

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

PRINTED: 12/21/2010
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/08/2010
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41175	
(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.	F 000		
F.203 SS=D	A Recertification and Abbreviated survey, related to ARO KY#15628, was conducted on 12/08/10 through 12/08/10. A Life Safety Code Survey was conducted on 12/07/10. Deficiencies were cited with the highest scope and severity being a "F". ARO KY#15628 was determined to be unsubstantiated, with unrelated deficiencies cited. 483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	F 203	To the best of my knowledge and belief, as an agent of South Shore Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requires. Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. South Shore Nursing & Rehabilitation Center strives to ensure that residents, and if known, a family member or legal representative of the resident are notified in writing and in a language and manner they understand of the transfer or discharge. Resident #13 was discharged on 10/1/10. An audit will be conducted by the Administrator by 1/14/2011 on all residents who were transferred or discharged to ensure residents, family members, and legal representatives if known, are notified in writing and in a language and manner they understand.	1/15/2011
	Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sarah Miller* TITLE: *Administrator* (X6) DATE: *1-3-11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the resident and/or family member was notified of a discharge and the reason for the the move, related to Resident #13. The findings include: Review of Resident #13's medical record revealed diagnoses which included Mild Mental Retardation, Dementia with Agitation, Polycythemia Vera, anxiety and Diabetes Mellitus. The resident's record also revealed he/she had aggressive behaviors, hit another resident and was sent to specialized facilities to assist with	F 203	The Administrator and the Director of Nursing reviewed and revised the system for transferring/discharging residents on 12/28/2010. The Social Service Director, all registered nurses and licensed practical nurses will be educated on the new system and ensuring that residents, and if known, a family member or legal representative of the resident are notified in writing and in a language and manner they understand of the transfer or discharge. This education will be completed by the Director of Nursing or designee by 1/14/2011. The administrator or designee will audit 5 transfer or discharge records per month to ensure compliance with 483.12 Notice requirements before transfer or discharge. The results of the audit will be forwarded to the Continuous Quality Improvement Committee for further actions if necessary.	

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F 203	<p>Continued From page 2 present behaviors.</p> <p>Review of Resident #13's Minimum Data Assessment, dated 09/29/10, revealed the facility assessed the resident as having moderately impaired decision making abilities.</p> <p>Review of Social Services notes revealed on 08/26/10 the Social Services worker offered resident # 13 a room change and the resident declined, per the notes. Continued review of the Social Services notes dated 08/27/10 revealed a member of the resident's family stated while the resident was at a specialized facility for behavioral health the resident had stated he/she did not want to return to the long term care facility. Per Social Services notes the facility stated it would work with the resident and family towards finding new placement and referrals had already been made to two (2) other skilled nursing facilities that specialize in behavior. Continued review revealed the facility discussed with the residents Power of Attorney (POA) about placement in a facility that specialized in behaviors and the residents POA was in agreement. Further review of the Social Service notes revealed on 09/27/10 a staff member from the referred behavioral facility visited with the resident was quoted to ask when he/she would be moving and stating he/she wanted to go to the other facility. Per the Social Services notes dated 09/29/10 the Social Services worker and Director of Nursing met with the resident's family about the residents discharge to another facility.</p> <p>Interview with the Social Worker on 12/08/10 at 1:20 PM revealed she had not given the family any paperwork to sign concerning the notification of discharge.</p>	F 203			

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185282

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

C

12/08/2010

NAME OF PROVIDER OR SUPPLIER

SOUTH SHORE NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

JAMES E. HANNAH DRIVE
SOUTH SHORE, KY 41176

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X6)
COMPLETION
DATE

F 203

Continued From page 3

F 203

F 241

Interview with the Administrator on 12/08/10 at 4:45 PM revealed the facility would not have given a thirty (30) day notice of transfer or discharge because the resident had told staff at a behavioral health facility he/she did not want to return to the long term care facility and then the resident was offered alternative placement and was accepting. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

F 241

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

South Shore Nursing & Rehabilitation Center strives to promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

1/15/2011

This REQUIREMENT is not met as evidenced by:

Based interview and record review it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, in full recognition of his or her individuality for one (1) of fourteen (14) sampled residents (Resident #6) as evidenced by the resident's call light not being answered timely, which resulted in the resident voiding on self.

