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

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FORM APPROVED
OMB NO. 0938-0391

RECEIVED APR - 6 2012 Division of Health Care Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185282		02/23/2012
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 000	INITIAL COMMENTS A standard health survey was conducted on 02/21-23/12. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	To the best of my knowledge and belief, as an agent of South Shore Nursing & Rehab 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 and 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 provision of Federal and State law.	
F 174 SS=B	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policies, the facility failed to ensure residents had reasonable access to the use of a telephone to make private telephone calls. Residents were given access to use of the telephone located at the nurses' station and the hallway and could not place or receive telephone calls without being overheard by staff and other residents. The findings include: The facility Telephone Policy (dated 04/02/06) revealed that each resident had access to use of the telephone. A group interview conducted with four alert and oriented residents on 02/22/12, at 4:45 PM, revealed the only telephones for resident use were located at the nurses' station and in the hallway. Residents attending the meeting further stated the telephone calls were not private if residents and staff members were at the nurses' station or in the hallways. The residents further	F 174	South Shore Nursing and Rehabilitation Center strives to ensure that resident's rights are respected and that residents have reasonable access to the use of a telephone where calls can be made without being overheard. A telephone was installed, by the Maintenance Director, in a private area for resident use on 3/14/2012. All residents will be notified of the location of the new phone via verbal communication by the Activity Director	4/7/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sarah Willis — TITLE: Administrator — (X6) DATE: 4-6-12

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 174	Continued From page 1 stated the noise level made it difficult for them to hear the conversation. An observation on 02/22/12, at 6:30 PM, revealed one phone at the nurses' station and one phone in each hallway. On 02/22/12, at 4:15 PM, Resident #11 was observed to use the telephone at the nurses' station with staff and other residents present. An interview with Resident #11 on 02/23/12, at 10:30 AM, confirmed he/she received a telephone call from his/her family member on 02/22/12, at 4:15 PM, and an employee informed the resident that the call could be taken at the nurses' station. The resident further stated the employee did not offer a private office for the telephone conversation and it was difficult to hear because of the noise level. The resident stated there was never a private place offered for a telephone conversation. An interview was conducted with the facility Social Services Director (SSD) on 02/23/12, at 5:00 PM. The SSD stated the telephones provided for resident use were the telephones at the nurses' station, in private offices, and hallways. The SSD also stated some residents have cell phones and their own phones in their rooms provided by themselves and/or their families. An interview was conducted with the facility Administrator on 02/23/12, at 10:45 AM. The Administrator stated if a resident requested to use a telephone for privacy, staff would take them to an office and leave the office to give the resident privacy. According to the Administrator,	F 174	or Social Services Director by 3/19/2012. Residents will also be notified of the location of the new telephone at the regularly scheduled residents' council meeting set for 3/19/2012. All staff will be re-educated by the Director of Nursing, on resident rights and resident telephone use. The level of satisfaction will be monitored monthly by the Activity Director during the monthly resident council meetings for three months. The results will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.	

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F 174	Continued From page 2 most of the time the residents came to the nurses' station to make or receive telephone calls.	F 174		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services were provided as ordered by the physician for one of fifteen sampled residents. Resident #11 had a physician's order dated 12/31/11, for 7.5/500 Lortab to be administered every six hours as needed for pain. Interview conducted on 02/22/12, at 4:15 PM, revealed Resident #11 had requested pain medication at approximately 12:30 PM, upon returning from a procedure that had been performed in the physician's office, however, interview and documentation revealed Resident #11 did not receive the medication until over two and one-half hours after the resident's request. The findings include: An interview with the Director of Nursing (DON) on 02/23/12, at 10:20 AM, revealed the facility did not have a medication administration policy	F 246	South Shore Nursing and Rehabilitation Center strives to ensure that all residents receive services in the facility with reasonable accommodations of individual needs and preferences, expect when the health or safety of the individual or other residents would be endangered. The pain medication was effective per nursing documentation at 4:13 p.m. on 2/22/12. CMT #1 received disciplinary action and individual education by the Director of Nursing on 2/23/12, on residents' rights and on providing services in the facility with reasonable accommodations of individual needs and preferences. All residents were assessed for pain on 2/23/12 by a licensed nurse, which identified no other resident with complaints of pain or problems receiving PRN medications. All licensed nurses and certified medication technicians will be re-educated on medication	4/7/2012

