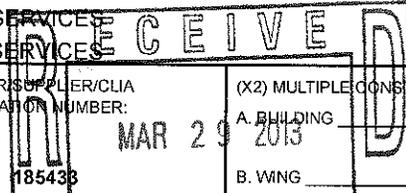


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185438	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/07/2013
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NAME OF PROVIDER OR SUPPLIER  TRI-CITIES NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1017 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A standard health survey was conducted on 03/05-07/13. Deficient practice was identified with the highest scope and severity at "E" level.  An abbreviated standard survey (KY19868) was also conducted at this time. The complaint was unsubstantiated.	F 000	Tri-Cities Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced	F 329	Tri-Cities Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tri-Cities Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3-27-13
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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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F 329	<p>Continued From page 1</p> <p>by:</p> <p>Based on record review, interview, and review of facility policy/procedure it was determined the facility failed to ensure the drug regimen for one of sixteen sampled residents was free from unnecessary drugs (Resident #9). Resident #9 had Lexapro (antidepressant) since 03/25/11 and Xanax (antianxiety) since 09/01/11 as part of the resident's routine medication regimen. However, there was no evidence the facility had attempted a gradual dose reduction or elimination of these medications for Resident #9.</p> <p>The findings include:</p> <p>Review of the facility "Antipsychotic Drug Therapy" policy (no date) revealed gradual dose reduction would be attempted with residents who received antipsychotic medication, unless clinically contraindicated. The policy noted examples that would support continued use of the antipsychotic medications included rationale provided by the physician as to why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability, or the resident's targeted symptoms returned or worsened after dosage reduction had been attempted.</p> <p>Review of the medical record revealed the facility admitted Resident #9 on 10/16/08 with diagnoses including Degenerative Intervertebral Disc Disease, Cardiomegaly, Hypertension, Depressive Disorder, and Anxiety. Review of the significant change comprehensive assessment dated 02/12/13 revealed the resident's Brief Interview for Mental Status (BIMS) assessment identified the resident to have a score of 04,</p>	F 329	<p><b><u>ID Prefix Tag F329</u></b></p> <p>The facility will continue to ensure the drug regimen for residents is free from unnecessary drugs.</p> <p>Resident #9's psychotropic medications were reviewed by the DON and the physician was informed about the need for gradual dose reduction (GDR) on 3-11-13. The physician elected not to have a GDR for Lexapro 20mg and Xanax 0.25mg BID and a denial for a Pharmacological Dose Reduction Request was signed by the physician on 3-12-13. The pharmacy consultant reviewed the resident's chart on 3-16-13 and made a recommendation for Xanax 0.25mg BID be changed to Xanax 0.25mg QHS which was approved by the physician.</p> <p>A 100% chart audit was completed by the Social Worker (also a licensed LPN) on 3-9-13 and 3-10-13 to identify residents that may need a GDR. The names of the residents identified along with the medications identified were given to the attending</p>		

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F 329	<p>Continued From page 2</p> <p>which indicated the resident was severely impaired in cognition. The assessment further revealed the resident had no indicators of psychosis and no behaviors were identified. In addition, the resident's depression score was 01, which indicated minimal depression. The assessment further revealed Resident #9 was assessed to have symptoms of "feeling down, depressed, or hopeless" 2-6 days during the assessment reference period.</p> <p>Review of the physician's orders for Resident #9 dated 03/13/13, revealed the resident received Lexapro (antidepressant) 20 mg daily and Xanax (antianxiety) 0.25 mg, twice a day. Further review of the physician's orders revealed the Lexapro was initiated on 03/05/11 and the Xanax was initiated on 09/01/11.</p> <p>Review of the drug regimen review conducted by the facility's pharmacist from January 2012 to February 2013 revealed the pharmacist had conducted the required monthly review of the resident's medication regimen. However, there was no evidence the pharmacist had reviewed/recommended a dose reduction for the Lexapro or the Xanax for Resident #9. In addition, there was no documented clinical rationale for the continued use of these medications.</p> <p>Interview with the consultant pharmacist on 03/07/13, at 4:20 PM, revealed the pharmacist reviewed each resident's drug regimen monthly. According to the pharmacist, she considered contraindications for use when reviewing the resident's psychotropic medications. The pharmacist stated recommendations were</p>	F 329	<p>physician on 3-11-13 with new orders noted. The pharmacy consultant reviewed charts on 3-16-13 with further recommendations for GDR's and the physician provided orders as recommended.</p> <p>The DON and Social Worker will do 100% audits monthly to ensure that the physician, pharmacy consultant and psychiatrist are aware of which residents are due for possible GDR's. The list will be given to each of these disciplines for possible GDR's and if a GDR is not ordered, the Psychopharmacological Medication Dose Reduction Request Form will be completed and signed by the attending physician.</p> <p>The result of the audits will be reviewed by the Administrator, DON and QI committee monthly for interventions and changes as indicated.</p>	3-29-13	