The Director of Nursing Services spoke with resident #6 on 12-23-10 regarding the timeliness of answering call lights and dignity and respect. Interview with resident #6 revealed that the complaint of voiding on self was not reported to staff. The Director of Nursing Services encouraged resident #6 to notify staff with any concerns related to care issues or quality of life issues.

The findings include:

Review of Resident #6's clinical record revealed diagnoses which included Diabetes, Joint Stiffness, Debility and History of falls.

The Director of Nursing Services or designee will assess all residents by visual and or verbal communication by 1/14/10 to identify any problems or concerns with the timeliness of answering call lights or dignity and respect of individuality.

Review of the Minimum Data Set (MDS) dated 11/21/10 revealed the facility assessed the resident as requiring extensive assist of two (2) persons to ambulate, as continent of Bladder and

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F 241	Continued From page 4 having a Colostomy. Interview on 12/08/10 at 3:00 PM with Resident #6 revealed the facility staff didn't respond quickly to the resident's call bell last week. The resident voided on him/herself twice before they assisted him/her to the bathroom and the resident was embarrassed. The resident stated being aware of the need to void and did not want to void on self. The resident indicated voiding on self made him/her feel like he/she was losing control over their body.	F 241	The Director of Nursing Services or designee will educate all staff by 1/14/2011 on promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The Director of Nursing Services or designee will audit five (5) call light response times once per week for four weeks, and monthly thereafter for one year. The Social Service Director will interview 25% of residents weekly for four weeks then quarterly thereafter, to ensure that care is being provided in a manner that enhances dignity, respect and individuality. The results will be forwarded to the monthly Continuous Quality Improvement Committee for further actions if necessary.		
F 364 SS=E	Interview on 12/07/10 at 8:05 AM with Certified Nursing Assistant #3 revealed call lights were to be answered timely, she was unaware that resident's call light wasn't answered timely last week and resident voided on self. Interview with Licensed Practical Nurse #2 on 12/08/10 at 4:30 PM revealed call lights were to be answered immediately or as soon as staff was available. Further interview revealed she was unaware of it ever taking 30 minutes to answer a call bell, however if it did she would counsel the staff member and report it to the Director of Nursing. Interview on 12/08/10 at 7:00 PM with the Director of Nursing revealed she was unaware of a resident voiding on themselves because their call light wasn't answered timely, if the resident had told her or other staff, she would have investigated the incident. She further stated that all staff know that call lights are to be answered timely. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364	South Shore Nursing & Rehabilitation Center strives to ensure that 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.	1/15/2011	

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F 364	Continued From page 5 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 record review it was determined the facility failed to prepare food which was palatable and at the proper temperature. The findings include: 1. Observation on 12/07/10 at 7:55 AM of temperature measurements taken of a test tray revealed the following; scrambled eggs of one hundred sixteen (116) degrees Fahrenheit, sausage patty of one hundred twelve (112) degrees Fahrenheit. The milk was noted to be forty-four (44) degrees Fahrenheit and the coffee was one hundred forty (140) degrees Fahrenheit. Interview with the Dietary Manager, on 12/07/10 at 7:38 AM revealed her goal was for temperatures to be one hundred thirty-five (135) degrees or greater for hot foods and less than forty-one (41) degrees Fahrenheit for cold foods at point of service to residents: Review of the facilities policy titled "Minimum Temperature at Point of Service to Resident," which was not dated, revealed meat was to at a minimum one hundred fifteen degrees Fahrenheit and coffee was to be greater than one hundred fifty (150) degrees Fahrenheit.	F 364	The Dietary Manager measured temperatures of test trays on 12/7/2010 for the lunch and dinner to ensure that the temperatures were within range of the minimum temperatures at point of service per facility policy. Random resident interviews conducted by the Dietary Manager on 12/7/2010 revealed no complaints from residents regarding food temperature, palatability or presentation during lunch or dinner service. Meal service protocols were reviewed and no changes were made. The DON and Dietary Manager or designees will provide additional education to all nursing and dietary staff by 1/14/2011 regarding facility meal service protocols to ensure that food is prepared by methods that conserve nutritive value, flavor and appearance, and food that is palatable, attractive, and at the proper temperature. The dietary manager or designee will audit food preparation and point of service temperatures for two meals per day each week for four weeks and monthly thereafter for one year to ensure that the food is palatable, attractive and at the proper temperature. The results will be forwarded to the monthly CQI committee for monitoring and further actions, if necessary.	
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	F 441		