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F 246	Continued From page 3 regarding PRN medication. A review of the medical record for Resident #11 revealed the facility admitted the resident on 12/30/11, with diagnoses that included Cerebral Embolism with Infarction, Diabetes, Spinal Stenosis, Muscle Weakness, Peripheral Vascular Disease with Claudication, Bilateral Lower Extremity Ulcerations, and Hypertension. A comprehensive Minimum Data Set (MDS) assessment dated 01/06/12, revealed Resident #11's cognition was intact with no impairment. Documentation in Resident #11's medical record revealed the resident was assessed to have received regularly scheduled medication for pain as well as additional pain medication as needed and requested by the resident. According to the MDS assessment, the resident reported he/she had experienced frequent pain within five days prior to the assessment. A review of physician's orders for Resident #11 revealed the resident was to receive Skelaxin (muscle relaxant) three times daily, Neurontin (anti-convulsant) three times daily, Percocet (narcotic analgesic) once daily, and Celebrex (anti-inflammatory) twice daily on a routine schedule, and Lortab every six hours on an as-needed basis when requested. Skelaxin is a muscle relaxant used to reduce pain. Neurontin is sometimes used to treat diabetic neuropathy. Percocet is a medication used to treat moderate to severe pain. Celebrex is used to relieve pain due to arthritis and Lortab is used to treat moderate to severe pain. An interview with Resident #11 on 02/22/12, at 4:15 PM, revealed the resident had returned from	F 246	administration, residents' rights on receiving services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. All licensed nurses and certified medication technicians will also receive education on the importance of administering PRN medications as quickly as possible in order to provide reasonable accommodation of needs and preferences and the Electronic Medical Records downtime policies by April 7, 2012. The Social Services Director will conduct five resident interviews per week for one month and monthly thereafter, regarding facility practices on providing services in the facility with reasonable accommodations of individual needs and preferences. The results will be forwarded to the monthly CQI Committee meeting for further monitoring and continued compliance.	

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F 246	Continued From page 4 a physician's visit "sometime around 12:30 PM" on 02/22/12, and had requested pain medication. According to the resident, staff told him/her the computer was down and he/she would have to wait. Resident #11 stated he did not receive pain medication until much later. A review of the Medication Administration Record (MAR) for 02/22/12, revealed Resident #11 had received Lortab at 9:11 PM on 02/21/12, 15 hours prior to the resident's request for the medication at approximately 12:30 PM. An interview with Certified Medication Technician (CMT) #1 on 02/23/12, at 9:15 AM, revealed Resident #11 requested pain medication at approximately 12:30 PM on 02/22/12. CMT #1 stated that the computer that contained each resident's medication records "went down" and she went to ask at the nurses' station to obtain another computer to use for the administration of medications to residents. CMT #1 stated when she went to the desk, she was told the nurse or medical records staff would use the backup computer to print paper copies of the MARs, but was told the computers throughout the facility were down. According to CMT #1, she informed Resident #11 that he/she would have to wait for the pain medication because the computer was down and she did not have his/her MAR. CMT #1 stated she was administering medications on the opposite hall from Resident #11 and she was "in a mess" trying to get medications administered on time and failed to administer Resident #11's pain medication. CMT #1 further stated she did not notify the Charge Nurse (CN) that she was having difficulty administering medications within timeframes.	F 246		

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F 246	Continued From page 5 An interview with CMT #2 on 02/22/12, at 5:45 PM, revealed CMT #1 had told CMT #2 that Resident #11 had requested pain medication but CMT #2 thought CMT #1 had administered the resident's pain medication. According to CMT #2, a nurse aide informed CMT #2 at approximately 2:15 PM on 02/22/12, that Resident #11 requested pain medication. CMT #2 stated she administered the resident's pain medication "right away" but did not document the administration of the medication until 3:15 PM. An interview with the Charge Nurse (CN) on 02/23/12, at 9:45 AM, revealed the facility had been utilizing "eMARs" (electronic medication administration records) since "June or July 2011." The CN stated after the facility transitioned to the "eMARs" the facility had initially kept a paper copy of each resident's medications to use if/when the computer was "down" but the policy changed and staff currently was to request either the nurse or the medical records staff to print copies of current MARs from the "backup" computer. The CN stated when the computer "went down" at around 12:00 PM on 02/22/12, she called the IT service and was told they were unsure how long the computers would be unavailable to the staff and she had requested Medical Records to print the MARs. According to the CN, CMT #1 requested MARs for the location where she was passing medications, but had not requested the MAR for Resident #11. The CN further stated when the "eMARs" were unavailable she did not ask CMT #1 if she was behind or if the CMT needed assistance. An interview with the Director of Nursing (DON) on 02/23/12, at 10:20 AM, revealed the facility did	F 246		