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F 329	Continued From page 3 suggested to the physician every six months for the psychotropic medications. The pharmacist further stated she was at a meeting and was unable to review the information from the drug regimen reviews for Resident #9.  Interview with the Director of Nurses (DON) on 03/07/13, at 5:25 PM, revealed the pharmacist was responsible to review the resident's psychotropic medication use during the monthly medication review. The DON further stated she relied on the pharmacist to make the recommendations for dosage reduction to the physician for psychotropic medications.	F 329	<b><u>ID Prefix Tag F332</u></b>  The facility will continue to ensure that it is free of medication error rates of five percent or greater.  Resident A's MAR had the correct time for the medication Nateglinide 60mg to be administered three times a day before meals. The resident had no signs of hypoglycemia that evening and continued to eat a good meal. The resident's accucheck for that evening was 313.  Resident D's MAR had the correct order on the MAR for Potassium to be given with food. The resident denied any nausea or stomach upset from receiving the medication without food that morning. The resident did receive her Levothyroxine 75 mcg that day.  A 100 % audit was completed by the administrative nursing team to make sure residents had the correct time for medications to be given before meals and that medications that needed to be given with food were present on the resident's MAR. The	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure that it was free of medication error rates of five percent or greater. Observations of a medication pass on 03/05/13 and 03/06/13 revealed a total of forty-two opportunities with three errors, resulting in a medication error rate of seven percent.  The findings include:  A review of the facility's Medication Administration policy (no date) revealed routine medications could be administered one hour before or after	F 332		

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F 332	<p>Continued From page 4</p> <p>the time indicated on the Medication Administration Record (MAR). The policy further noted the staff was responsible to compare the MAR with the medication package label to ensure medications were administered correctly per the MAR guidelines. In addition, the policy noted medications ordered to be administered with meals would be administered up to one hour after the meal was completed.</p> <p>1. A review of Resident A's physician's orders, dated March 2013, revealed Nateglinide 60 mg (blood glucose medication) was to be administered three times a day before meals. Review of the MAR revealed the medication was scheduled to be administered at 5:30 PM.</p> <p>Review of the Geriatric Dosage Handbook, Edition 12, by Lexi-Comp's Drug Reference Handbook revealed Nateglinide should be administered 1-30 minutes prior to a meal and the resident should be monitored for signs/symptoms of hypoglycemia.</p> <p>Observation of a medication pass on 03/05/13, at 3:55 PM, revealed Licensed Practical Nurse (LPN) #5 administered Nateglinide 60 mg to Resident A (1 hour and 35 minutes) prior to the time indicated on the MAR. Further observations revealed the evening meal was served at 5:30 PM (1 hour and 35 minutes later).</p> <p>2. Review of Resident D's physician's orders and MAR dated March 2013 revealed the resident had orders to receive Potassium Chloride Extended Release (ER) 20 meq (a potassium supplement) once a day with food. In addition, the resident also had orders to receive</p>	F 332	<p>audit included any blanks on MAR's for medications that could have been missed and none were identified. This was completed on 3-8-13.</p> <p>All medication nurses and CMT's were inserviced on guidelines for giving medications with food, timely administration of medication, and omissions of medication by the DON on 3-8-13. For all medications that are ordered to be given with food, the MAR now includes that the medication be given with four ounces of pudding/applesauce. All medication nurses and CMT's were given a performance review using the Medication Pass Audit form from the facility QI manual with the opportunity to pass or fail. The performance reviews were given by the QI nurse and completed March 8-17, 2013. All personnel given the performance reviews were able to pass. The QI nurse will do random performance reviews on at least three medication nurses and/or CMT's to assure medications are being given with food, timely administration of medication, and omissions of medication. These reviews will be weekly for one month, bi-weekly for</p>		

