

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

PRINTED: 05/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185282</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/12/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTH SHORE NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>JAMES E. HANNAH DRIVE</b> <b>SOUTH SHORE, KY 41175</b>
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 05/02/14.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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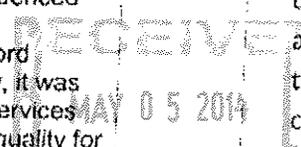
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F 000	INITIAL COMMENTS  AMENDED  A Recertification Survey was initiated on 03/25/14 and concluded on 03/27/14, with deficiencies cited at the highest Scope and Severity of an "F".	F 000	To the best of my knowledge and belief, as an agent of South Shore Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.	5.2.14
F 281 SS=F	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews and review of the facility's policy, it was determined the facility failed to ensure services provided met professional standards of quality for three (3) of fourteen (14) sampled residents (Resident #3, Resident #1, Resident #6). Resident #3's skin assessment revealed an unidentified abrasion and the nurse failed to follow the wound care policy.  Resident #1's and Resident #6's experienced periods of no documented bowel movements (BMs), however the residents' Physician's Orders and the facility's standing orders was not followed.  Additionally, there was no documented evidence the daily calibration of the facility's two (2) glucometer's were calibrated on a daily basis, potentially affecting twenty-five (25) residents (Resident #1, Resident #3, Resident #4, Resident #5, Resident #7, Resident #8, Resident #9, Resident #11, Resident #12, Unsampled	F 281	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 conclusions 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 and Rehabilitation Center strives to ensure that services are provided to meet professional standards of quality.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Elizabeth Townsend</i>	TITLE ADMINISTRATOR	(X6) DATE 5.2.14
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F 281	<p>Continued From page 1</p> <p>Resident #B, Unsampld Resident #F, Unsampld Resident #I, Unsampld Resident #J, Unsampld Resident #K, Unsampld Resident #L, Unsampld Resident #M, Unsampld Resident #N, Unsampld Resident #O, Unsampld Resident #P, Unsampld Resident #Q, Unsampld Resident #R, Unsampld Resident #S, Unsampld Resident #T, Unsampld Resident #U and Unsampld Resident #V.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, "Pressure Ulcer Treatment", effective date of 03/01/13, and the facility's "Care System Guidelines for Skin Care", which was based on the interpretive guidelines from the National Pressure Ulcer Advisory Panel (NPUAP), revealed when an open area was identified the nurse should: implement resident specific interventions immediately; notify the Physician and document the notification; complete a new risk assessment, Braden scale, to determine what risk factors might have changed and help establish and initiate a care plan with individual interventions for each problem/risk factors. Further review of the policy and guideline revealed interventions were to be placed on the State Registered Nursing Assistant (SRNA) "care card" and the nurse was to document evaluation of the wound in the resident's electronic medical record (EMR).</p> <p>Review of Resident #3's medical record revealed the facility admitted the resident on 05/21/03, with diagnoses which included Multiple Sclerosis (MS), Diabetes, Peripheral Vascular Disease (PVD), Ulcer of Lower Limbs, Pain in Lower Limbs, Dysphagia Oral Phase, Chronic Kidney</p>	F 281	<p>On 3/26/14, Director of Nursing assessed Resident #3's left lower buttock area, notified the Physician, and Registered Dietician, obtained an order to treat the skin abrasion. The Interdisciplinary Care Plan Team updated the current plan of care on 3/27/14.</p> <p>During the dates 3/27/14 through 4/2/14, charge nurses performed skin audits for each resident to ensure that any skin condition noted had appropriate treatment orders in place. No additional areas were found during the facility wide skin audit.</p> <p>The DON reviewed the bowel habits for resident #1 and #6 on</p>		

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F 281	<p>Continued From page 2</p> <p>Disease, Generalized Muscular weakness, Intestinal Disorder, General Osteoarthritis, Abnormal Posture, and Cholecystitis.</p> <p>Observation on 03/26/14 at 09:50 AM, of Resident #3's skin assessment and wound care provided by Licensed Practical Nurse (LPN) #4 revealed an unidentified skin abrasion on the resident's left lower buttock. Continued observation revealed LPN #4 did not assess the area until Surveyor intervention, then took off the Stage II sacral Pressure Ulcer dressing and reapplied the dressing to also cover the left lower buttock abrasion.</p> <p>Interview, with LPN #4, during the skin assessment and wound care observation, revealed she did not feel it was necessary to assess the abrasion or followup with the Physician for treatment orders for the area. She stated the reapplying the Stage II sacral Pressure Ulcer dressing to cover the abrasion was sufficient care for the area.</p> <p>Interview with the Director of Nursing (DON) on 03/26/14 at 10:30 AM, revealed it was her expectation for all nursing staff to follow the facility's wound care policy and procedure, to assess all areas of residents' skin breakdown and to notify the Physician for wound care orders. The DON subsequently assessed Resident #3's left lower buttock area, observed the abrasion, notified the Physician and obtained an order to treat the skin abrasion.</p> <p>2. Review of the facility's policy titled, "Bowel Continence Program", revised 08/01/12, revealed the purpose of the policy was to provide a method by which to assess resident's ability to control</p>	F 281	<p>3/28/14. The charge nurse notified the physician of resident #1's irregular bowel habits on 3/28/14. The physician added additional bowel regimen medications for resident #1 on 3/28/14. Review of resident #6 bowel regimen by the DON on 3/28/14 revealed no need for a change in bowel regimen.</p> <p>On 4/16/14, the DON reviewed the bowel habits of all residents for the last 30 days. Any resident identified to have irregular bowel patterns (requiring additional interventions three or more times in a 30 day period) will be reviewed by the attending physician no later than April 18<sup>th</sup> to determine if additional interventions should be added to the bowel regimen protocol.</p> <p>On 3/28/14, the Director of Nursing observed that current Glucometer Calibration logs were up to date.</p>	
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F 281 Continued From page 3  
 bowel function. Review of the policy revealed the ultimate goal of the Bowel Continence Program was to promote regular bowel habits without laxative support. Continued review of the policy revealed staff would chart each shift whether or not residents had a bowel movement (BM) and if a resident had not had a BM after the third day, a laxative was to be given if ordered by the Physician.