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F 441	<p>Continued From page 6</p> <p>safe, sanitary and comfortable environment and 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 - (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.</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 and interview it was</p>	F 441	<p>South Shore Nursing & Rehabilitation Center strives to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>The tubing for Resident #9 was replaced by the LPN Charge Nurse on 12/6/2010, once nursing staff was made aware.</p> <p>An audit was conducted on 12/6/2010 by the LPN-charge nurse to ensure that all oxygen tubing was properly stored and that the facility was following infection control policies and procedures.</p> <p>All staff will be educated by the DON or designee by 1/14/2011 regarding the facility infection control program, preventing spread of infection and appropriate linen handling to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>The DON or designee will audit 25% of residents weekly for four weeks then monthly thereafter for one year to ensure proper storage and infection control practices for nasal canula's and oxygen tubing to ensure sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p>	1/15/2011	

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F 441	<p>Continued From page 7</p> <p>determined the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection as evidenced by one (1) of four (4) sampled residents (Resident #9). Resident #9's nasal cannula was observed lying on the floor and the bed. The nasal cannula was observed to have almost been placed back into the resident's nose.</p> <p>The findings include:</p>	F 441	<p>Additionally, the DON or designee will monitor the facilities infection control practices via daily (Monday-Friday) compliance rounds for four weeks and quarterly thereafter for one year. The results will then be forwarded to the monthly CQI committee for further actions, if necessary.</p>	
	<p>1. Observation on 12/06/10 at 2:45 PM revealed Resident #9's oxygen nasal cannula was lying in direct contact with the floor. The tubing was dated 12/05/10. Observation on 12/06/10 at 3:30 PM revealed Resident #9's oxygen nasal cannula was lying on the bed.</p> <p>Observation on 12/06/10 at 4:20 PM revealed Resident #9 was in his/her room with a Hospice Nurse and the Nurse was observed preparing to place the oxygen nasal canula on the resident. Intervention revealed the Hospice nurse was unaware the cannula had previously been lying on the floor, when she had entered the room it had been lying on the bed. The Hospice Nurse indicated she would let the nurses know to change the tubing and canula.</p> <p>Interview on 12/06/10 at 4:20 PM with Licensed Practical Nurse (LPN) #1, resident #9's Nurse, revealed all nasal cannulas were changed on Sundays and the date of the most recent change was 12/05/10. She further indicated whoever placed the tubing on the bed should have either changed the tubing or informed the Nurse or Nurse Aides so the tubing could have been</p>			

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F 441 F 465	<p>Continued From page 8</p> <p>changed secondary to the tubing lying on the floor was a concern for bacteria.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441 F 465	<p>South Shore Nursing & Rehabilitation Center strives to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>The Housekeeping Supervisor and staff cleaned resident bathrooms #2, 4, 8, 9, 11, 17, 18, 20, 21, 22, 25, 27, and 29 on 12/8/2010 following the Environmental Tour. The Maintenance Director ordered toilet caps on 12/8/2010 to cover the exposed rusty bolts that were sticking up from the base of the toilets.</p>	1/15/2011
	<p>Based on observation and interview it was determined the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.</p> <p>The findings include:</p> <p>Observation during the Environmental Tour on 12/08/10 at 10:25 AM revealed black substances on floors, toilet bases and inside the sinks in resident bathrooms #2, 4, 8, 9, 11, 17, 18, 20, 21, 22, 26, 27 and 29. Th toilets in those bathrooms also had rusty bolts sticking up approximately one inch from the base of the toilets.</p> <p>Interview on 12/08/10 at 11:45 AM with the Housekeeping Supervisor revealed bathroom floors and toilets were cleaned daily, per facility protocol. She stated the floors were old which made them appear dirty even after they were cleaned. Further interview revealed she observed the black substances in the sinks, on the toilet bases and floors. She stated she would inservice the housekeeping staff to thoroughly clean the facility and ensure this was done.</p>		<p>The Housekeeping Supervisor and Maintenance Director assessed the facility environment on 12/8/2010 for safety, function, sanitation, and comfort. Additionally, the maintenance director assessed all toilet bases for exposed rusty bolts on 12/8/2010. The toilet caps arrived and were placed on all exposed bolts on 12/29/2010.</p> <p>The Housekeeping Supervisor educated all housekeeping staff by 12/9/2010 on proper cleaning. The Maintenance Director or designee will educate all staff by 1/14/2011 on providing a safe, functional, sanitary and comfortable environment for residents, staff and public.</p> <p>The Maintenance Director, Housekeeping Supervisor and Administrator conducted an environmental audit of the facility on 12/28/2010 and identified objects needing replaced or repaired, all of which will be completed by 1/14/2011.</p>	

