure the vaccines were administered, if indicated, to the residents.	F 334		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure foods were palatable and at the proper temperature for residents on the "Back Hall" of the facility during the evening meal on 08/14/12.  The findings include:  A review of the facility Internal Food Temperature policy (dated 10/21/10) revealed temperature	F 364	F364 A change in the process for delivering trays was implemented. The Management staff will monitor the dining rooms during meal times to free up the dining room C.N.A. to go to the floor to assist residents. The evening meal a nurse manager is scheduled until 7:00 p.m. to ensure all hall trays are delivered timely. On the weekend the weekend manager is responsible to ensure all hall trays are delivered timely for all meals.  The facility will conduct at least one "test tray" temperature audit 3 times per week for a period of four weeks, then	

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F 364	<p>Continued From page 14</p> <p>guidelines to be utilized to decrease the risk of foodborne illness. The policy noted food temperature also affected the quality of food. However, the policy did not reflect temperature guidelines for the point of service for the residents.</p> <p>Observation of the evening meal revealed a closed cart was transferred from the kitchen to the "Back Hall" at 6:58 PM. The cart was observed to contain 12 trays. The last tray was removed at 7:30 PM (32 minutes after it arrived at the unit) and was intercepted by the surveyor to conduct a test tray.</p> <p>Observations of the test tray conducted with the Registered Dietitian (RD) on 08/14/12, at 7:32 PM, revealed the country fried steak tasted barely warm, the oven potatoes tasted cold, and the carrots tasted cold. The RD confirmed the palatability of the food items.</p> <p>Interview with the Dietary Manager (DM) on 08/15/12, at 4:45 PM, revealed test tray audits of the breakfast and lunch meals were conducted routinely. However, the DM stated she was not usually at the facility during the dinner meal and there had not been any test tray audits conducted to test the palatability of the foods for approximately four to six months. The DM stated ideally 12 trays should have been delivered within 15 minutes.</p> <p>Interview conducted with the Director of Nursing (DON) on 08/15/12, at 5:20 PM, revealed the facility did not have a policy regarding timeframes for tray delivery or food palatability. The DON stated she had not monitored tray delivery to</p>	F 364	<p>once a week for eight weeks from all three meals.</p> <p>The Registered Dietician will complete the Nutritional Services Evaluation Tool monthly, which addresses food palatability. This tool will be used to monitor compliance with the corrective actions herein to insure ongoing compliance is maintained</p> <p>The facility will utilize the Angel Care program and to ask residents weekly about any concerns with food temperatures. Any concerns will be written up and taken to the morning meeting as part of the white board process for immediate follow by the NSM.</p> <p>The Nutrition Services Manager and/or Registered Dietician will be available to attend the facility monthly Resident Council Meeting in order to discuss food temperature concerns that the residents may have. Any concerns will be immediately addressed at that time and will also be presented at the monthly Performance Improvement (PI) Committee meeting for the next three</p>	

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F 354	Continued From page 15 ensure food was palatable when served to the residents.	F 364	months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.		
F 368 SS=E	453.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.  There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.  The facility must offer snacks at bedtime daily.  When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to provide meals at regular times for residents during the evening meal on 08/14/12. The evening meal was scheduled to begin at 5:00 PM; however, observations revealed the first meal cart was not delivered to the Reflections Hall from the kitchen until 6:50 PM.  The findings include:  A review of the Meal Frequency policy (dated	F 368	The NSM and/or RD will educate all nursing and dietary staff with regard to the facility's policies and procedures related to serving food within the palatable temperature range of 120 to 130 degrees Fahrenheit for hot food and 40 to 60 degrees Fahrenheit for cold foods.  Completion date: September 30, 2012  F368 A system has been implemented in which the dietary staff will document the time the cart leaves the kitchen and the nursing staff will document the time the cart is received on the hallway. These audits will be reviewed daily by the NSM and any concerns will be addressed immediately.  The facility will utilize the Angel Care program to identify any concerns residents have with meal service. Any concerns will be written up and taken to the morning meeting as part of the white		