Interview with the DON revealed her expectation was if a resident failed to have a BM in three (3) days, the nurse should contact the Physician to initiate the facility's standing order which was: if no BM on day four (4) the resident should receive a suppository; if no results from the suppository on day five (5) the resident should receive Lactulose (a laxative); and if no results from the Lactulose, on day six (6) the resident should receive an enema and notify the Physician who might order an examination of the resident's abdomen.

Review of Resident #1's medical record revealed the facility admitted the resident with diagnoses which included Type II Diabetes, Acute Kidney Failure and Depressive Disorder. Review of Resident #1's Significant Change Minimum Data Set (MDS) Assessment dated 02/25/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of two (2) which indicated severe cognitive impairment. Further review of the MDS revealed the facility assessed Resident #1 as having constipation during the assessment period. Review of the Comprehensive Care Plan revealed a care plan related to constipation due to decreased oral intake, impaired mobility and pain medication use. Continued review of the care plan revealed

F 281  
 On 3/28/14, the Director of Nursing performed an audit of the last three months of blood sugars of all residents who receive glucometer checks. No glucose levels were noted to be out of normal individual range for any resident reviewed.

LPN #4 received one-on-one education from the DON on 3/26/14 regarding the facility's "Care System Guidelines for Skin Care," facility protocols for performing head to toe assessments, and facility protocols for treating newly identified skin conditions.

The DON will provide education to all nursing staff by 5/2/14 regarding the importance of providing or arranging services that meet professional standards of quality. This education will include special emphasis on skin protocols, following physician's standing orders regarding bowel protocols, and calibration of

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F 281	<p>Continued From page 4</p> <p>a goal/target date of 05/21/14, and interventions which included staff to evaluate the resident for constipation and administer a laxative or stool softener as ordered.</p> <p>Review of Resident #1's March 2014 monthly Physician's Orders revealed an order dated 10/28/11 for the resident to receive a Bisacodyl (a laxative suppository) as needed (PRN) if no BM for three (3) days.</p> <p>Review of Resident #1's "Bowel Movement Roster" dated 03/01/14 thru 03/27/14, revealed no documented evidence the resident had a BM for the following dates: 03/01/14 through 03/05/14, a four (4) day period. Review of the March 2014 Medication Administration Record (MAR) revealed the order for the Bisacodyl suppository, however there was no documented evidence of the Bisacodyl suppository having been administered on the third day without a BM as ordered.</p> <p>Continued review of Resident #1's BM Roster revealed no documented evidence the resident had a BM from 03/12/14 through 03/20/14, a period of eight (8) days. Review of the March 2014 MAR revealed the Bisacodyl suppository was given on the third day, 03/15/14. Record review revealed no documented evidence of results from the administration of the suppository, and no documented evidence the facility's standing orders had been implemented to notify the Physician to initiate the standing orders, to administer Lactulose on day five (5) and on day six (6) administer an enema and notify the Physician for additional orders.</p> <p>Further review of the BM Roster revealed no</p>	F 281	<p>glucometer machines on a daily basis.</p> <p>The DON will visually monitor at least three head to toe skin assessments or dressing changes per week for four weeks to ensure that these services meet professional standards of quality. Thereafter, monitoring will occur at least weekly by the DON.</p> <p>The DON or the Health Information Management Coordinator (HIMC) will monitor the Bowel Protocol Utilization sheet during daily nursing meeting (M-F) to ensure that facility protocols regarding bowel care are implemented as ordered. The RN Supervisor will monitor on Saturday and Sunday. The Bowel Protocol Utilization sheet will be monitored daily for four weeks then weekly for an additional four weeks. DON will forward results of the auditing of the Bowel Protocol Utilization</p>		

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F 281 Continued From page 5  
documented evidence Resident #1 had a BM from 03/21/14 through 03/25/14, a period of four (4) days. Further review of the MAR revealed no documented evidence the Bisacodyl suppository was administered on the third (3) day as ordered.

Interview with LPN #1 on 03/27/14 at 2:39 PM and 6:23 PM, revealed it was the facility's policy to provide residents with a suppository if the resident did not have a BM within three (3) days. She stated if a resident did not have a BM after the suppository was given, then the resident was to receive Lactulose. According to LPN #1, each resident had a "standing order" from the Physician in regards to lack of BMs. After reviewing Resident #1's record and reviewing the MAR, LPN #1 stated the Physician's Orders were not followed, however should have been. LPN #1 indicated Resident #1 should have been given a Bisacodyl suppository per the Physician's Orders after three (3) days with no BM, and then been given Lactulose when the resident continued to have no BM for more than five (5) days per the facility's standing orders. LPN #1 stated the Physician should have been notified when the resident had no documented BM for a period of eight (8) days.