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F 246	Continued From page 6 not have a medication administration policy regarding medication to be administered on an "as needed" basis. According to the DON, she did not think there were any concerns related to the lack of access to the computer to administer medications on 02/22/12, and did not investigate to see if there had been any problems related to the administration of resident medications.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. On 02/23/12, a heavy buildup of dirt and wax was observed on facility baseboards and on the floor near corners of hallways and doorframes. Observations also revealed torn wallpaper, nonworking lights, and an emergency power outlet that was loose from the wall. The findings include: 1. A review of the facility policy/procedure titled "Stripping Floors of Old Wax" (dated 06/22/99) revealed housekeeping personnel were to spread wax stripper on the floor to remove a buildup of	F 253	South Shore Nursing and Rehabilitation Center strives to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Facility staff will clean the buildup of dirt/wax from the floor, baseboards, and in the corners of hallways and doorframes by April 7, 2012. The new baseboard and floor tile is scheduled to be installed by the Maintenance Director to replace any disheveled/wore baseboard and chipped floor tile. The wall paper was repaired on 3/14/12 by the Maintenance Director. The non-working lights and emergency power outlet were also replaced on 2/23/2012 by the Maintenance Director. An environmental tour was conducted by the Administrator and Maintenance Director on 3/14/2012 to identify	4/7/2012

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F 253	Continued From page 7 wax. A review of the Housekeeping Cleaning Schedule revealed the facility floors were stripped/waxed bi-annually. Observations conducted during an environmental tour of the facility on 02/23/12, at 1:40 PM, revealed a buildup of old wax and dirt in corners of the front hall near the nurses' station and on the floor near doorframes of resident rooms on both the long and short hallways. In addition, baseboards were observed with a buildup of dirt and wax on the long, short, and front hallways. An interview conducted with the Housekeeping Supervisor on 02/23/12, at 1:50 PM, revealed the facility floors were stripped two times a year and were due to be stripped in June. The Housekeeping Supervisor also stated some tiles and baseboards were to be replaced by Maintenance. Additional interview revealed the Housekeeping Supervisor was not aware of the heavy buildup of old wax and dirt in the corners of the hallways and near the edges of the door frames. 2. A review of the facility policy titled "Repair Requisitions" (dated 01/01/95) revealed residents, visitors, and employees were to report all maintenance needs to the Charge Nurse or other supervisory personnel and a repair requisition was to be filled out and sent to the Maintenance Department. Further review of the policy revealed the Maintenance Supervisor was required to review the request and prioritize a schedule for the repair request to be completed. Observations during an environmental tour conducted with the Maintenance Director on	F 253	environmental areas for improvement. A repair requisition was completed for each area and given to the Maintenance Director on 3/14/2012. The Housekeeping Supervisor and Maintenance Director will receive education by the Administrator by April 7, 2011 regarding daily compliance rounds. All facility staff will be re-educated on the process for completing Repair Requisitions by April 7, 2012. The facility will monitor housekeeping and maintenance services via daily compliance rounds (Monday-Friday) by the Administrator. Additional audits of housekeeping/maintenance services will be conducted monthly and results will be forwarded to the CQI Committee for monitoring and continued compliance.	

