

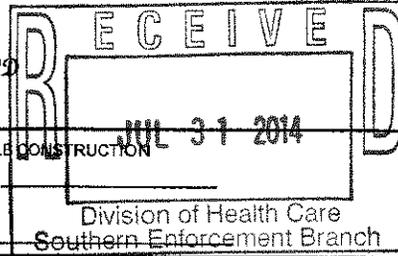
From:

07/31/2014 16:29

#515 P.002/028

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

2nd SCD



PRINTED: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2014
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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380
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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	<p>INITIAL COMMENTS</p> <p>--AMENDED--</p> <p>A standard health and abbreviated standard survey (KY21835) was conducted on 06/17-19/14 in conjunction with a revisit for the 03/13/14 and 04/23/14 abbreviated surveys. The complaint (KY21835) was unsubstantiated.</p> <p>The facility continued to be in noncompliance with 42 CFR 483.25 Quality of Care (F323) at a scope and severity of "D" from the 03/13/14 abbreviated survey. Deficiencies from the 04/23/14 survey were corrected. Other deficient practice was also identified with the highest scope and severity at "F" level.</p>	F 000	<ol style="list-style-type: none"> 1. New fire doors have been ordered to replace the fire doors on Hallway 100. Temporary repairs have been made to the doors until the new doors arrive and are installed to replace the old ones. 2. Resident room 102 removed from service until repairs are complete. Resident room 102 is scheduled for repairing and painting.. 3. The broken wire shower rack has been removed from the shower room 4. The wheel chair arm on patient 11's wheelchair has been repaired. 5. The A/C unit in room 206 has been repaired. 	
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure services were provided to maintain a sanitary and comfortable interior. Observations made on 06/18/14 and 06/19/14 revealed the following: one (1) of four (4) fire doors was observed to have chipped and splintered wood; the walls to the left and right side of the sink in resident room 102 had chipped drywall with rough, sharp edges, and were in need of repair; one (1) of four (4) shower rooms had a rusted wire rack that was broken with a sharp piece of</p>	F 253	<p>All doors and rooms have been inspected by the Maintenance Director to insure that all fire doors, resident rooms meet regulatory requirements. Rooms that were in need of repair are scheduled for repair and being removed from service until repairs are completed in systematic order. Room rounds will be completed weekly by Housekeeping, MDS, Social Services, Medical Records, Human Resources, Dietary Manager, and Unit Managers to insure compliance until August 31, 2014.</p>	

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

[Handwritten Signature]

TITLE

NH Admin

(X6) DATE

7-31-14

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.

From:

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F 253	Continued From page 1 wire protruding out toward the shower area; the armrests of (1) one of (15) fifteen sampled residents' wheelchairs (Resident #11) was torn and in need of repair; and the control panel door on the heating/air unit in resident room 206 was broken and had sharp, jagged edges. The findings include: Review of the facility's policy titled, "How to Complete a Work Order Request," undated, revealed that staff was to log on to the facility's website for "The Equipment Lifecycle System (TELS)" and create a new work order for repairs. 1. Observations on 06/17/14 at 12:05 PM and 06/18/14 at 11:16 AM, of the left fire door on the 100 Hallway revealed the wooden door had a large chipped and splintered area that was in need of repair. 2. Observation of resident room 102 on 06/18/14 at 11:21 AM revealed both sides of the wall around the sink area had chipped and splintered drywall and were in need of repair. 3. Observation of the left shower room on the 100 Hall on 06/18/14 at 3:45 PM revealed a rusted and broken wire shower rack that had a piece of rusted wire extending into the resident shower area. 4. Observation of Resident #11's wheelchair on 06/18/14 at 11:23 AM revealed both armrests were cracked and in need of repair. 5. Observation of resident room 206 on 06/18/14 at 11:21 AM revealed the control panel door on the heating and air conditioning unit was broken	F 253	The Maintenance Director will make rounds weekly to insure compliance with no stop date. The Administrator and DNS will review all reports and forward to QA committee for review and appropriate action. All wheelchairs in use by patient have been inspected, repaired or removed from service. Wheelchairs will be inspected weekly by unit managers. Those found needing repaired will be reported to the Maintenance Director through TELS system. The Administrator will monitor the TELS system to insure prompt repair is completed. All employees have been in-serviced on use of the tels system 7/21/7/28 2014. A room round sheet is used for recording findings during room rounds. See Exhibit A The completed rounding sheets are forwarded to the Administrator or his designee for review. The Administrator or his designee will forward the completed round sheets to the QA committee for review and appropriate response.	July 28, 2014	

From:

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#515 P.004/028

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F 253	Continued From page 2 and had sharp, jagged edges. Interview with the Maintenance Supervisor on 06/19/14 at 4:37 PM revealed all staff was required to use "TELS" to create work orders when they identified something that needed repair. The Maintenance Supervisor stated that he had trained all facility staff, including the housekeeping staff, to use the system. He reported that he checked "TELS" twice a day for work orders. The Maintenance Supervisor stated that he had not received work orders for the identified areas. In addition, the Maintenance Supervisor stated he randomly monitored the facility for areas in need of repair and had not identified any concerns. Interview with the facility's Administrator on 06/19/14 at 4:52 PM revealed staff had not reported any of the findings identified during the environmental tour to him.	F 253			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure care was provided in accordance with the resident's written plan of care for one (1) of fifteen (15) sampled residents (Resident #9). Review of the Comprehensive	F 282			

From:

07/31/2014 16:30

#15 P.005/028

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

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F 282	<p>Continued From page 3</p> <p>Care Plan for Resident #9 dated 05/15/14, revealed a care plan intervention for the resident to have non-skid strips in front of the sink. However, the facility failed to ensure that the non-skid strips were in place in the resident's room in front of the sink.</p> <p>The findings include:</p> <p>Review of the facility's "Protocol for Care Plan," not dated, and "Care Plan Policy Statement," not dated, revealed the policies did not address implementing resident care plans.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 06/03/13, with diagnoses which included Osteoporosis, Kyphosis, Mental Retardation, Schizophrenia, Psychosis, Partial and Nuclear Sclerosis, and Hammer Toe.</p> <p>Review of Resident #9's recent Quarterly Minimum Data Set (MDS) dated 05/06/14, revealed the facility assessed Resident #9 to have a Brief Interview for Mental Status (BIMS) score of 9, which indicated that the resident's cognition was moderately impaired. The MDS revealed the resident had not had any falls in the past six months. Further review of the MDS revealed the resident was ambulatory with supervision.</p> <p>Review of Resident #9's care plan dated 12/26/13, revealed the resident was at risk for injury related to falls due to diagnoses of Osteoporosis, Kyphosis, Mental Retardation, Schizophrenia, and Psychosis. The facility determined non-skid strips would be in place in front of the resident's sink as a nursing</p>	F 282		

From:

08/21/2014 16:36

#643 P.005/005

From:

07/31/2014 16:30

#515 P.006/028

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

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F 282	<p>Continued From page 4 Intervention to prevent falls.</p> <p>Review of Physician's Orders for Resident #9, dated 06/01/14, revealed the physician had ordered non-skid strips to be applied to the floor in front of the resident's sink and in the bathroom.</p> <p>Interview with Registered Nurse (RN) #1 on 07/03/14 at 1:45 PM (post-survey interview) revealed when new Physician's Orders were received for non-skid strips, a communication slip should be sent to Maintenance so that Maintenance could place the strips on the floor. The new order was also to be placed on the Treatment Administration Record (TAR) and the Care Plan. RN #1 stated that nursing staff was required to monitor to ensure care plan interventions such as non-skid strips were being implemented and document on the treatment record that they were in place.</p> <p>Review of the TAR for Resident #9 revealed the physician's order for the non-skid strips in the bathroom and in front of the sink had been transcribed to the Treatment Administration Record (TAR). Continued review of the TAR revealed staff had documented on the TAR, from 06/03/14 through 06/17/14, that the non-skid strips were present. Observation on 06/18/14 at 9:26 AM revealed non-skin strips were observed in the bathroom; however, there were no non-skid strips in front of the resident's sink that was located in the resident's bedroom.</p> <p>An interview with Unit Coordinator #2 on 07/03/14 (post-survey interview) at 1:50 PM revealed Unit Coordinators were required to review residents' TARs and Care Plans to ensure everything was implemented. Unit Coordinator #2 stated she</p>	F 282	<p>Patient #9 Care Plan has been reassessed and new orders received from Physician discontinuing the use of non-skid strips. The care plan was updated to reflect the changes</p> <p>All current patient comprehensive care plans will be audited to identify that care plans are correct and being followed. Care plans that require revision will be reported to the MD and or Medical Director. New MD orders will be implemented and care plans corrected. A one-time audit of all residents using nonskid strips will be completed and correctly reflect MD orders</p> <p>All residents that have orders for non-skid strips will be will be reassessed for fall risk and appropriate interventions implemented and reflected on the comprehensive care plan.</p> <p>All licensed nursing staff will be reeducated on implementing, revising and following comprehensive care plans. The DNS and or Unit Managers will provided the education On July 7, and July 14 2014. Off cycle revisions will be monitored through the daily QA process. Patient who require off cycle care plan changes due to falls or accidents will be reviewed by the QA Committee to insure compliance The QA monitoring form is included as Exhibit B</p> <p>All audit findings will be forwarded to the QA Committee by the Administrator/DNS for review and appropriate response.</p>	<p>July 28 2014</p>	