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F 358	<p>Continued From page 16</p> <p>10/31/08) revealed residents were to be served at least three meals per day at regular times comparable to normal meal times of the community. The policy also noted a schedule of meal times would be posted at each nursing unit and resident areas.</p> <p>A review of the meal schedule revealed the first breakfast food cart would be delivered at 7:00 AM, the first lunch cart would be delivered at 11:45 AM, and the first dinner food cart would be delivered at 5:00 PM. The last evening food cart was scheduled to be delivered to the Unit I Back Hall between 6:05 PM and 6:20 PM.</p> <p>An interview with Resident #10 on 08/15/12, at 4:30 PM, revealed the supper meal was often served late. Resident #10 stated breakfast and lunch were usually served close to their scheduled times and stated when the supper meal was served late, the food was often "lukewarm." Resident #10 further stated that having supper so late also interfered with the evening activities schedule.</p> <p>Observations conducted during the evening meal on 08/14/12, revealed the first cart was transferred from the kitchen to the Reflections Hall at 6:50 PM. The last cart was observed to be delivered to the Unit I Back Hall at 6:58 PM.</p> <p>Interview with CNA #1 on 08/14/12, at 6:55 PM, revealed the dinner meal was not always delivered to the units at the scheduled times and, as a result, the residents "often" received their evening meal "late."</p> <p>Interview with the Dietary Manager (DM) on</p>	F 358	<p>board process for immediate follow by the NSM.</p> <p>The Nutrition Services Manager and/or Registered Dietician will be available to attend the facility monthly Resident Council Meeting in order to discuss food temperature concerns that the residents may have. Any concerns will be immediately addressed.</p> <p>The NSM or RD will educate all dietary staff with regard to the facility's policies and procedures related to meal delivery times from September 13, 2012 through September 17, 2012.</p> <p>The NSM will present at the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter any concerns regarding meal service. Further inventions/corrective actions will be implemented as necessary.</p> <p>Completion date: September 30, 2012</p>		

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F 368	Continued From page 17 08/16/12, at 4:45 PM, revealed she was not usually at the facility during the evening meal and had not monitored the meal service to ensure the meal was delivered according to the posted schedule, but no concerns had been reported to her. The DM stated the dietary cook had become "nervous" and did not know what caused the delay in the meal service.	F 368			
F 372 SS-4C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure garbage and waste were disposed of properly. During the initial tour of the facility on 08/14/12, the facility's two large dumpsters were observed to have litter and trash on the ground adjacent to the dumpsters. In addition, the two dumpsters had a brown greasy substance with a foul odor spilled down the outside of both dumpsters, creating an environment accessible to rodents, flies, and roaches.  The findings include:  A review of the facility's Non-Hazardous Waste Disposal policy, dated 04/28/09, revealed the non-hazardous waste was collected and discarded by Housekeeping and all other personnel as needed (i.e. kitchen staff). The policy also stated not to leave any trash along the top of the dumpster.	F 372	F372 Maintenance Director immediately cleaned the area and picked up trash and litter around the dumpster. He also pressure washed the area.  Maintenance Director and/or his designee will audit the dumpster area on a daily basis and pressure wash are needed.  The SDC or Maintenance Director will educate all staff from September 13, 2012 through September 17, 2012 in regard to reporting to the Maintenance department if they observe an unclean dumpster area  The dumpster audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting for the next three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.  Completion date: September 30, 2012		

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F 372	Continued From page 18  The initial tour of the facility Dietary Department on 08/14/12, at 10:30 AM, revealed the dumpster to have scattered bits of paper litter, nine disposable gloves, and spillage under the dumpster sliding window. The substance appeared to be a brown greasy substance with a foul odor.  An interview was conducted with the Dietary Manager on 08/14/12, at 11:00 AM. The Dietary Manager (DM) stated the Maintenance Department was responsible for cleaning the area, which would include hosing the concrete pad and cleaning the litter and trash in the surrounding area. The DM stated she was not certain when Maintenance staff cleaned the trash storage area.  An interview with a Maintenance staff person was conducted on 08/16/12, at 3:30 PM; the Maintenance staff person stated the dumpster area had not been cleaned "for a week or two." The Maintenance staff person also stated he was not sure how often the dumpster area was scheduled for a detailed cleaning with a pressure washer.	F 372			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	F425 MD was called and order was received for potassium gluconate 2.5 mg for Resident B. On 8/17/2012 labs were obtained and potassium was within therapeutic range.  The Unit Managers will audit the medication carts to ensure that the		