Interview with the DON on 03/27/14 at 6:45 PM, revealed it was the facility's policy to contact the Physician on the sixth day if a resident had not had a BM. The DON reviewed Resident #1's record and stated the Physician's Orders and facility's standing orders were not followed, however should have been. She stated Resident #1 should have received a Bisacodyl suppository as ordered on the third day for the two (2) episodes of no BM for four (4) days, which would have been on 03/04/14 and 03/24/14. The DON

F 281  
Sheets to the facility monthly QAPI meeting for further monitoring and continued compliance. After three months, the QAPI team will review the results of these audits and determine a schedule for additional monitoring.

The glucometer calibration sheet will be reviewed each day in morning meeting (M-F) by the DON or HIMC to ensure that the machine is calibrated daily as per facility protocols. The RN Supervisor will monitor on Saturday and Sunday. If a problem is identified, it will be addressed with immediate one to one education and remedied as needed, according to facility policy. Audits will continue daily for four weeks, then weekly for an additional four weeks. HIMC will forward the results of these audits to the facility QAPI meeting for further monitoring and continued compliance. After three months, the QAPI

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F 281 Continued From page 6  
stated the Physician should have been contacted on the sixth day of Resident #1 not having a BM.

3. Review of Resident #6's medical record revealed diagnosis which included Pain, Anxiety, Depression and Range of Motion and Communication Problems. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/19/13, revealed the facility assessed Resident #6 /she to be incontinent of bowel and bladder and to have had constipation during the assessment period.

Review of Resident #6's January 2014 BM Roster revealed "no BM" documented from 01/07/14 through 01/12/14, a period of five (5) days. Review of the January 2014 monthly Physician's Orders revealed Resident #6 had no PRN orders for laxatives. Review of the Nurse's Notes for the five (5) day period Resident #6 had no documented BM, revealed no documented evidence the Physician was notified of this information and orders received to treat. Review of the Telephone Orders revealed no documented evidence an order had been received to treat Resident #6 for constipation.

Continued review of the January 2014 BM Roster revealed no documented evidence Resident #6 had a BM from 01/22/14 to 01/25/14, a four (4) day period. Continued review of the Telephone Orders revealed the Physician had been notified on 01/26/14 and an order received for a Bisacodyl suppository PRN for no BM in three (3) days.

Interview with State Registered Nursing Assistant (SRNA) #7, who had cared for Resident #6, revealed a resident should never go more than two (2) days without a BM. She stated if a

F 281 team will review the results of these audits and determine a schedule for additional monitoring.

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F 281 : Continued From page 7  
resident went more than two (2) days, staff notified the charge nurse.

Interview with the DON on 03/27/14 at 6:40 PM, revealed her expectation was for the Physician to have been notified when Resident #6 went greater than three (3) days without a BM to implement the facility's standing orders. The DON stated the facility's process included for nurses in morning report to pass along if residents had not had a BM for three (3) days and the resident would be put on the "no BM list". She stated for Resident #6, nurses had failed to notify the Physician, write the standing orders and start the medications. In addition, she stated Resident #6 was not on her no BM list, so she was not notified the resident had not had a BM for more than three (3) days.

4. Review of the facility's policy titled, "Glucose Monitoring Equipment", effective date of 08/01/12, revealed the purpose of the policy was to properly maintain the glucose monitor to validate its accuracy. Continued review of the policy revealed quality control testing would be performed daily and, a log maintained of all the results which was to be stored in the medication room.

Review of the glucometer quality control testing log book revealed no documented evidence the quality control testing had been performed daily as per the facility policy. Review of the January 2014 quality control testing log for Glucometer #1 revealed the testing had only been performed on seven (7) days of the thirty-one (31) days. Review of the January 2014 quality control testing log for Glucometer #2 revealed the testing had only been performed three (3) days during the thirty-one

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F 281	Continued From page 8  (31) day period. Review of the February 2014 quality control testing log for Glucometer #1 and Glucometer #2 revealed the testing had only been performed seventeen (17) of the twenty-eight (28) days. Review of the March 2014 quality control testing log revealed Glucometer #1 and Glucometer #2 had not been tested on one (1) day 03/12/14.  Record review revealed there were twenty-five (25) current residents having their blood sugars checked with the glucometer's. The residents include Resident # 1, Resident #3, Resident #4, Resident #5, Resident #7, Resident #8, Resident #9, Resident #11, Resident #12, Unsampld Resident #B, Unsampld Resident #F, Unsampld Resident #I, Unsampld Resident #J, Unsampld Resident #K, Unsampld Resident #L, Unsampld Resident #M, Unsampld Resident #N, Unsampld Resident #O, Unsampld Resident #P, Unsampld Resident #Q, Unsampld Resident #R, Unsampld Resident #S, Unsampld Resident #T, Unsampld Resident #U and Unsampld Resident #V.  Interview with LPN #1 on 03/27/14 at 4:45 PM and at 4:50 PM with LPN #2, revealed the glucometer calibration (quality control testing) checks were performed on a daily basis on the evening (2:00 PM to 10:00 PM) shift.  Interview with the DON on 03/27/14 at 5:00 PM, revealed it was her expectation for all the glucometer checks to be done on a daily basis as per the policy. She indicated not performing the checks could potentially affect the accuracy of the readings. The DON indicated the last scheduled in-service on glucometer's was on 01/16/14.	F 281			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185282</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/27/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH SHORE NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41175</b>		
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F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident 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 and review of the facility's policy and Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure the environment remained free of accident hazards as possible as evidenced by observation on initial tour revealed chemicals unsecured in the shower room and beauty shop with the facility currently having nine (9) wandering residents potentially affected (Resident #2 and Unsampled Residents A, B, C, D, E, F, G, and H).</p> <p>The findings include:</p> <p>Interview with the Administrator on 03/25/14 at 6:00 PM, revealed the facility had no policy for the storage of chemicals except the Dietary Services "Chemical Storage" policy. Review of the facility's Dietary Services policy titled, "Chemical Storage" dated 08/01/12, revealed it did not address storage of chemicals outside the dietary area.</p> <p>Observation on 03/25/14 at 2:30 PM, during initial tour, revealed containers of of Virex Tb (a disinfectant) and Dawnmist Shave Cream sitting on the whirlpool tub unsecured.</p>	F 323	<p>South Shore Nursing and Rehabilitation Center endeavors to ensure an environment free of accident hazards as possible; and, each resident receives assistive devices to prevent accidents.</p> <p>On 3/25/14, the Administrator locked the Beauty Shop immediately.</p> <p>No residents entered the Beauty Shop during the short time it was unlocked; no residents were adversely affected.</p> <p>On 4/13/14, the Maintenance Director placed an automatic door closure on the Beauty Shop door. An automatic keypad lock will be installed by Maintenance Director no later than 5/2/14.</p> <p>Virex and Dawnmist Shave Cream were removed from the whirlpool tub by DON on 3/25/14.</p>	5.2.14	