From:

07/31/2014 16:30

#515 P.006/028

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

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F 282	<p>Continued From page 4 intervention to prevent falls.</p> <p>Review of Physician's Orders for Resident #9, dated 06/01/14, revealed the physician had ordered non-skid strips to be applied to the floor in front of the resident's sink and in the bathroom.</p> <p>Interview with Registered Nurse (RN) #1 on 07/03/14 at 1:45 PM (post-survey interview) revealed when new Physician's Orders were received for non-skid strips, a communication slip should be sent to Maintenance so that Maintenance could place the strips on the floor. The new order was also to be placed on the Treatment Administration Record (TAR) and the Care Plan. RN #1 stated that nursing staff was required to monitor to ensure care plan interventions such as non-skid strips were being implemented and document on the treatment record that they were in place.</p> <p>Review of the TAR for Resident #9 revealed the physician's order for the non-skid strips in the bathroom and in front of the sink had been transcribed to the Treatment Administration Record (TAR). Continued review of the TAR revealed staff had documented on the TAR, from 06/03/14 through 06/17/14, that the non-skid strips were present. Observation on 06/18/14 at 9:26 AM revealed non-skin strips were observed in the bathroom; however, there were no non-skid strips in front of the resident's sink that was located in the resident's bedroom.</p> <p>An interview with Unit Coordinator #2 on 07/03/14 (post-survey interview) at 1:50 PM revealed Unit Coordinators were required to review residents' TARs and Care Plans to ensure everything was implemented. Unit Coordinator #2 stated she</p>	F 282	<p>Patient #9 Care Plan has been reassessed and new orders received from Physician discontinuing the use of non-skid strips. The care plan was updated to reflect the changes</p> <p>All current patient comprehensive care plans will be audited to identify that care plans are correct and being followed. Care plans that require revision will be reported to the MD and or Medical Director. New MD orders will be implemented and care plans corrected. A one-time audit of all residents using nonskid strips will be completed and correctly reflect MD orders</p> <p>All residents that have orders for non-skid strips will be will be reassessed for fall risk and appropriate interventions implemented and reflected on the comprehensive care plan.</p> <p>All licensed nursing staff will be reeducated on implementing, revising and following comprehensive care plans. The DNS and or Unit Managers will provided the education On July 7, and July 14 2014. Off cycle revisions will be monitored through the daily QA process. Patient who require off cycle care plan changes due to falls or accidents will be reviewed by the QA Committee to insure compliance The QA monitoring form is included as Exhibit B</p> <p>All audit findings will be forwarded to the QA Committee by the Administrator/DNS for review and appropriate response.</p>		

From:

07/31/2014 16:31

#515 P.007/028

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

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F 282	Continued From page 5 was new to the position and was not aware why staff had documented the non-skid strips were in front of the resident's sink. Interview with the Interim Director of Nursing (DON) on 06/19/14, at 4:30 PM, revealed she had been the Interim DON for approximately two weeks. According to the Interim DON, nurses were required to notify maintenance staff when new physician's orders were obtained for items that required installation. The Interim DON stated nurses, nurse aides, and Unit Coordinators were required to monitor to ensure devices were in place. The Interim DON stated she conducted observations two to three times a week, at random, of resident care and had not identified any resident care issues. The Interim DON also stated she had not monitored 100 percent of the care areas. Interview conducted with the Maintenance Supervisor on 06/19/14, at 4:37 PM, revealed he was responsible for applying non-skid strips to residents' floors. However, the Maintenance Supervisor stated he had not been notified by nursing staff of the physician's order to place non-skid strips in front of Resident #9's sink. Interview with the Administrator on 06/19/14 at 4:52 PM revealed all resident rooms should be equipped to accommodate residents. The Administrator stated he was not aware Resident #9 did not have non-skid strips on the floor in front of his/her sink.	F 282	Patient #9 Care Plan has been reassessed and new orders received from Physician discontinuing the use of non-skid strips. The care plan was updated to reflect the changes All current patient comprehensive care plans will be audited to identify that care plans are correct and being followed. Care plans that require revision will be reported to the MD and or Medical Director. New MD orders will be implemented and care plans corrected. A one-time audit of all residents using nonskid strips will be completed and correctly reflect MD orders All residents that have orders for non-skid strips will be will be reassessed for fall risk and appropriate interventions implemented and reflected on the comprehensive care plan. All licensed nursing staff will be reeducated on implementing, revising and following comprehensive care plans. The DNS and or Unit Managers will provided the education On July 7, and July 14 2014. Off cycle revisions will be monitored through the daily QA process. Patient who require off cycle care plan changes due to falls or accidents will be reviewed by the QA Committee to insure compliance The QA monitoring form is included as Exhibit B All audit findings will be forwarded to the QA Committee by the Administrator/DNS for review and appropriate response.	July 28, 2014	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323			