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F 425	<p>Continued From page 19</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, policy review, and a review of a facility contract, it was determined the facility failed to ensure pharmaceutical services, including procedures to assure the accurate dispensing of drugs and biologicals, had been provided for one of two unsampled residents (Resident B). Resident B had a physician's order for 2 milliequivalents of Potassium Gluconate to be administered orally every day. However, pharmaceutical services dispensed, and the nurse administered, 2.5 milliequivalents of Potassium Gluconate to the resident on 08/14/12, 08/15/12, and 08/16/12.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Medication Administration," dated 08/31/11, revealed the licensed nurses or certified personnel were required to read the medication administration record (MAR) and compare the MAR with the label on the medication to ensure medications</p>	F 425	<p>medication that is ordered is actually the medication in the cart. Any concerns identified will be corrected immediately and the Pharmacy will be notified.</p> <p>The SDC reeducated LPN #3 on the process to verify the correct dosage and strength of medications.</p> <p>Monthly the Director of Nursing and the Pharmacy representative will randomly audit the medication carts to ensure that the medication that is ordered is actually the medication in the cart. Any concerns identified will be corrected immediately.</p> <p>The Staff Development Coordinator will in-service all licensed nursing staff on medication pass techniques including checking the medication against the MAR to ensure the correct medication and dosage is being given. This will take place on September 13 through September 17, 2012. Also an educational video on preventing medication errors will be viewed as part of this training.</p> <p>The Director of Nursing will bring any concerns identified to the monthly</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/16/2012
NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
(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 425	<p>Continued From page 20</p> <p>prepared and administered were the right medication name and strength.</p> <p>A review of the facility's contract with the pharmacy service utilized by the facility, dated 07/01/04, revealed the pharmacy would provide pharmaceutical services to the facility and the facility's residents in accordance with the orders of the residents' attending physicians.</p> <p>A review of the physician's orders for Resident B dated 08/01/12, revealed a physician's order for 2 milliequivalents (meq) of Potassium Gluconate to be administered orally every day.</p> <p>Observation of medication administration for Resident B on 08/16/12, at 9:00 AM, revealed Licensed Practical Nurse (LPN) #3 administered 2.5 meq of Potassium Gluconate, orally, to the resident.</p> <p>An observation of the medications provided by the contracted pharmaceutical services for Resident B, revealed a medication container that held Potassium Gluconate in a dosage of 2.5 meq. Continued observation of the container and the MAR revealed that based on the number of the 2.5 meq doses of Potassium Gluconate dispensed by Pharmaceutical Services and the number of the 2.5 meq doses of Potassium Gluconate that remained in the container, Resident B had received 2.5 meq of Potassium Gluconate on 08/14/12, 08/15/12, and 08/16/12, instead of 2 meq of Potassium Gluconate as prescribed by the physician.</p> <p>LPN #3 acknowledged in interview conducted on 08/16/12, at 9:05 AM, that she had failed to</p>	F 425	<p>Performance Improvement (PI)</p> <p>Committee meeting for the next three months and as needed thereafter. Further interventions/corrective actions will be implemented as necessary</p> <p>Completion date: September 30, 2012</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/16/2012
NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
(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 425	<p>Continued From page 21</p> <p>compare the Potassium Gluconate with the resident's MAR. The LPN stated she had administered the 2.5 meq of Potassium Gluconate that had been dispensed by Pharmaceutical Services to Resident B for three days. The LPN acknowledged Pharmaceutical Services had provided the wrong dosage of the medication.</p> <p>The pharmacist from the contracted pharmaceutical services that provided medications to the facility acknowledged in an interview conducted on 08/16/12, at 1:55 PM, the wrong dosage of Potassium Gluconate had been sent to the facility because the pharmacy did not have the correct dosage in stock. The pharmacist stated pharmacy staff should have notified the facility when the dosage of a medication that had been ordered by the physician was unavailable and stated pharmacy staff had failed to notify the facility of the medication substitution.</p> <p>An interview conducted with the Director of Nursing (DON) on 08/16/12, at 3:30 PM, revealed the facility expected the pharmacy to notify Nursing Services whenever a dosage of medication prescribed by a physician was not available. The DON also stated the LPN should have ensured she was administering the correct dosage of medication to the resident by comparing the medication card with the MAR. The DON stated she had conducted an audit of medication administration for approximately one month and had not identified any problems.</p>	F 425			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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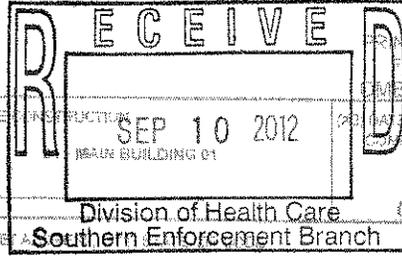
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/16/2012
NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
(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)	DATE COMPLETION DATE	
F 431	<p>Continued From page 22</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, it was determined the facility failed</p>	F 431	<p>F431</p> <p>All medication carts in the facility were immediately cleaned and made free of pill debris and spills.</p> <p>Medication carts will be audited twice a week by the Unit Managers and the Weekend Manager for 1 month and then weekly for the following 2 months and ongoing audits monthly for an indefinite period of time.</p> <p>The DNS will randomly audit a medication cart every week and ongoing.</p> <p>SDC will provide education on September 13 through September 17, 2012 to the licensed nurses on proper medication storage and cleaning of the medication carts daily.</p> <p>The medication cart audits will be reviewed in the monthly Performance Improvement (PI) Committee for the next three months and as needed thereafter. Further inventions/corrective actions will be implemented as necessary.</p> <p>Completion date: September 30, 2012</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  08/16/2012
NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
(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 431	<p>Continued From page 23</p> <p>to store medications according to acceptable professional principles. Unlabeled, loose pills were observed in two medication carts on Unit 2.</p> <p>The findings include:</p> <p>A review of the facility's Storage of Medication Policy, dated 02/23/11, revealed staff was to keep medications in the containers dispensed by the provider pharmacy. In addition, medication storage areas were to be clean, free of clutter, and monitored on a routine basis.</p> <p>Observations of the medication carts on 08/16/12, at 4:00 PM, revealed the following:</p> <ol style="list-style-type: none"> <li>1. The Unit 2, Hall 1 medication cart contained 17 whole and 4 half unlabeled and unpackaged pills in the bottoms of the drawers as well as pill debris and empty packages.</li> <li>2. The Unit 2, Hall 2 medication cart contained two loose, unpackaged pills in the bottom of a drawer. In addition, the drawer utilized to store liquid medications had a brown sticky substance in the bottom of the drawer.</li> </ol> <p>An interview with the Unit 2 Manager on 08/16/12, at 4:15 PM, revealed there was no schedule for cleaning the medication carts; nurses were to clean as they had time. The Unit Manager further stated she did not monitor the carts to ensure the carts were clean and neat and that medications were stored in labeled containers and not loose/unlabeled in the drawers of the medication cart.</p>	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ICD PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185127	1.A. MULTIPLE IDENTIFICATION NUMBER: A. BUILDING B. WING	2012 SURVEY COMPLETED SEP 10 2012 JEAN BUILDING 01
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NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION	STREET ADDRESS 642 NORTH THIRD STREET DANVILLE, KY 40422
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ICD 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)	DATE COMPLETE DATE
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K 000	INITIAL COMMENTS  BUILDING: 01  PLAN APPROVAL: 1951, 1982, 1987  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V Unprotected  SMOKE COMPARTMENTS: 7  FIRE ALARM: Complete automatic fire alarm system  SPRINKLER SYSTEM: Complete automatic dry sprinkler system  GENERATOR: Type II diesel generator  A life safety code survey was initiated and concluded on 08/14/12. The findings that follow demonstrate non-compliance with Title 42, Code of Federal Regulations, 403.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
K 051 857E	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building.	K 051	We are contracting Simplex Grinnell to install two additional pull stations in the facility. One pull station will be located in the laundry hall way between the two nurses' stations and another pull station will be located in the Reflections unit.	