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F 323	Continued From page 10  Observation on 03/25/14 at 5:00 PM, of the beauty shop area revealed the door was unlocked with two (2) pair of scissors unsecured and Barbicide (a disinfectant), Magic Power Multi-purpose Cleaner and Degreaser, Sani-Cloth Disinfecting Wipes and Sanis Citrus Slice air freshener.  Review of the list of residents having the potential to wander provided by the facility revealed nine (9) residents listed, Resident #2, Unsampled Resident A, Unsampled Resident B, Unsampled Resident C, Unsampled Resident D, Unsampled Resident E, Unsampled Resident F, Unsampled Resident G and Unsampled Resident H.  Review of the MSDS for Virex Tb dated 01/23/07, revealed contact with the skin, eyes and clothing was to be avoided as the product was irritating to these areas. Continued review if ingested the product was irritating to the mouth, throat and stomach. Further review revealed if the product came into contact with any of these areas medical attention was to be sought.  Review of the MSDS for Dawnmist Shave Cream dated 11/22/10, revealed if the product was ingested the Physician or Poison Control Center was to be notified immediately. Continued review revealed the product was irritating to eyes, skin and if inhaled medical attention was to be sought.  Review of the MSDS for the Barbicide dated 10/23/12, revealed the product was irritating to eyes and skin. Continued review revealed if ingested immediate medical attention was to be sought. Further review revealed prolonged inhalation of the product might cause nausea,	F 323	On 3/28/14, the DON reviewed the Incident/Accident log to ensure that no incidents had occurred regarding resident access to chemicals or hazardous areas of the facility. None were identified.  All staff members will be educated by DON by 5/2/14 regarding the importance of resident safety, by ensuring the environment is as free of accident hazards as possible, and each resident receives assistive devices to prevent accidents. Special attention will be paid to chemical storage.  Administrator, or DON will conduct Daily Compliance Rounds (attached) Monday through Friday for four weeks, then weekly thereafter. Administrator will forward results of these rounds to the facility monthly QAPI meeting		

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F 323	Continued From page 11 dizziness or disorientation.  Review of the MSDS for the Magic Power Multi-purpose Cleaner and Degreaser dated 02/24/09, revealed ingestion and contact with the eyes and skin were to be avoided.  Review of the MSDS for the Sani-Cloths Disinfecting Wipes dated 01/20/11, revealed prolonged contact with skin and eyes might cause irritation and the product might be harmful if swallowed.  Review of the MSDS for the Sanis Citrus Slice air freshener revealed contact with the eyes and skin were to be avoided  Interview with Licensed Practical Nurse (LPN) #5 on 03/25/14 at 5:01 PM, revealed the Maintenance Director had been in the beauty shop a few minutes earlier. She indicated he might have left the door unlocked. LPN #5 further stated the chemicals in the beauty shop would be harmful to a resident.  Interview with the Maintenance Director on 03/25/14 at 5:10 PM, revealed he had left the beauty shop door unlocked when he went to check the water temperatures. He stated the beauty shop door should always be locked to prevent residents access to the chemicals and sharp objects stored there.  Interview with the Administrator on 03/25/14 at 5:05 PM, revealed she had found the beauty shop door unlocked earlier and had locked it back herself. She stated the beauty shop door was to be locked at all times. She indicated the chemicals in the beauty shop and unsecured in	F 323	In addition to daily compliance rounds, Administrator, Maintenance Director, or DON will conduct an Environmental Round (attached) weekly for one month and monthly thereafter.  If a problem is identified, it will be addressed with immediate one to one education and remedied as needed, according to facility policy.  The results of all audits will be forwarded to the monthly QAPI meeting for further monitoring and continued compliance. After three months, the QAPI team will review the results of these audits and determine a schedule for additional monitoring.		