From:

07/31/2014 16:31

#515 P.008/028

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

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F 323	<p>Continued From page 6</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. The facility failed to ensure non-skid strips were placed on the floor in front of the sink to prevent falls for one (1) of fifteen (15) sampled residents (Resident #9) as required by the resident's Physician Order dated 06/01/14, and the resident's care plan.</p> <p>The findings include:</p> <p>1. Review of the facility's "Accidents and Incidents: Report, Investigation, Follow-up, and Final Disposition" policy, revised July 2010, defined an avoidable accident as an incident that occurred when the facility failed to implement interventions consistent with resident goals, needs, plans of care, and standards of practice.</p> <p>Review of the facility's "Protocol for Care Plan," not dated, and "Care Plan Policy Statement," not dated, revealed the policies did not address implementing resident care plans.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 06/03/13. Resident #9's recent Quarterly Minimum Data Set</p>	F 323		

From:

07/31/2014 16:31

#515 P.009/028

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F 323	<p>Continued From page 7</p> <p>(MDS) dated 05/06/14, revealed the facility assessed Resident #9 as being ambulatory with supervision with no falls in the past six months. Resident #9's care plan dated 12/26/13, revealed the facility identified the resident was at risk for injury related to falls and determined non-skid strips would be in place in front of the resident's sink as an intervention to prevent falls.</p> <p>Review of Resident #9's Physician Orders dated 06/01/14, revealed Resident #9 was required to have non-skid strips in front of the sink.</p> <p>Review of a copy of Resident #9's fall risk assessment was requested from the facility's Director of Nursing; however, no document was produced for review during the survey.</p> <p>Observation of Resident #9's room on 06/18/14 at 9:26 AM revealed there were no non-skid strips on the floor in front of the sink as ordered by the physician; and as required as an intervention on the resident's plan of care.</p> <p>On 07/03/14 at 1:45 PM (post-survey interview) an interview with Registered Nurse (RN) #1 revealed when physician's orders were received for non-skid strips, a communication slip should be sent to Maintenance so that Maintenance could place the strips on the floor. RN #1 stated nurses should also place new orders on the resident's Treatment Administration Record (TAR) and care plan. RN #1 stated that nursing staff was required to monitor to ensure care plan interventions such as non-skid strips were being implemented and should document on the treatment record that they were in place.</p> <p>An interview with Unit Coordinator #2 on 07/03/14</p>	F 323			

From:

07/31/2014 16:32

#515 P.010/028

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

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F 323	Continued From page 8 at 1:50 PM (post-survey interview) revealed Unit Coordinators were required to monitor residents' TARs and care plans to ensure care plan interventions and physician's orders were being implemented. Interview with the Director of Nursing (DON) on 06/19/14, at 4:30 PM, revealed that nursing staff was required to notify maintenance staff when a new physician's order was received for non-skid strips and maintenance staff was responsible for the installation of the strips. The DON stated nursing staff and Unit Coordinators were required to monitor to ensure interventions were in place. Further interview revealed the DON also monitored resident care areas two to three times a day and had not identified any residents, including Resident #9, who did not have non-skid strips. Interview with the Administrator on 06/19/14 at 4:52 PM revealed resident rooms should be equipped to accommodate the residents and the Administrator was not aware Resident #9 did not have non-skid strips, which was ordered by the physician and required by the plan of care.	F 323		
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:	F 364	The written protocol for Assistance with Meals and Dining rooms has been reviewed and revised to address the time interval a tray may remain on the service cart before being served to a resident. The food delivery process has been reviewed with appropriate changes made. A New reach in freezer, reach in refrigerator, milk cooler, and plate warmer has been purchased to insure the highest level of quality before the food preparation begins. Audits of food temperatures	

From:

07/31/2014 16:32

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2014
NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
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F 364	<p>Continued From page 9</p> <p>Based on observation, interview, and a review of facility policy, it was determined the facility failed to serve foods at a palatable temperature during the evening meal on 06/17/14. Observation of a meal pass on the North Hall on 06/17/14 revealed the meal cart arrived on the floor at 5:58 PM. Further observation revealed the last tray was removed at 6:26 PM, a timeframe of twenty-seven (27) minutes. Temperatures were obtained of the food items on the last tray removed from the meal cart (the test tray), and the temperature of the milk was forty-eight (48) degrees Fahrenheit and warm to taste; the ice cream was forty (40) degrees Fahrenheit and was completely melted.</p> <p>The findings include:</p> <p>Interview with the Registered Nurse (RN) Project Specialist and the Dietary Manager on 06/19/14 at 3:15 PM revealed the facility did not have a policy related to food temperatures at the point of service or a timeframe for the maximum length of time a meal tray could remain on the cart before it was served to a resident. The RN Project Specialist stated the facility should follow state and federal regulations.</p> <p>Interview with the Dietary Manager on 06/17/14 at 5:30 PM revealed that, in her opinion, meal trays should not be left on the meal cart for longer than 20 minutes after arriving at the nursing unit. According to the Dietary Manager, if the meal trays were on the cart longer than 20 minutes they should be returned to the kitchen and new meal trays prepared for the resident(s). The Dietary Manager acknowledged the facility did not have a policy related to how long a meal tray could be left on the meal cart before serving.</p>	F 364	<p>before leaving the kitchen will be conducted daily until August 31, 2014 then weekly without and end date. The Audits will be conducted by the Dietary Manager or her designee The audit findings will be forwarded to the QA Committee for review and appropriate response until August 31, 2014 then weekly thereafter. All dietary staff were in serviced on July 22,2014 on proper food handling to insure the highest quality food is served that also meets the regulatory requirements for temperatures. All Nursing staff was in serviced on July 21, 2014 and July 27, 2014 on tray delivery to patients and steps to be taken if delays occur in the tray delivery process that may affect temperature of the food beyond acceptable limits according to regulatory requirements and facility protocol. Test trays will be reviewed daily for temperature, taste and texture until August 31, 2014. The results of these audits will be forwarded to the QA committee For review and appropriate response.</p>	July 28, 2014	

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F 364	<p>Continued From page 10</p> <p>Observation of the meal cart on the North Hall revealed the cart arrived on the floor on 06/17/14 at 5:58 PM and the last tray was removed at 6:26 PM, a timeframe of 27 minutes. The Dietary Manager obtained temperatures of the food items on the tray on the North Hall cart at the completion of the tray pass. Observations revealed the temperature of the milk was 48 degrees Fahrenheit and was warm to taste; the ice cream was 40 degrees Fahrenheit and was completely melted.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 06/17/14 at 6:35 PM, and SRNA #2 on 06/17/14 at 6:45 PM revealed, in their opinion, the meal trays should not remain on the meal carts greater than 15 to 20 minutes before they were delivered to the residents. SRNAs #1 and #2 stated they were not aware the meal cart that contained the meal trays had been on the nursing unit for the timeframe identified before they were delivered.</p> <p>Interview with eight alert and oriented residents during the group interview on 06/17/14 at 3:30 PM revealed the food items on the meal trays served to residents in their rooms were not served at proper temperatures two to three times per week and stated the hot foods were not hot and cold foods were not cold.</p> <p>The Dietary Manager acknowledged in interview on 06/17/14 at 5:30 PM that the temperatures of the milk and the ice cream on the test tray were too warm. The Dietary Manager said she conducted meal pass observations at random, on all shifts, and had identified a problem with the milk and ice cream being too warm. She further</p>	F 364			

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F 364	Continued From page 11 stated the kitchen staff had started placing the milk in the freezer an hour before the trays were served to ensure the milk stayed cooler. The Dietary Manager also acknowledged that the last meal tray was removed from the cart approximately 27 minutes after the cart was delivered to the floor. According to the Dietary Manager, it was her opinion that if the meal trays were on the cart longer than 20 minutes, they should be returned to the kitchen and new trays prepared for the resident(s).	F 364			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to store, prepare, and serve food under sanitary conditions. Observations on 06/17/14, 06/18/14, and 06/19/14 revealed a buildup of grease and food particles on the storage rack for the pots and pans, the dry food storage rack, all of the coffee carafes, and the electrical outlet on the floor at the end of the food preparation table.	F 371	The entire kitchen was deep cleaned. July 22, 2014. New preparation tables have been purchased and installed. Food storage racks has been replaced with new racks. The daily, weekly and monthly cleaning schedule has been reviewed, revised and approved by the QA Committee. The Dietary Manager or her designee will review the cleaning schedule for compliance daily. The completed cleaning schedules will be forwarded to the Quality Assurance Committee weekly for review and appropriate response until August 31, 2014 The results of the audits will forwarded to the QA committee for review and appropriate response. All dietary staff was educated on the new cleaning schedule. July 22 2014. See Cleaning Schedule Exhibit C	July28, 2014	