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F 253	Continued From page 8 02/23/12, at 2:15 PM, revealed chipped floor tiles near the nurses' station on the front hallway, a loose emergency power outlet box on the front hallway near the entrance foyer, torn wallpaper on the long hallway across from the nurses' station, and nonworking lights in resident rooms 4 and 18. An interview conducted with the Maintenance Director on 02/23/12, at 2:15 PM, revealed the Maintenance Director was made aware of items in need of repair by maintenance requisitions completed by the staff and no requisitions had been completed for the chipped tiles, torn wallpaper, nonworking lights, or the loose electrical outlet. Further interview revealed the Maintenance Director made rounds daily to identify items in need of repair but was not aware of items in need of repair identified during the tour. The Director stated new baseboards were available to replace the present baseboards but no specific timeframe was given.	F 253		
F 256 SS=E	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide adequate and comfortable lighting levels in all areas. Interviews and observations revealed resident rooms did not have adequate lighting for residents to read and for staff to provide care for residents. A light meter was used to obtain foot-candle levels (a foot-candle is a measure of	F 256	South Shore Nursing and Rehabilitation Center strives to ensure adequate and comfortable lighting levels in all areas. The facility replaced the light bulbs in Residents' # 4 and 7's rooms on 2/27/2012. Additional lighting was installed in resident rooms' #4, #7, and #17. The Administrator spoke with the RN Supervisor/Treatment Nurse on 4/2/2012 regarding lighting in resident #4's room, who stated that the addition of lighting in room #4 was adequate to perform personal care. The RN	4/7/2012

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F 256	Continued From page 9 visible light or lumen per one square foot of area) in resident rooms and also revealed the lighting was inadequate. The findings include: An interview conducted with the Maintenance Director on 02/23/12, at 2:15 PM, revealed the facility did not have a policy regarding facility lighting. Facility staff conducted a skin assessment for Resident #4 on 02/22/12, at 2:10 PM. Observation of the skin assessment revealed there was not a light available over and/or above the resident's bed and as a result Licensed Practical Nurse (LPN #2) was observed to use a flashlight to conduct the skin assessment and observe the resident's skin. An interview conducted with LPN #2 on 02/22/12, at 2:10 PM, revealed a flashlight was utilized because there was not enough light in the resident's room to adequately visualize the resident's skin. Observations of Resident #7's room on 02/22/12, at 11:30 PM, revealed the room accommodated four residents and there were no overbed lights observed above the residents' beds. An interview conducted with Resident #7 on 02/22/12, at 11:30 PM, revealed the resident enjoyed reading but did not have an overbed light to read by when he/she was in bed. Resident #7 stated if he/she was awake at night and turned on the overhead lights in the room to see, all lights in the room would come on and disturb the other residents who share the resident's room. Resident #7 stated he/she utilized a flashlight to	F 256	Supervisor/Treatment Nurse observed personal care and was able to successfully complete a complete body assessment on Resident #4 on 4/2/2012 with the increased lighting. The Administrator spoke with Resident #7 (room 17) on 4/2/2012 regarding lighting levels and ability to read, Resident #7 stated she was able to read with the increased lighting. The facility purchased a light meter on 2/27/12. The Maintenance Director audited all resident rooms, common areas, nurses' stations, and hallways on 2/28/2012 to identify areas in need of additional lighting or that did not meet the minimum foot-candle requirements. The Social Service Director will interview all alert and oriented residents and a sample of staff by April 7, 2012, to determine if lighting is satisfactory to perform work duties and if lighting is satisfactory for reading or personal preferences. All areas in need of increased lighting per the audit and foot candle requirements will be replaced by April 7, 2012. Any resident or staff expressing concerns will be provided additional lighting (e.g. lamps, reading lights, etc.) Nursing staff will provide	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185282		02/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE NURSING & REHABILITATION CENTER	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 256	Continued From page 10 read at night. A light meter was used to obtain foot-candle light levels in numerous resident rooms. An acceptable range for foot-candle light levels in resident rooms is noted to be at least 30 for reading. On 02/23/12, at 2:15 PM, a foot-candle light level was obtained in Resident #7's room and revealed a foot-candle light level of 12 foot-candles over Resident #7's bed with all available lights turned on and window curtains open. Observation of foot-candle levels in Resident #4's room revealed a measurement of 3 foot-candles. Resident room 17 was observed to have a foot-candle level of 12. A resident in room 17 stated the light was not adequate for reading and the resident had a personal reading lamp clamped to the headboard of the bed. An interview conducted on 02/23/12, at 2:15 PM, with the Maintenance Director revealed that some resident rooms did not have lights over the resident's bed. Further interview revealed the Maintenance Director was not aware of the lighting requirements for the facility or that residents and staff had concerns with lighting in resident rooms.	F 256	portable lighting (e.g. portable lightweight floor lamp, etc.) if concerns are noted. The Maintenance Director received education by the Administrator on 3/9/2012 regarding the minimum lighting requirements as in 902 KAR 20:310-18 Section 18. The Maintenance Director will replace, add, or modify lighting in all resident rooms, common areas, nurses' stations, and hallways to meet the required foot candle requirements by April 7, 2012. The Maintenance Director will use the light meter to ensure compliance with the lighting and foot candle requirements daily for four weeks via daily compliance rounds (Monday-Friday).	
F 281 SS=D	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 observation, interview, record review, and a review of facility policies/procedures, the	F 281	**F256 continued on next page.**	