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F 323	Continued From page 12 the shower room would be harmful to residents.	F 323	South Shore Nursing and Rehabilitation Center strives to	
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 and review of the facility's policy, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by an expired food item in the kitchen refrigerator during initial tour; food temperatures during the meal service tray line not documented; staff with their hair not fully covered during meal service; no thermometers present in the kitchenette/nourishment room freezers and expired food items in the kitchenette/nourishment rooms and refrigerators.  The findings include:  1. Review of the facility's policy titled, "Refrigerated Storage", dated 06/01/13, revealed all foods were to be properly wrapped and/or stored in sealed containers and dated and labeled. Further review revealed food would also be discarded within appropriate shelf life.	F 371	store, prepare, distribute, and serve food under sanitary conditions.  On 3/25/14, the tomato juice was discarded by the Dietary Manager.  Food temps at the dinner and lunch meal were within acceptable range at point of service so resident meal service was not affected.  On 3/27/14, Dietary Manager immediately secured her hairnet with a clip.  On 3/27/14, all outdated items found in the nourishment room located behind the nurses' station were discarded.  On 3/27/14, a thermometer was placed in the freezer of the nourishment room located behind the nurses' station.	5.2.14

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F 371	<p>Continued From page 13</p> <p>Review of the facility's policy titled, "Leftover Food", dated 08/01/12, revealed left over food was to be dated and labeled. Continued review revealed if the left over food was refrigerated it was to be used within five (5) days or discarded.</p> <p>Observation on 03/25/14 at 1:47 PM, during the initial tour of the kitchen area, revealed a container of tomato juice stored in the refrigerator with an expiration date of 03/23/14.</p> <p>Interview with the Dietary Manager, on 03/25/14 at 1:49 PM, during the initial kitchen tour, revealed the tomato juice should have been discarded. Observation revealed she discarded the tomato juice.</p> <p>2. Review of the facility's policy titled, "Tray Line and Meal Service Temperatures", dated 08/01/12, revealed food temperatures were to be taken prior to the start of each meal at the service line by the cook on duty or Dietary Manager and recorded on either the temperature checklist or the menu.</p> <p>Observation on 03/25/14 at 4:56 PM, of the dinner meal tray line service, in the kitchen area, revealed Dietary Cook #7, calibrated the thermometer and took the temperatures of the food on the line which was to be served to residents. Continued observation revealed Dietary Cook #7 did not document the food temperatures, nor did anyone else in the kitchen as per the facility policy.</p> <p>Observation on 03/26/14 at 11:17 AM, of the lunch meal tray line service, in the kitchen area, revealed Kitchen Aide #6 took the food</p>	F 371	<p>On 3/28/14, the DON reviewed infection control log for the last 90 days to ensure that no resident had been identified to have symptoms consistent with any food borne illness. None were identified.</p> <p>Dietary Manager will re-educate Dietary Staff members regarding the importance of storing, preparing, distributing, and serving food under sanitary conditions. This includes discarding expired foods, documenting temps at point of service, and utilization of hair nets.</p> <p>The DON will provide additional education to all nursing staff by 5/2/14 regarding the importance of discarding expired items from the nourishment room, ensuring thermometers are in place in the refrigerator, as well as the freezer, and recording temps nightly on the log provided.</p>	

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F 371	<p>Continued From page 14</p> <p>temperatures, however was not observed to document the temperatures as per facility policy.</p> <p>Interview with Dietary Cook #7, on 03/27/14 at 1:13 PM, revealed it was the job of the cook to write down the food temperatures as they were taken. Dietary Cook #7 stated if the temperatures were not documented after taken she would forget what the temperatures were. She stated she should have written down the temperatures as she took them, however had forgotten.</p> <p>Interview with the Dietary Manager on 03/27/14 at 1:42 PM, revealed it was her expectation staff would document the food temperatures as soon as they had taken the temperatures as per facility policy, otherwise, they would forget.</p> <p>3. Review of the facility's policy titled, "Employee Sanitary Practices", dated 08/01/2012, revealed staff were to wear hair nets or hair restraints.</p> <p>Observation of Dietary Manager, on 03/25/14 at 5:00 PM and on 03/26/14 at 11:22 AM, revealed she had the top of her hair covered with a hair net, however the bottom of her hair was exposed.</p> <p>Interview with the Dietary Manager, 03/27/14 at 2:00 PM, revealed all of her hair should be covered by the hair net. She stated her hair net rises up in the back, but all hair should be covered due to concerns with infection control.</p> <p>4. Review of the facility's policy titled, "Frozen Storage", dated 08/01/12, revealed frozen food would be stored at a temperature of ten (10) degrees Fahrenheit or below. Continued review revealed every freezer would be equipped with a</p>	F 371	<p>The Dietary Manager will perform weekly sanitation audits weekly for eight weeks and then monthly thereafter. These audits include observation of outdated items, hairnets, and recording food temps accurately.</p> <p>The DON will audit the nourishment refrigerator weekly for eight weeks and then monthly thereafter to ensure items are discarded appropriately, thermometers are in place, and that temperature logs are completed each night.</p> <p>The results of all audits will be forwarded by the Dietary Manager and the DON, respectively, to the monthly QAPI meeting for further monitoring and continued compliance. After three months, the QAPI team will review the results of these audits and determine a schedule for additional monitoring.</p>	
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F 371	<p>Continued From page 15</p> <p>visible thermometer and temperatures would be documented daily.</p> <p>Interview with the Director of Nursing, (DON), on 03/27/14 at 11:21 AM, revealed it was her expectation that the night shift nurses would discard any outdated food.</p> <p>Observation on 03/27/14 at 11:09 AM, of the Nourishment room located behind the nurses station, revealed one (1) vanilla ice cream carton in the freezer, without an expiration date. Continued observation revealed no thermometer visibly located in the freezer and no evidence of temperature logs for the freezer as indicated in the policy. Further observation revealed: the nourishment room refrigerator contained a fast food milkshake in the freezer dated 02/26/14 and a raspberry sherbet icee dated 02/24/14; and in the reformatory eighteen (18) cans of 1.2 Cal Glucerna (a nutritional supplement) all with an expiration date of December 2013.</p> <p>Interview with Licensed Practical Nurse (LPN) #5 on 03/27/14 at 11:16 AM, revealed it was the policy of the facility to throw away outdated food. She stated nursing staff was responsible for discarding the expired 1.2 Cal Glucerna supplements. LPN #5 stated it was the night shift nurses' responsibility to discard the outdated food, as well as, dietary staff. Continued interview with LPN #5 revealed she was not certain if the freezer needed a thermometer, but would check with dietary.</p> <p>Interview with the Dietary Manager on 03/27/14 at 1:55 PM, revealed dietary aides were responsible for discarding outdated food in the refrigerator, however nurses were responsible for the expired</p>	F 371			