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F 371	Continued From page 12 The findings include: Review of the Dietary Services Cleaning Schedule dated May 2014, revealed the food storage room was to be cleaned on Sundays. The table for the pots and pans was to be cleaned on Saturdays, and the floors and coffee pots/carafes were to be cleaned daily. Observations of the kitchen on 06/17/14 (Tuesday) at 5:30 PM; on 06/18/14 (Wednesday) at 9:30 AM; and, on 06/19/14 (Thursday) at 2:45 PM, revealed the table that held the pots and pans, the electrical plug on the floor of the food preparation table, the storage shelves in the dry storage room, and all the coffee carafes had a buildup of grease and food particles. Interview with the Dietary Manager on 06/19/14 at 2:45 PM revealed the staff in the kitchen had assignments and should be cleaning the "greasy areas" on a weekly basis. Further interview revealed she was unaware the areas/items were in need of cleaning. Interview with the Registered Dietitian (RD) on 06/19/14 at 2:45 PM, revealed the kitchen had a cleaning schedule and she had not observed any concerns related to cleanliness of the area when she was in the kitchen on a weekly basis. However, the RD acknowledged the kitchen was in need of cleaning at the time of the interview.	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441			

From:

08/21/2014 16:35

#643 P.003/005

From:

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F 441	Continued From page 13 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, manufacturer's guidelines, and facility policy review, it was determined the facility failed to establish and	F 441	1. The Infection Control practice protocol has been reviewed and appropriate revisions completed. The QA committee has reviewed the protocol revisions and has approved them. All licensed staff was educated on the revised protocols July 21, July 28, 2014. Specifically all licensed staff has been educated on the proper use of glucose monitoring equipment. Audits of glucose monitoring techniques will occur five out of seven days weekly until August 31, 2014 The audits will be conducted by the DNS and or Unit Managers. Results of the audits will be forwarded to the QA committee for review and appropriate response 2. All nursing staff has been reeducated on proper handling of patient trays during meal service. Audits will be conducted five of seven days weekly of patient tray service by staff until August 31, 2014. Results of the audit will be forwarded to the QA committee for review and appropriate response. Audits will be conducted by Unit Managers, Director of Nursing and her designees. Education was provided on 7/21/7/24 2014.	July 28 2014	

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F 441	<p>Continued From page 13</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, manufacturer's guidelines, and facility policy review, it was determined the facility failed to establish and</p>	F 441	<p>1. The Infection Control practice protocol has been reviewed and appropriate revisions completed. The QA committee has reviewed the protocol revisions and has approved them. All licensed staff was educated on the revised protocols July 21, July 28, 2014. Specifically all licensed staff has been educated on the proper use of glucose monitoring equipment. Audits of glucose monitoring techniques will occur five out of seven days weekly until August 31, 2014 The audits will be conducted by the DNS and or Unit Managers. Results of the audits will be forwarded to the QA committee for review and appropriate response</p> <p>2. All nursing staff has been reeducated on proper handling of patient trays during meal service. Audits will be conducted five of seven days weekly of patient tray service by staff until August 31, 2014. Results of the audit will be forwarded to the QA committee for review and appropriate response. Audits will be conducted by Unit Managers, Director of Nursing and her designees. Education was provided on 7/21/7/24 2014.</p>	July 21 2014	

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F 441	<p>Continued From page 14</p> <p>maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for two (2) unsampled residents (Resident B and Resident C).</p> <p>Observation during medication administration on 06/17/14, revealed staff failed to utilize gloves while performing blood glucose monitoring for Resident B, and failed to wash/sanitize their hands after cleaning the glucose-monitoring device and prior to administering insulin to Resident C.</p> <p>In addition, observation of the lunch meal service on the South Hall on 06/17/14, revealed staff removed a meal tray from the tray cart and set the meal tray on a resident's overbed table. However, the resident refused the meal tray and the State Registered Nurse Aide (SRNA) replaced the tray back on the meal cart with trays that contained meals that had not been served to other residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Blood Glucose Monitoring Technique," which was not dated, revealed staff was required to put on disposable gloves prior to performing the blood glucose monitoring.</p> <p>Review of the manufacturer's guidelines for the blood glucose-monitoring device used by the facility (undated) revealed staff would wear gloves while disinfecting the device and would wash/sanitize their hands after taking off the gloves.</p>	F 441			