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

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F 256	Continued From page 10 read at night A light meter was used to obtain foot-candle light levels in numerous resident rooms. An acceptable range for foot-candle light levels in resident rooms is noted to be at least 30 for reading. On 02/23/12, at 2:15 PM, a foot-candle light level was obtained in Resident #7's room and revealed a foot-candle light level of 12 foot-candles over Resident #7's bed with all available lights turned on and window curtains open. Observation of foot-candle levels in Resident #4's room revealed a measurement of 3 foot-candles. Resident room 17 was observed to have a foot-candle level of 12. A resident in room 17 stated the light was not adequate for reading and the resident had a personal reading lamp clamped to the headboard of the bed. An interview conducted on 02/23/12, at 2:15 PM, with the Maintenance Director revealed that some resident rooms did not have lights over the resident's bed. Further interview revealed the Maintenance Director was not aware of the lighting requirements for the facility or that residents and staff had concerns with lighting in resident rooms.	F 256	**F256 continued.** The Activity Director will discuss lighting in the regularly scheduled Resident's Council Meeting for the next 3 months to determine the residents' satisfaction with lighting. The Director of Nursing will interview 5 facility staff members per month for three months to ensure that staff has adequate lighting to perform personal care. The results will be forwarded to the CQI Committee for monitoring and continued compliance for three months	
F 281 SS=D	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 observation, interview, record review, and a review of facility policies/procedures, the	F 281	South Shore Nursing and Rehabilitation Center strives to ensure that services are provided to meet professional standards of quality. The Director of Nursing verified placement on Resident #10 on 2/21/2012.	4/7/2012

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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 281	Continued From page 11 facility failed to provide services to meet professional standards of quality for one of fifteen sampled residents. On 02/21/12, staff was observed to administer Resident #10 medications through a feeding tube but staff failed to check placement of the tube and failed to flush the tube with water after administering medications. The findings include: A review of the Policy/Procedure (no date given) revealed staff was to check placement of the feeding tube prior to medication administration by attaching a syringe and pulling back on the plunger until stomach contents were visualized. According to policy, staff was to return the contents to the stomach, flush the feeding tube with at least 30 milliliters (ml) of warm water, and administer the medication. Following medication administration, the policy/procedure directed staff to flush the tubing with at least 30 ml of warm water to clear the tube. Observation on 02/21/12, at 5:45 PM, revealed Licensed Practical Nurse (LPN) #1 administered medications to Resident #10. LPN #1 was observed to turn off the resident's tube feeding pump and administer Resident #10's medications without checking placement of the tube. Following medication administration, the LPN reconnected/restarted the tube feeding without flushing the tube with 30 ml of warm water as directed. An interview with the LPN at 5:51 PM on 02/21/12, revealed the LPN was aware he should have checked placement but was "just nervous."	F 281	The Director of Nursing observed LPN #1 verifying placement on another g-tube resident on 2/21/2012 to ensure correct technique was used. All residents with g-tubes were monitored for adverse effects such as signs and symptoms of aspiration including shortness of breath, gurgling, and coughing for 24 hours on 2/21/2012, none were documented in the medical record. Additional monitoring included abdominal distention, nausea, and vomiting. All residents with G-tubes were checked by the Director of Nursing on 2/21/12 to ensure that each g-tube was intact and properly placed. LPN #1 received individual education by the Director of Nursing on g-tube administration on 2/21/2012 regarding appropriate methods for flushing /administering g-tubes. All licensed nurses will be educated by the Director or Nursing by April 7, 2012 on the facilities g-tube medication administration policy. The Director of Nursing will conduct staff assessments on each licensed nurse on g-tube medication administration and oral medications administration, and each **F281 continued on next page.**	