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F 371	Continued From page 16 Glucerna. The Dietary Manger stated thermometers should be located in the freezer of the refrigerators based on facility policy.	F 371	South Shore Nursing and Rehabilitation Center strives to establish and maintain an infection control program designed to help prevent the development and transmission of disease and infection for all its residents.	
F 441 SS=D	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 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	F 441	Resident #1 was assessed by Charge Nurse on 4/3/14 to ensure that there were no signs of infection to any body system including the integumentary system. There were no negative outcomes identified.  On 3/28/14, the DON reviewed the infection control log for the last 90 days to determine that no trends or patters were identified related to improper hand washing techniques. No trends were identified.  The DON provided one-to-one education to RN #1 and SRNA #3 on 3/27/14, regarding the	5.2.14

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F 441	Continued From page 17 transport linens so as to prevent the spread of infection.  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 establish and maintain an infection control program designed to help prevent the development and transmission of disease and infection for one (1) of fourteen (14) sampled residents (Resident #1). Staff was observed to follow improper hand washing and gloving technique during the observation of a skin assessment for Resident #1.  The findings include:  Review of the facility Policy and Procedure for Hand washing/Hand Hygiene, revised 08/12, revealed the facility considered hand hygiene the primary means to prevent the spread of infections. The Policy stated, all personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. In most situations, the preferred method of hand hygiene was with an alcohol-based hand rub. According to the Policy, if hands were not visibly soiled, staff were to use an alcohol-based hand rub containing 60-95% (percent) ethanol or isopropanol for all the following situations; before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, and after removing gloves. The Policy stated, the use of gloves did not	F 441	importance of proper hand washing techniques.  The DON will provide additional education to all nursing staff by 5/2/14 regarding the importance of establishing and maintaining 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. Special emphasis will be placed on the importance of hand hygiene.  The DON will visually monitor at least three head to toe skin assessments or dressing changes per week for four weeks to ensure that appropriate hand washing protocols and infection control techniques are followed. Thereafter, visual monitoring of body assessments and/or dressing changes will occur at least weekly by the DON.		

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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
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F 441 Continued From page 18

replace hand washing/hand hygiene.

Review of Resident #1's clinical record revealed he/she was admitted to the facility on 01/22/09, with diagnoses which included; Diabetes, Urinary Tract Infection, Acute kidney failure, Dementia with Behavioral disturbances, and Cardiac Dysrhythmia.

Observation on 03/27/14 at 10:00 AM, during a skin assessment performed on Resident #1 by Registered Nurse (RN) #1 revealed the nurse began to perform a head to toe skin assessment and assessed the resident's anterior surface and then began to examine the resident's posterior surface. RN #1 opened Resident #1's incontinence brief and touched the resident's peri-rectal area to assess the skin for any skin breakdown, closed the incontinence brief, and continued with the skin assessment, touching the resident's back and posterior aspect of her/his head and scalp. SRNA #3 who was assisting, touched the resident's peri-rectal area, and continued to assist RN #1 with the skin assessment, reapplying the resident's brief, touching her/his clothes, sheets, blanket and side rails. At the conclusion of the skin assessment RN #1 and SRNA #3 removed their gloves and washed their hands.

An interview with RN #1 during the skin assessment revealed she was aware of the facility hand washing policy and the need to change gloves and wash hands when moving from a dirty area to a clean area of the resident's body. RN #1 related she did not know why she did not change her gloves and wash her hands during the skin assessment when moving from a dirty to a clean area, "I guess I was nervous and

F 441

DON or Health Information Management Coordinator (HIMC) will conduct "Monitoring Compliance with Infection Control Checklist" (attached) weekly for three months. If a problem is identified, it will be addressed with immediate one to one education and remedied as needed, according to facility policy. The results of all audits will be forwarded to the monthly QAPI meeting for further monitoring and continued compliance. After three months, the QAPI team will determine a schedule for additional monitoring.

