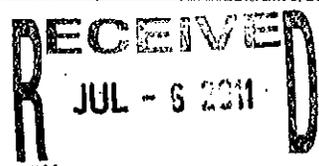


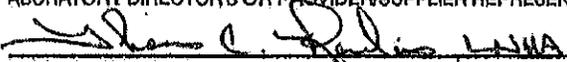
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2011
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SPENCER COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071
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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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</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</p>	F 431		<p>F 431 Drug Records, Label/Store Drugs & Biologicals</p> <ol style="list-style-type: none"> 1. There were no residents identified in the findings to be directly affected, 2. Any vaccines that were present were immediately disposed of and replaced. A complete chart audit was immediately conducted for the residents on Unit #1 that had received vaccines within the dates of 04/01/2011 to present. This was conducted to determine if any negative outcomes occurred from prescribed vaccines. The audit revealed that no negative outcomes occurred. <p>The unit #1 refrigerator was Replaced and new stationary thermometer was placed to ensure accuracy of refrigerator temperatures.</p> <ol style="list-style-type: none"> 3. Nursing staff were reeducated on the facility's policy and procedure on vaccine storage and that vaccines must be

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 07/06/2011
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SPENCER COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 626 TAYLORSVILLE RD TAYLORSVILLE, KY 40071
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F 431	<p>Continued From page 1 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, record review, and review of the facility's policy it was determined the facility failed to store medications under proper temperature controls to preserve their integrity. Review of the facility's temperature logs for the vaccine storage refrigerator on Unit One, dated 04/01/11 through 06/16/11, revealed recorded temperatures of thirty-four (34) degrees Fahrenheit or below on seventy-two (72) of seventy-three (73) AM shifts and seventy-one (71) of seventy-one (71) PM shifts, which was outside of the temperature range for proper storage.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure for vaccine storage revealed "Vaccine MUST be stored between thirty-five (35) degrees Fahrenheit and forty-six (46) degrees Fahrenheit to maintain potency". Further review revealed if the temperature is outside of range to store the vaccine under proper conditions, as quickly as possible, call the vaccine manufacturers to determine whether the potency of the vaccines has been affected.</p> <p>Record review of the Vaccine Storage Temperature Logs for the refrigerator on Unit One, dated 04/01/11 through 06/16/11, revealed the facility had recorded the temperature as being</p>	F 431	<p>stored between thirty-five (35) degrees Fahrenheit and forty-six (46) degrees Fahrenheit. The Nursing staff were also re-educated on proper usage of the temperature documentation log and that temperature checks are to occur daily. Any irregularities will be reported immediately to the Director of Nursing and/or designee. If the temperature is above or below established parameters, the nurse will adjust the refrigerator temperature controls. The nurse will recheck the temperature within thirty (30) to sixty (60) minutes. If the temperature still is not within established parameters, the maintenance department will be notified for further servicing of the refrigerator. Also, the Director of Nursing and/or designee will call the pharmacy and vaccine manufacture to determine whether the potency of the vaccines have been affected.</p> <p>4. The refrigerator temperature logs will be audited daily for three (3) months by the Unit Manager and/or designee to ensure daily temperature checks are being completed and temperatures are within appropriate range. The Pharmacy consultant will audit</p>	

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F 431	<p>Continued From page 2</p> <p>thirty-four (34) degrees Farenheit or below on seventy-two (72) of seventy-three (73) AM shifts and seventy-one (71) of seventy-one (71) PM shifts.</p> <p>Interviews with Licensed Practical Nurse (LPN) #6, #10, and #11 on 06/16/11 at 10:55 AM revealed they were not aware a recorded temperature of below thirty-five (35) degrees Farenheit was outside of acceptable parameters.</p> <p>Observation of Unit One's thermometer located in the vaccine storage refrigerator 06/16/11, at 11:05 AM, revealed medications including, pneumococcal and tuberculin vaccines, stored at thirty (30) degrees Farenheit.</p> <p>Interview with Unit One's Nurse Manager on 06/16/11 at 1:55 PM, revealed temperatures are monitored by nursing staff daily. She stated she was unaware the temperature had been in the unacceptable range from 04/01/11 through 06/15/11. Further review revealed there had been no attempts to insure the temperature readings were accurate and make adjustments and corrections as needed. Further interview revealed the facility failed to notify the vaccine manufacturers to determine whether the potency of the vaccine had been affected per the facility procedure.</p> <p>Interview with the facility's Pharmacist on 06/16/11 at 3:00 PM revealed she completed random checks of the medication storage refrigerator but had failed to note the actual temperatures were recorded outside of the acceptable range.</p>	F 431	<p>the refrigerator temperatures monthly. The results of the audits and any temperature issues will be reported to the QA committee for three (3) months and continued at the discretion of the QA Committee.</p> <p>5. Completion Date:</p>	July 1, 2011