REGULATORY DIRECTOR'S OF PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: \_\_\_\_\_ DATE: 9/8/2012  
*Sumana Ghosh Executive Director*

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 30 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 42 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of corrective is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  E. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2012
NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
(4) 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)	(5) COMPLETION DATE	
K 051	Continued From page 1 Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have an adequate number of fire alarm pull stations according to NFPA standards. This deficient practice affected three of seven smoke compartments, staff, and approximately 50 residents. The facility has the capacity for 105 beds with a census of 100 on the day of the survey.  The findings include:  During the Life Safety Code survey on 08/14/12,	K 051	Education will be provided to the staff by the SDC or Maintenance Director on the location and proper use of the fire pull stations from September 13, 2012 through September 17, 2012.  A systematic change will take place by adding the fire pull stations to the environmental round audit that will be completed by the Maintenance Director and/or his designee and report to the Performance Improvement (PI) Committee monthly for 3 months. The PI Committee will monitor the environmental round audits to ensure there is no deficient practice pertaining to the fire pull stations in the facility.  Start date: 9/11/2012 Completion date: 10/11/12		

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NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 642 NORTH THIRD STREET DANVILLE, KY 40422		
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K 051	<p>Continued From page 2</p> <p>at 1:10 PM, with the Director of Maintenance (DOM) exit doors located in the Alzheimer's unit were observed not to have manual fire alarm pull stations adjacent to the doors. Pull stations may be omitted at exits if located at all nursing stations. The nursing station in the Alzheimer's unit did not have a pull station. Pull stations were observed to be spaced over 200 feet between Unit 1 and Unit 2 nursing stations. Pull stations cannot be spaced over 200 feet on the same floor level. An interview with the DOM on 08/14/12, at 1:10 PM, revealed the pull stations at the exits were removed before he started working there and he depended on the fire alarm contractors to keep the fire alarm system compliant.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.4.2* Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems.</p> <p>Exception No. 1. Manual fire alarm boxes in patient sleeping areas shall not be required at exits if located at all nurses' control stations or other continuously attended staff location, provided that such manual fire alarm boxes are visible and continuously accessible and that travel distances required by 9.6.2.4 are not exceeded.</p> <p>9.6.2.4* Additional manual fire alarm boxes shall be located so that, from any part of the building, no horizontal distance on the same floor exceeding 200 ft (60 m) shall be traversed to reach a</p>	K 051			

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NAME OF PROVIDER OR SUPPLIER  DANVILLE CENTRE FOR HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 542 NORTH THIRD STREET DANVILLE, KY 40422		
(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 051	Continued From page 3 manual fire alarm box.	K 051			