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F 441	<p>Continued From page 15</p> <p>Review of the facility's policy titled, "Meal Tray Pass," undated, revealed the policy did not address where a meal tray would be placed after it had been delivered to the resident's room.</p> <p>1. Observation of blood glucose monitoring for Unsamped Resident B on 06/17/14, at 5:30 PM, revealed Licensed Practical Nurse (LPN) #1 performed the test without wearing gloves.</p> <p>Observation of blood glucose monitoring for Unsamped Resident C on 06/17/14, at 5:35 PM, revealed LPN #1 wore gloves to perform a blood glucose test and to clean the blood glucose-monitoring device. However, although the LPN wore gloves to test the resident's blood sugar and to clean the device, she failed to wash/sanitize her hands after she removed the soiled gloves, and prior to putting on clean gloves to administer insulin to Resident C.</p> <p>Interview conducted with LPN #1 on 06/17/14, at 5:40 PM, revealed she was aware she had failed to wear gloves while performing the blood glucose monitoring for Resident B and should have wash/sanitized her hands after cleaning the blood glucose-monitoring device and prior to administering insulin to Resident C.</p> <p>Interview conducted with the Director of Nursing (DON) on 06/19/14, at 2:35 PM, revealed staff was required to wear gloves when they conducted a test of the residents' blood glucose levels. In addition, the DON stated staff was required to wash/sanitize their hands after cleaning a blood glucose-monitoring device and before administering insulin. The DON stated all nurses were required to do a competency skills check upon hire and annually. During further</p>	F 441			

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F 441	Continued From page 16 interview with the DON, she stated LPN #1 had completed a skills check and no concerns had been identified regarding her performing blood glucose monitoring. 2. Observation of the lunch meal service on the South Hall on 06/17/14, at 12:37 PM, revealed State Registered Nurse Aide (SRNA) #1 removed a meal tray from the tray cart, took the meal tray into a resident's room, and set the tray on the resident's overbed table. However, the resident refused the meal tray, and SRNA #1 returned the resident's meal tray to the tray cart and placed the tray between six other clean meal trays which were then delivered to other residents. Interview conducted with SRNA #1 on 06/17/14, at 12:50 PM, revealed she was unaware she should not place a meal tray that had been delivered to a resident back on the tray cart while other meal trays, intended to be delivered to residents, remained on the meal cart. The SRNA stated the resident had refused the tray and she thought she was supposed to put the tray back in the spot from where she had removed the tray. Interview conducted with the Director of Nursing (DON) on 06/19/14, at 2:35 PM, revealed staff was required to send trays back to the dining room after being taken into a resident's room. The DON stated trays should never be placed back on a cart with clean meal trays after the tray had been taken into a resident's room. The DON stated the facility had not identified any concerns with meal tray delivery.	F 441			
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456			

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F 456	<p>Continued From page 17</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure all essential equipment was maintained in safe operating condition. Observations on 06/17/14, 06/18/14, and 06/19/14 of the milk cooler revealed the gasket of the cooler was worn and, as a result, a tight seal could not be created. Continued observation revealed a thick buildup of frost/ice on the inside walls of the milk cooler.</p> <p>The findings include:</p> <p>Interview with the Dietary Manager on 06/19/14 at 2:45 PM revealed the milk distributor provided the milk cooler to the facility and the distributor would be responsible to repair or replace the cooler if it was not in safe operating order.</p> <p>Observation of the kitchen on 06/17/14, 06/18/14, and 06/19/14 revealed the seal of the cooler was worn and an airtight seal could not be created. The milk cooler was observed to have a buildup of ice/frost on the inside of the cooler.</p> <p>Interview with the Dietary Manager on 06/19/14 at 2:45 PM revealed the cleaning schedule in the kitchen included cleaning the milk cooler and making sure there was no ice/frost present. According to the Dietary Manager, the milk cooler was rented from the milk distributor and could/should be replaced if it was not in safe</p>	F 456	<p>The written protocol for Assistance with Meals and Dining rooms has been reviewed and revised to address the time interval a tray may remain on the service cart before being served to a resident. The food delivery process has been reviewed with appropriate changes made. A New reach in freezer, reach in refrigerator, milk cooler, and plate warmer has been purchased to insure the highest level of quality before the food preparation begins. Audits of food temperatures before leaving the kitchen will be conducted daily unit August 31, 2014 then weekly without and end date. The audit findings will be forwarded to the QA Committee for review daily for review and appropriate response by the Administrator until August 31, 2014 then weekly thereafter. All dietary staff have been in serviced on the proper food handling to insure the highest quality food is served that also meets the regulatory requirements for temperatures. All Nursing staff have been in serviced on tray delivery to payments and steps to be taken if delays occur in the tray delivery process that may affect temperature of the food beyond acceptable limits according to regulatory requirements and facility protocol. Test trays will be reviewed daily for temperature, taste and texture until August 31, 2014. The results of these</p>		