Additional infection control monitoring will occur weekly by the Administrator and/or DON via Compliance Rounds. These Compliance Rounds will occur daily, Monday through Friday, for four weeks, then at least weekly thereafter for at least three months. DON will forward results of these Compliance

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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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F 441	Continued From page 19 just forgot".  Interview with SRNA #3 during the skin assessment revealed that she was aware of the hand washing policy and the need to change gloves and wash hands when moving from a dirty area to a clean area of the resident's body. SRNA #3 related she did not know why she did not change her gloves and wash her hands during the skin assessment when she moved from a dirty to a clean area. "I guess I just forgot".  Interview with the Director of Nursing on 03/27/14 at 5:00 PM revealed it was her expectation for all nursing staff to follow the facility policy and procedure for hand washing and infection control. She related it was her expectation for staff to remove their gloves and wash their hands when moving from a dirty to a clean area of a resident's body during nursing care.	F 441	Rounds to the facility monthly QAPI meeting for further monitoring and continued compliance. After three months, the QAPI team will review the results of these audits and determine a schedule for additional monitoring.	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based upon observation, interviews and review of the facility's policy and documents, it was determined the facility failed to ensure the kitchen's physical environment was clean, safe and sanitary. Observations in the kitchen area revealed: three (3) holes in the walls in different locations; the wood behind the kitchen door was	F 465	South Shore Nursing and Rehabilitation Center strives to ensure that the facility maintains an environment that is functional, sanitary, and comfortable for residents, staff, and the public.  On or before 4/1/14, three holes in the walls in different locations were repaired by Maintenance Director.	5.2.14

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F 465	<p>Continued From page 20</p> <p>decaying; food particles scattered throughout the kitchen floor; splattered food particles on the walls; and a red sticky substance in the bottom of the medication/nourishment room refrigerator.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Sanitation", revised 08/01/12, revealed it was the facility's policy to maintain equipment, work surfaces, walls and floors in sanitary condition through daily ongoing procedures. Continued review revealed cleaning schedules were established to assign specific tasks to scheduled employees on a daily, weekly and monthly basis. Further review of the policy revealed training was provided to appropriate personnel regarding correct procedure, cleaning agents, and frequency of cleaning.</p> <p>Review of the nursing, "Midnight Cleaning Schedule" document, undated, revealed nurses were to clean out the refrigerator in the medication/nourishment room on Sundays.</p> <p>Review of the kitchen cleaning schedule for March 2014 revealed no documented evidence on some days of staff signing off the cleaning assignments as completed.</p> <p>Observation on 03/25/14 at 4:43 PM, and at 5:03 PM, of the kitchen area during meal preparation, revealed food particles scattered throughout on the kitchen floor and walls. Continued observations revealed a row of ants traveling along the wall, on the floor, and several ants surrounding food particles located on the floor. Further observation of the kitchen walls, near the mixing bowl, revealed a white dried substance</p>	F 465	<p>On or before 4/1/14, decaying wood behind the kitchen door was repaired by Maintenance Director.</p> <p>Food particles found on the floor on 3/25/14 were swept up immediately following meal preparation by Dietary Aide.</p> <p>Per facility contract, a pest control contractor came on-site and exterminated ants that were witnessed on 3/25/14.</p> <p>The white, dried substance on the wall near the mixer was also cleaned by the Dietary Manager as soon as it was identified on 3/25/14.</p> <p>On 3/26/14, the green dried jello was also was also immediately cleaned by the Dietary Manager.</p>		

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F 465	<p>Continued From page 21 scattered on the walls.</p> <p>Observation on 03/26/14 at 9:06 AM, of the kitchen walls, located near the mixing bowl, revealed a green dried substance which Dietary Aide #15 indicated was probably the jello prepped the night before. Observation at 11:10 AM that same day revealed: a hole a little larger than the palm of a hand located on the wall under the fire extinguisher; the wood behind the door of the kitchen was decaying; and there was two (2) penny-sized holes on the column located in the dishwasher room. Continued observation on 03/26/14 at 11:16 AM of the kitchen area revealed one (1) ant present under the stove and food particles under the stove.</p> <p>Interview with Dietary Aide #15 on 03/26/14 at 9:06 PM, revealed food often would splatter on the walls after using the mixer and it would be the responsibility of the staff who used the mixer to wipe down the walls after use.</p> <p>Interview with Dietary Aide #10 on 03/27/14 at 1:13 PM, revealed she observed the ants on the floor after sweeping the floor on 03/25/14. She stated there was a cleaning schedule in which staff were responsible for cleaning the walls, floors, and baseboards. Dietary Aide #10 stated it was the responsibility of the dietary aides to clean the dishes and the floors, and for cooks to clean the cooking equipment. After reviewing March 2014 kitchen cleaning schedule, she revealed it appeared staff had not signed off on cleaning their assigned sections.</p> <p>Interview with the Dietary Manager on 03/27/14 at 1:42 PM, revealed she had not observed the ants on 03/25/14, but was informed by staff the next</p>	F 465	<p>On 3/27/14, Charge Nurse cleaned the Nourishment Room refrigerator.</p> <p>By 5/2/14, the Administrator, DON, and/or the Dietary Manager will provide additional education to all staff regarding the importance of providing a safe, functional, sanitary, and comfortable environment for residents, staff, and public. All staff were re-educated regarding the utilization of cleaning schedules and repair requisitions in order to assist in maintaining an environment that meets expectations.</p> <p>The Administrator, Dietary Manager, DON, or Maintenance Supervisor will conduct environmental rounds weekly for two months and monthly thereafter to ensure that the facility is maintained in a safe, functional, sanitary, and comfortable manner.</p> <p>The Administrator will report the results of the environmental rounds</p>	
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F 465	<p>Continued From page 22</p> <p>day ants were observed. She stated she contacted maintenance to call pest control to come and take care of the ants. The Dietary Manager stated she observed the one (1) ant on 03/26/14. According to the Dietary Manager, the area under the stove should have been swept better to ensure no food particles remained. She stated her expectation was staff would clean off the walls after food particles splattered on them during meal preparation. Continued interview revealed she had noticed the hole below the fire extinguisher before, however had not reported it to maintenance for repair. She stated she told maintenance about the wood behind the kitchen door and "believed" a work order had been placed regarding the location. The Dietary Manager stated she was not aware of the two (2) smaller holes located within the dishwasher area and reported she would contact maintenance regarding those holes. She stated it was important to keep the kitchen area clean and sanitary due to infection control concerns. She indicated it was her expectation staff would follow the cleaning schedule and ensure the documentation was present.</p> <p>Interview with the Dietician on 03/27/14 at 2:00 PM, revealed her expectation was that staff would clean up the kitchen areas if food was dropped or left on the floor. The Dietician stated it was important to make sure the kitchen observed good sanitation practices due to concerns with potential cross contamination.</p> <p>Interview with the Maintenance Director on 03/27/14 at 2:52 PM, revealed the facility was using an Electronic Logging System (TELS), which allowed staff to report items needing to be repaired via the computer. He stated he had</p>	F 465	<p>to the facility monthly QAPI meeting for further monitoring and continued compliance. After three months, the QAPI team will review the results of these audits and determine a schedule for additional monitoring.</p>	
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F 465 Continued From page 23  
 been made aware of the decaying wood behind the kitchen door and was working on it. However, he indicated he was unable to provide any documentation showing he had begun the process of working on the area. According to the Maintenance Director, he was not aware of the other areas requiring repair in the kitchen, however should have been notified.