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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 281	Continued From page 11 facility failed to provide services to meet professional standards of quality for one of fifteen sampled residents. On 02/21/12, staff was observed to administer Resident #10 medications through a feeding tube but staff failed to check placement of the tube and failed to flush the tube with water after administering medications. The findings include: A review of the Policy/Procedure (no date given) revealed staff was to check placement of the feeding tube prior to medication administration by attaching a syringe and pulling back on the plunger until stomach contents were visualized. According to policy, staff was to return the contents to the stomach, flush the feeding tube with at least 30 milliliters (ml) of warm water, and administer the medication. Following medication administration, the policy/procedure directed staff to flush the tubing with at least 30 ml of warm water to clear the tube. Observation on 02/21/12, at 5:45 PM, revealed Licensed Practical Nurse (LPN) #1 administered medications to Resident #10. LPN #1 was observed to turn off the resident's tube feeding pump and administer Resident #10's medications without checking placement of the tube. Following medication administration, the LPN reconnected/restarted the tube feeding without flushing the tube with 30 ml of warm water as directed. An interview with the LPN at 5:51 PM on 02/21/12, revealed the LPN was aware he should have checked placement but was "just nervous."	F 281	**F281 continued.** CMT on oral medication administration by April 7, 2012. The Director of Nursing will audit/observe select nursing staff during daily compliance rounds (Monday-Friday) weekly for four weeks and then monthly for three months. During these rounds the Director of Nursing will monitor g-tube medication administration, g-tube feeding administration, and personal care of residents with g-tubes to ensure that care is being delivered to residents in a manner that meets Professional Standards of Quality. The Director of Nursing will also audit an additional two g-tube medication administrations per month to ensure that staff is administering g-tube medications according to facility policy and professional standards of quality. Results will be forwarded to the CQI Committee for four months for monitoring and continued compliance.	

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F 281	Continued From page 12 An interview with the Director of Nursing (DON) on 02/23/12, at 6:25 PM, revealed the LPN had been educated regarding care.	F 281		
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, interview, record review, and a review of facility policy/procedure, the facility failed to ensure it was free of medication error rates of five percent or greater. Observation of a medication pass on 02/21/12 and 02/22/12, revealed facility staff administered a total of forty-two medications and three medication errors were identified. The facility's medication error rate was seven percent. The medication errors affected two of fifteen sampled residents and one unsampled resident (Residents #1 and #10 and unsampled Resident B). The findings include: A review of the facility policy/procedure, Preparation and General Guidelines, Medication Administration (no date given) revealed medications were to be administered within 60 minutes of the scheduled time, except for before/after meal orders which were to be administered based on mealtimes. A review of the policy revealed staff was to administer enteral nutrition and Dilantin suspension separately to minimize interaction. According to the facility's	F 332	South Shore Nursing and Rehabilitation Center strives to ensure that it is free of medication error rates of five percent or greater. All residents receiving Dilantin with supplement are monitored by a licensed nurse each shift beginning 2/23/2012 for adverse effects such as headache, nausea, vomiting, constipation, dizziness, drowsiness, trouble sleeping, nervousness interactions, and seizure activity; none were noted in the residents' medical records. Resident #1 was monitored by licensed nursing staff for adverse effects such as an upset stomach for 24 hours after medication administration on 2/22/12 related to Phoslo not being administered with meals and no adverse effects were noted. Resident B was monitored by licensed nursing staff on 2/22/2012 for adverse effects such as headache and abdominal pain for 24 hours none were noted in the residents' medical record. Additional documentation is required each shift for all residents receiving	4/7/2012