From:

07/31/2014 16:34

#515 P.020/028

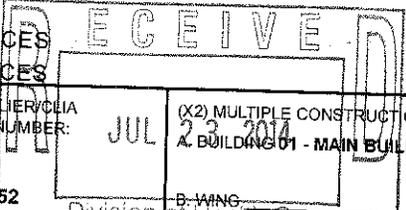
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2014
NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
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F 456	Continued From page 18 operating order. However, the Dietary Manager stated she was unaware of the buildup of frost/ice in the milk cooler or that the gasket in the milk cooler was torn and in need of repair. Further interview revealed the milk distributor had not been contacted related to the seal on the milk cooler. Interview with the Registered Dietitian on 06/19/14 at 2:45 PM revealed the milk cooler should not have a frost/ice buildup and the gasket should be repaired.	F 456	Audits will be forwarded to the QA Committee For appropriate review and response	July 28 2014	

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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380
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K 000	<p>INITIAL COMMENTS</p> <p>FACILITY TYPE: SNF/NF</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Six smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II generator. Fuel source is LP gas.</p> <p>A Life Safety Code survey was initiated and concluded on 06/17/14. 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 with Medicare and Medicaid.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *RHA* (X6) DATE: 7/22/14

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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K 066	Continued From page 2 residents, staff, and visitors. The facility has the capacity for eighty-two (82) beds with a census of sixty-six (66) on the day of the survey. The findings include: During the Life Safety Code tour on 06/17/14 at 1:10 PM with the Director of Maintenance (DOM), an outside employee smoking area was observed to have numerous cigarette butts on the grounds area. Disposing of cigarettes in this manner creates a potential fire hazard. An interview with the DOM on 06/17/14 at 1:10 PM revealed the proper disposal of cigarette butts had been discussed in prior staff meetings. The DOM stated the grounds were recently cleaned up but the cigarette butts continue to be disposed of in this manner. The findings were revealed to the Administrator upon exit.	K 066		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	K 144	The generator is now being tested manually on a monthly basis. The Maintenance Director has been educated on the process by the Administrator. The results of the tests will be forwarded to the Administrator for review and proper response. The manual test will be run weekly until August 31 2014 Results of the audits will be provided to QA committee for review and appropriate response.	July 28 2014

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NAME OF PROVIDER OR SUPPLIER STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
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K 144	<p>Continued From page 3</p> <p>Based on interview and record review it was determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. This deficient practice affected (6) six of (6) six smoke compartments, staff, and all the residents. The facility has the capacity for eighty-two (82) beds with a census of sixty-six (66) on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 06/17/14 at 1:15 PM, and interview and review of the generator maintenance record with the Director of Maintenance, revealed he was not aware that he should be manually testing the generator transfer switch on a monthly basis as required. This testing helps ensure the transfer switch is operating as intended.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p>	K 144			
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p>	K 147	<p>All power strips being used for Medical Equipment have been removed. The Maintenance Director and all Medical staff have been educated on the protocol of non use of power strips for medical equipment.</p>		

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K 147	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that electrical power strips were being used in an approved manner. This deficient practice affected two (2) of six (6) smoke compartments, staff, and approximately forty-five (45) residents. The facility has the capacity for eighty-two (82) beds with a census of sixty-six (66) on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 06/17/14, at 12:30 PM with the Director of Maintenance (DOM), a patient bed, oxygen concentrator, and nebulizer were observed to be plugged into a multi-outlet adapter (power strip) in resident room 100. Power strips cannot be used for medical equipment or high draw appliances, to help prevent against electrical shock and fire.</p> <p>An interview on 06/17/14, at 12:30 PM with the DOM revealed he was not aware power strips could not be used with medical equipment. During the survey, resident room 218 was also observed to be utilizing a power strip for the same type of medical equipment.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-3.2.1.2 D</p>	K 147	<p>Rooms will be audited weekly for compliance to this practice to this protocol until August 31, 2014.</p> <p>Audits will be conducted by Maintenance Director, Unit Managers and or House Keeping employees</p> <p>Audits will be forwarded to the QA committed for review and appropriate response.</p>	July 28 2014	

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K 147	Continued From page 5 2. Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			