2. Observation on 03/27/14 at 11:09 AM, of the nourishment/medication room refrigerator revealed there was a red dried substance on the bottom of the refrigerator.

Interview with the Dietary Manager on 03/27/14 at 1:42 PM, revealed the cleanliness of the nourishment/medication room was the responsibility of nursing staff and indicated this was not the responsibility of dietary aides.

Interview with the Director of Nursing (DON) on 03/27/14 at 11:21 AM, revealed her expectation was third shift nursing staff would clean the refrigerator every Sunday night and, anyone who spilled something in the refrigerator would clean it up right away.

F 465

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{K 000}

INITIAL COMMENTS  
  
Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 05/02/14 as alleged.

{K 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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 000 INITIAL COMMENTS

Building: 01

Survey under: NFPA 101 (2000 Edition)

Plan approval: 1938, 1988

Facility type: SNF/NF

Type of structure: One (1) story with basement:  
Type III (211) 1988  
Type III (200)  
1937

Smoke Compartments: four (4)

Fire Alarm: Complete fire alarm with smoke detectors in corridors and electrical room.  
Heat detector located in basement.  
New panel installed 2011.

Sprinkler System: Complete automatic sprinkler system (dry) installed 1988

Generator: Type II fuel source is propane installed 2003

A standard Life Safety Code survey was conducted on 03/26/14 and the facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was fifty-three (53). The facility is licensed for sixty (60) beds.

The following demonstrate noncompliance with Title 42 of Seq. Code of Federal Regulations, 483.70(a) (Life Safety from Fire). Deficiencies were cited with the highest deficiency of a "D".

K 000 To the best of my knowledge and belief, as an agent of South Shore Nursing and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.

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 conclusions 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.

RECEIVED  
APR 18 2014  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Margaret Brown</i>	TITLE Administrator	(X6) DATE 4/18/14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 147 SS=D NFPA 101 LIFE SAFETY CODE STANDARD  
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:  
Based on observations and interviews, it was determined the facility failed to ensure electrical wiring was according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twenty-one (21) residents, staff and visitors.

The findings include:

Observation on 03/26/2014 1:10 PM, revealed in resident room #17 the flexible power cord for the overhead bed light was attached to the wall using nail clamps. Continued observation revealed the flexible power cords for the overhead bed light were attached in the same manner resident rooms #18, #22, #16, #14, #13, #12, #11, and #9. Interview, with the Maintenance Director, during the resident room observations revealed he was responsible for attaching the overhead bed light flexible power cords to the wall with the nail clamps. He indicated the flexible power cords had been attached in that manner to prevent residents from becoming entangled in the cords of the overhead bed lights.

Continued observation on 03/26/2014 at 2:57 PM, with the Maintenance Director revealed a multi-plug adapter was attached to the wall of a beautician stand in the beauty shop. Interview

K 147 South Shore Nursing and Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standards requiring electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2.

By 5/2/14, the Maintenance Director will install "Wall Cord Cover" channels over the flexible power cords for overhead bed lights in room numbers 17, 18, 22, 16, 14, 13, 12, 11, and 9.

On 4/15/14, the Maintenance Director unfastened the multi-plug adapter from the wall in the beauty shop.

On 4/18/14, the Maintenance Director was educated by the Administrator on the importance of not securing flexible power cords or multi-plug adapters to the facility walls.

As part of the Environmental Round, the Beauty Shop and flexible power

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K 147	Continued From page 2 with the Maintenance Director, during the observation, revealed he was unaware of who attached the multi-plug adapter to the wall of the beautician stand. Further interview revealed the facility did not have a policy regarding multi-plug adapter use.  The census of seventy-seven (77) was verified by the Administrator on 03/26/2014 at 3: 18 PM.  Reference: NFPA (1999 Edition)  400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147	cords will be audited weekly for one month and monthly thereafter by Maintenance Director, Administrator, or DON.  The results of all audits will be forwarded to the monthly QAPI meeting for further monitoring and continued compliance. After three months, the QAPI team will review the results of these audits and determine a schedule for additional monitoring.	
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