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F 465	Continued From page 9 Interview on 12/08/10 at 11:30 AM with the Maintenance Supervisor revealed he had replaced a few of the bathroom floors but all the rest needed to be replaced, the floors always looked dirty. Further interview revealed he was unaware that toilet bolts could pose a safety hazard for residents and he would correct the problem as soon as he could get the caps.	F 465	The Housekeeping Supervisor and/or Maintenance Director will conduct an environmental audit of the facility monthly for one year to ensure that the facility is providing a safe, functional, sanitary, and comfortable environment for residents, staff and the public and to ensure compliance. The results will be forwarded to the CQI Committee for further actions, if necessary.	
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	F 468	South Shore Nursing & Rehabilitation Center strives to ensure that all corridors are equipped with firmly secured handrails on each side. The Maintenance Director tightened all loose handrails found during the Environmental tour on 12/8/2010. All handrails were audited on 12/8/2010 by the Maintenance Director to ensure that all were firmly secured. The Maintenance Director or designee will educate all staff by 1/14/2011 on ensuring that all handrails are secure and the reporting of loose handrails. The Maintenance Director or designee will audit all handrails weekly for four weeks, then monthly thereafter for one year to monitor for continued compliance. The results will be forwarded to the Continuous Quality Improvement Committee for further actions if necessary.	1/15/2011
	This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to equip corridors with firmly secured handrails on each of the hallways, as evidenced by loose handrails located in the hallway near Room 21; on both Dining Room ramps and on left side of the skilled hallway. The findings include: Observation during Environmental tour on 12/08/10 at 10:25 AM revealed loose handrails located in the hallway near Room 21; on both Dining Room ramps; and on the left side of the skilled hallway. Interview on 12/08/10 at 11:30 AM with the Maintenance Supervisor revealed he checks the handrails weekly for loose ones, however indicated the handrails noted above needed to be tightened.			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185282	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2010
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NAME OF PROVIDER OR SUPPLIER