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F 332	Continued From page 5 Levothyroxine 75 mcg (thyroid medication) once a day at 8:00 AM.  Observation conducted of a medication pass revealed Certified Medication Technician (CMT) #1 administered the Potassium Chloride with water to Resident D on 03/06/13, at 8:30 AM. There was no evidence the Levothyroxine was administered to Resident D as ordered by the physician.  Interview conducted with CMT # 1 on 03/06/13, at 9:45 AM, revealed she had been trained to review the MAR to verify the accuracy of medications administered to the resident. CMT #1 stated she overlooked the Levothyroxine order. CMT #1 confirmed she knew the Potassium Chloride was to be administered with food, but believed it was okay to administer the medication at 8:30 AM, since the resident had breakfast approximately 1 hour and 30 minutes earlier.  Interview with the DON on 03/07/13, at 5:25 PM, revealed the staff had been trained to administer medications as directed by the resident's MAR. The DON stated medication audits were routinely conducted to review for medication errors. In addition, the DON stated daily rounds were conducted by the administrative nurses to monitor for medication administration.	F 332	one month then monthly for four months.  The medication nurses and CMT's will have the on-coming personnel to audit their MAR's before leaving the shift to make sure that all of their medications have been given and this will be logged by their initials on the provided form and the DON will check this weekly for three months.  The result of the audits will be reviewed by the Administrator, DON and QI committee monthly for interventions and changes as indicated.	3-29-13	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	<b>ID Prefix Tag F364</b>  The facility will continue to ensure that resident food is served at a palatable temperature.  The resident whose tray was found to be unacceptable temperature wise was given a new tray from the kitchen. No other complaints		

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F 364	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve resident foods at a palatable temperature at the evening meal on 03/05/13. Observation on 03/05/13 revealed dietary staff assembled fifty-one resident meal trays on four different food carts before transporting any of the meal trays to the resident units for delivery to residents which prolonged the time the meal trays sat on the food cart.  The findings include:  According to the Dietary Manager (DM), the facility did not have a policy/procedure related to food tray delivery.  On 03/05/13 at 5:50 PM, observation of the tray line for the evening meal revealed 21 resident trays had already been loaded onto a food delivery cart, and dietary staff was in the process of loading a second, smaller food delivery cart containing 8 resident trays. Both carts were pushed aside, and dietary staff proceeded to load resident food trays onto a third food delivery cart. The third food cart contained 17 resident food trays and when staff finished loading the food cart the staff pushed the cart aside. Staff continued loading food trays onto a fourth, smaller cart until the cart contained five resident food trays. At 6:00 PM on 03/05/13, dietary staff left the kitchen with all 4 food delivery carts which contained a total of 51 resident trays and delivered the carts to the resident living units. The first 2 food carts	F 364	regarding temperatures were voiced to the dietary manager on 3-5-13.  The dietary manager conducted a 100% audit with residents on 3-8-13 regarding their food temperatures. The dietary manager has since conducted random checks with residents regarding food temperatures and also conducted random temperatures on test trays.  The food cart delivery times have been revised to allow efficient delivery to the resident dining areas as soon as the cart is filled in the kitchen. Dietary and nursing staff were inserviced on 3-25, 26 and 27 <sup>th</sup> , 2013 on the new delivery times.  For staff not present, inservices will be given on their next scheduled shift or for new hires during the orientation program.  Compliance will be monitored with weekly random interviews with residents and temperatures from a test tray for one month and then monthly for two months.		

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F 364	Continued From page 7 containing 29 resident trays were delivered to the North Unit, and the other 2 food carts containing 22 residents trays were delivered to the South Unit.  Interview with the DM at 5:55 PM on 03/05/13 revealed staff on both units were waiting to serve trays, and the Kitchen attempted to deliver trays to both units at the same time.  A palatability test was conducted at 6: 20 PM on 03/05/13 with the surveyors accompanied by the Assistant Director of Nursing (ADON) and the Infection Control nurse. Staff present confirmed the hamburger and the macaroni and cheese were barely warm, and the coffee was warm but drinkable. Temperatures taken revealed the hamburger was 100.9 degrees Fahrenheit, the macaroni and cheese was 114.2 degrees Fahrenheit, and the coffee was 133.2 degrees Fahrenheit.  Review of the steam table temperatures at 6:05 PM on 03/05/13 revealed the hamburger was 177 degrees Fahrenheit, the macaroni and cheese was 172 degrees Fahrenheit, and the coffee was 184 degrees Fahrenheit prior to being placed on the resident trays.	F 364	Results will be reviewed by the Administrator and QI Committee monthly for recommendations or changes as necessary.	3-29-13	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program	F 441	<b>ID Prefix Tag F441</b>  The facility will continue to ensure that an Infection Control Program is established and maintained in order to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  Resident A, B and C have been assessed and have had no ill effects from LPN #5 not providing handwashing and handling resident's medications.  All resident's are at risk for possible spread of infections due to hand washing practices. The QI nurse did		