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F 431	Continued From page 3 Interview with the facility's Clinical Consultant on 06/16/11 at 4:00 PM, revealed the facility policy states Pharmacy and Nursing were responsible to monitor the temperature of the vaccine storage refrigerators and report irregularities as quickly as possible.	F 431		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185327	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2011
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SPENCER COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 625 TAYLORSVILLE RD TAYLORSVILLE, KY 40071
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K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 03/01/1992 K7 SURVEY UNDER: 2000 Existing K8 SNF A Life Safety Code Survey was initiated and concluded on 06/14/11. The facility failed to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "E".	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) smoke compartments, sixty-five (65) residents, and visitors. The findings include:	K 038	<p style="text-align: center;">RECEIVED JUL - 6 2011</p> <p>BY: _____</p> <p>K 038: Life Safety Code Standard</p> <ol style="list-style-type: none"> There were no residents identified in the findings to be directly affected. The keypad combination lock was removed from the 600 Hall Exit door and delayed egress device was installed <p>The mini blinds that were attached to the Unit #2 and 300 Hall exits were immediately removed on 06/14/2011.</p> <p>The stop sign that was attached to the Unit #2 exit was immediately removed on 06/14/2011.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 07/06/2011
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038	<p>Continued From page 1</p> <p>Observation on 06/14/11 at 11:45 AM revealed the exit door for the 600 Hall Exit was secured with magnetic locks using a keypad combination. The combination was not posted, and the doors were not equipped with a delayed egress device. The doors were not near a nurse's station. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 06/14/11 at 11:45 AM, with the Maintenance Director, revealed the door would release with the combination lock or when the fire alarm activated. The Maintenance Director confirmed the door was not equipped with a delayed egress device. This was also confirmed with the Administrator upon exit interview on 06/14/11 at 1:00 PM.</p> <p>Observation on 06/14/11 at 10:00 AM revealed mini blinds on the exit doors, at Unit#2 Exit and the 300 Hall Exit. In addition the Unit#2 Exit doors had a stop sign attached to both doors by means of Velcro. This could cause confusion of the direction of egress in the event of a fire or disaster. This was confirmed by the Maintenance Director.</p> <p>Interview on 06/14/11 at 10:00 AM with the Maintenance Director revealed he did not know they could not use mini blinds on the doors. He further stated the mini blinds were to deter wanderers from going through the doors and setting off the alarms.</p> <p>NFPA reference: NFPA 101 (2000 edition) 19.2.2.2.4 Doors within a required means of egress shall not</p>	K 038	<p>3. An in-service was conducted with the Maintenance Department that included the following: 1. Delayed egress devices need to be present on doors that are not near a nurses station. 2. No stop signs, blinds or any type of signage can be placed on exit doors that may cause confusion of the direction of egress.</p> <p>All exit doors will be checked by the Maintenance Director and/or Designee 5 times per week to ensure doors are working properly and no stop signs, blinds or any type of signage is present that could cause confusion of the direction of egress.</p> <p>4. The QA Committee will verify the installation of the delayed egress device on the 600 Hall Door. The results of the door checks will be presented to the QA Committee monthly and continued at the discretion of the QA Committee.</p> <p>5. Completion Date:</p>	07/15/2011

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K 038	<p>Continued From page 2</p> <p>be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p> <p>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)</p> <p>Exception No. 2:* Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p> <p>Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the</p>	K 038		

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K 038	Continued From page 3 tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		