SOUTH SHORE NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES E. HANNAH DRIVE
SOUTH SHORE, KY 41176

(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
K 000	INITIAL COMMENTS	K 000		
K 018 SS=D	<p>A Life Safety Code survey was initiated and concluded on 12/07/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p style="text-align: center;">RECEIVED JAN - 3 2011</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of resident room doors, according to NFPA standards. The deficiency had the potential to affect</p>	K 018	<p>To the best of my knowledge and belief, as an agent of South Shore Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requires.</p> <p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>South Shore Nursing & Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety code Standards requiring that there are no impediment to the closing of the doors.</p> <p>The ceiling tile placed in the door of the resident room was removed on 12/8/2010.</p> <p>An audit was conducted on 12/7/10 on all resident room doors to ensure that there were no impediments to the closing of the doors.</p> <p>The Administrator and Maintenance Director will seek other options within the Life Safety code Standards to keep the resident's dog from getting out of the resident's room and will implement by 1/14/2011.</p>	1/15/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shank Willis TITLE: Administrator (X6) DATE: 1-3-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 SOUTH SHORE NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41175		
(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	
K 018	Continued From page 1 approximately fourteen (14) residents, staff, and visitors. The findings include: Observation on 12/07/2010 at 12:57 PM revealed a piece of ceiling tile placed in the doorframe of the resident room door. The piece of ceiling tile prevented the door from closing. Interview on 10/26/2010 at 1:07 PM, with the Maintenance Director, revealed the ceiling tile was placed in the door of the resident room to prevent the resident's dog from getting out of the room. Further interview, with the Maintenance Director, revealed the ceiling tile must be removed from the door to allow the door to shut properly.	K-018	The maintenance director or designee educated the resident on 12/8/10. Additionally all facility staff will be educated by 1/14/2011 on ensuring that there are no impediments to the closing of resident room doors. The maintenance director or designee will audit all resident room doors monthly for three months then quarterly thereafter for one year to ensure that there are no impediments to the closing of the door. The results will be forwarded to the Continuous Quality Improvement Committee for further actions if necessary.		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the sprinkler system was maintained, according to NFPA standards. The deficiency had the potential to affect approximately sixty (60) residents, staff, and residents. The findings include: Review of the facility's sprinkler maintenance logs	K 062	South Shore Nursing & Rehabilitation Center strives to comply with NFPA 101 Life Safety Code Standards that require automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The Maintenance Director notified Sentry Fire, the facilities contractor for fire safety, on 12/7/2010 of the necessity for the internal pipe inspection for the dry pipe sprinkler system. Sentry Fire conducted the inspection for the dry pipe sprinkler system on 12/13/2010. The Maintenance Director was educated by the Administrator on 12/13/2010 on the requirements that automatic sprinkler systems are continuously maintained in	1/15/2011	

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NAME OF PROVIDER OR SUPPLIER SOUTH SHORE NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41175
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K 062	<p>Continued From page 2</p> <p>revealed no documented evidence of an internal pipe inspection for the dry pipe sprinkler system. The observation was confirmed by the Maintenance Director.</p> <p>Interview on 12/07/2010 at 2:05 PM, with the Maintenance Director, revealed he was unable to locate the documentation of the last internal pipe inspection for the dry pipe sprinkler system.</p> <p>Reference: NFPA 26 (1998 edition) 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p>	K 062	<p>reliable operating condition and are inspected and test periodically.</p> <p>The Maintenance Director added the inspection for the dry pipe sprinkler system in the facility tickler system on 12/23/2010 which will alert staff when the inspection is due.</p> <p>An annual audit was added on 12/23/2010 and will remain indefinitely to detect timeliness of the inspection for the dry pipe sprinkler system which will ensure that the sprinkler system is continuously maintained in reliable operating condition and inspected and tested periodically. The results will be forwarded to the monthly CQI committee for continued monitoring and further actions, if necessary.</p>	
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p>	K 072	<p>South Shore Nursing & Rehabilitation Center strives to ensure that means of egress are continuously maintained free of all obstructions or impediments to full instant use in case of fire or other emergency.</p> <p>On 12/8/2010 the facility ensured that all carts and lifts were not stored in corridors until a permanent solution was developed for their storage.</p> <p>An audit was conducted on 12/7/2010 by</p>	1/15/2011

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K 072	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. Exits must be maintained to ensure their use in an emergency. The deficiency has the potential to affect all staff and residents. The findings include:	K 072	the Maintenance Director to determine if there were any other items other than carts or lifts that could impede or obstruct the means of egress to full instant use in the case of fire or other emergency. The Administrator and Maintenance Director will develop a plan and place for storage of carts and lifts by 1/14/2011 that will not impede nor obstruct the means of egress and ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency.	
	An observation on 12/07/2010 at 1:19 PM, revealed three (3) clean linen carts not in use and stored in the hall corridor near the Nurses' Station. The Long Hall was observed to have three (3) medication carts not in use stored across from the Nurses' Station. Further observation revealed one (1) Patient lift stored next to the Bathroom on the Short Hall. The observation was confirmed with the Maintenance Director. An interview, on 12/07/2010 at 1:19 PM, with the Maintenance Director, revealed the carts were routinely left in the halls due to lack of storage space. Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency		The Maintenance Director or designee will audit the corridors to ensure that they are maintained free from obstructions to full instant use in the case of fire or other emergency. These audits will be conducted weekly for 4 weeks and monthly thereafter for one year. The results will then be forwarded to the monthly CQI Committee for monitoring and further actions if necessary	