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F 441	<p>Continued From page 8</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was 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</p>	F 441	<p>medication audits on all medication nurses and CMT's to assure that proper handwashing techniques are used and that resident medication are not handled with bare hands when preparing and administering medications. This was conducted March 8 – 17, 2013. The DON provided inservices on 3-8-13 on proper handling of medications and proper hand washing techniques including washing hands when reporting to and from work, before and after contact with residents, after coming in contact with any body fluids, after handling contaminated items, before and after eating or drinking, after using the bathroom and whenever hads are obviously soiled.</p> <p>On 3-26, 27 and 28<sup>th</sup>, 2013, the Staff Facilitator conducted an inservice for all staff on the Infection Control Program and maintaining a safe and sanitary environment and ways to help prevent the development and transmission of disease and infection.</p> <p>For staff not present, inservices will be given on their next scheduled shift</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185433</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/07/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>TRI-CITIES NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823</b>		
(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 441	<p>Continued From page 9</p> <p>of disease and infection for three unsampled residents (Residents A, B, and C). Observation of a medication pass conducted on 03/05/13 revealed facility staff failed to administer medications in a sanitary manner. Staff was observed to touch the medications for Residents A, B, and C with bare hands and failed to appropriately clean/sanitize hands between residents.</p> <p>The findings include:</p> <p>A review of the facility's Handwashing policy (dated 12/18/12) revealed staff should perform handwashing when reporting to/from work, before and after contact with residents, after coming in contact with any body fluids, after handling contaminated items, before and after eating or drinking, after using the bathroom, and whenever hands were obviously soiled.</p> <p>Observation conducted during a medication pass on 03/05/13, at 3:55 PM, revealed LPN #5 removed Ativan 0.5 mg (antianxiety medication) from the locked narcotic medication drawer. The LPN was observed to place the medication into her bare hand and then place the tablet into a medication cup. The LPN was then observed to administer the medication to Resident A. Further observation revealed the LPN did not clean/sanitize her hands after administering medication to Resident A.</p> <p>Further observation conducted on 03/05/13, at 4:00 PM, revealed LPN #5 removed Prilosec (antacid) 20 mg from the unit dose package with her bare hands to administer to Resident B and placed the medication into a plastic cup. No</p>	F 441	<p>or for new hires during the orientation program.</p> <p>The QI nurse will do random audits on at least three medication nurses and/or CMT's to assure proper infection control procedures during medication pass. These audits will be weekly for one month, bi-weekly for one month then monthly for four months.</p> <p>The result of the audits will be reviewed by the Administrator, DON and QI committee monthly for interventions and changes as indicated.</p>	3-29-13	

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

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NAME OF PROVIDER OR SUPPLIER  <b>TRI-CITIES NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US HIGHWAY 119 NORTH</b> <b>CUMBERLAND, KY 40823</b>		
(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 441	<p>Continued From page 10</p> <p>handwashing or cleaning of the LPN's hands was observed.</p> <p>Additional observation revealed LPN #5 removed Lortab (pain medication) 5/500 mg from the locked narcotics drawer on 03/05/13, at 4:05 PM, touched the tablet with her bare hands, and administered the medication to Resident C. There was no observation of the LPN cleaning or sanitizing her hands between each resident contact.</p> <p>Interview conducted with LPN #5 on 03/06/13, at 4:40 PM, revealed she had been trained to clean/wash her hands between each resident. The LPN stated she "just didn't do it."</p> <p>Interview conducted with the Infection Control Coordinator on 03/07/13, at 5:25 PM, revealed staff was trained to perform handwashing between each resident and not to handle the resident's medications with bare hands.</p> <p>An interview with the DON on 03/07/13, at 6:00 PM, revealed the DON confirmed staff should not touch the resident's medications with their bare hands. The DON stated daily room rounds were conducted by administrative staff to monitor for appropriate handwashing procedures and no problems had been identified.</p>	F 441			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185433</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/05/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>TRI-CITIES NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1995</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (111)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II propane generator</p> <p>A life safety code survey was initiated and concluded on 03/05/13, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	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.