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F 332	Continued From page 13 procedure guidelines, if enteral nutrition and Dilantin suspension were administered simultaneously, there should be appropriate monitoring and documentation. In addition, based on the policy long-acting or enteric-coated medications should not be crushed and an alternative should be sought. 1. A review of the medical record for Resident #10 revealed the facility admitted the resident on 08/30/2000, with diagnoses that included Seizure Disorder, Dementia, Dysphagia, and Benign Neoplasm of the Brain. According to the comprehensive Minimum Data Set (MDS) assessment, dated 08/18/11, Resident #10 was assessed to be in a "persistent vegetative state" and required tube feedings due to Dysphagia. A review of the physician's orders revealed Resident #10 was to receive an enteral feeding of Jevity 1.2 at 60 cubic centimeters (cc) per hour for 16 hours per day. According to the physician's orders, staff was to turn the enteral feeding off at 1:00 AM and back on at 5:00 AM. Further review of the physician's orders revealed Resident #10 was to receive 125 milligrams (mg) of Dilantin (anti-convulsant) at 5:00 AM and 5:00 PM. In addition, the physician ordered Dilantin levels to be obtained every three months. A review of the manufacturer's guidelines dated October 2011 revealed patients who have received enteral feeding preparations and/or related nutritional supplements have lower than expected phenytoin (Dilantin) plasma levels and therefore suggests that phenytoin not be administered concomitantly with an enteral feeding preparation. More frequent serum	F 332	Dilantin with enteral nutrition beginning 2/23/12 to include the monitoring of side effects such as headache, nausea, vomiting, constipation, dizziness, drowsiness, trouble sleeping, nervousness interactions, and seizure activity of Dilantin each shift. This documentation will be required for the duration that each resident receives Dilantin with supplement. An audit was conducted on 3/8/2012 by the consultant pharmacist which consisted of review of each resident's medication regime and medication observation to determine that all residents were receiving medications according to manufactures guidelines. LPN #1 and the CMT received one on one education regarding medication administration on 2/21/2012 (LPN #1) and 2/22/2012 for the CMT. All licensed nurses will receive education by the Director of Nursing by April 7, 2012 regarding g-tube administration, medication administration, and documentation which will include the specific medication administration procedure, required equipment,	

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F 332	Continued From page 14 phenytoin level monitoring may be necessary in these patients. Observation of a medication pass on 02/21/12, at 5:45 PM, revealed Licensed Practical Nurse (LPN) #1 disconnected Resident #10's enteral feeding, administered 125 milligrams/5 milliliters of Dilantin suspension, and reconnected the feeding. An interview with LPN #1 on 02/21/12, at 6:00 PM, revealed LPN #1 was unaware of the facility's policy and the manufacturer's guidelines to separate the administration of Dilantin and the enteral feeding to prevent interaction. In addition, LPN #1 stated he was "on leave" when the Medication Pass in-service was held. An interview with the Director of Nursing (DON) on 02/22/12, at 11:00 AM, revealed the DON was unaware of the manufacturer's recommendations and the facility's policy regarding Dilantin administration with tube feedings. 2. A review of the medical record for Resident #1 revealed the facility readmitted the resident on 06/01/10, with diagnoses that included Multiple Sclerosis, Diabetes, and Chronic Kidney Disease. A review of the physician's orders for Resident #1 revealed an order for PhosLo (electrolyte replacement) three times daily with meals. PhosLo is indicated in patients with end-stage renal failure to lower phosphate concentrations. It does not promote aluminum absorption. When taken with meals it combines with dietary phosphate to form insoluble calcium phosphate which is excreted in the feces per manufacturing	F 332	procedures of preparing and administering enteral tube medications. Additional education will be provided by the Director of Nursing by April 7, 2012 for all CMT's regarding medication administration policies and procedures, which will include oral medication administration, the required equipment, special considerations, and procedures. The Director of Nursing will conduct staff assessments on each licensed nurse and CMT on g-tube medication administration and oral medications administration by April 7, 2012. The Director of Nursing will audit medication administration of select staff via observation, both oral and g-tube, three times per week for four weeks. All licensed nurses and CMT's will be observed annually by the Director of Nursing on g-tube administration (licensed nurses) and medication administration (CMT's). The consultant pharmacist will also conduct a monthly audit consisting of a review of drug regimen, medication pass observation report, and a consultant pharmacist communication to the physician. The results will be forwarded to the CQI	

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F 332	Continued From page 15 guidelines. An observation during a medication pass on 02/22/12, at 10:25 AM, revealed the Certified Medication Technician (CMT) administered PhosLo 667 mg, one tablet by mouth with no meal. Observation revealed Resident #1 received a meal tray for lunch at 12:00 PM on 02/22/12. The CMT revealed in an interview following the medication pass that the time was highlighted at 10:00 AM for the medication to be given therefore the medication could be given an hour before or an hour after. The CMT stated the order did read the medication should be given with a meal and trays would be served at 11:00 AM. The interview with the CMT further concluded she did not know when the resident would receive a meal tray and the medication should not have been given without food. An interview with the DON on 02/22/12, revealed if the medication order stated to give with meals then it should be given with meals. 3. A review of the facility's approved "list" of medications that were not to be crushed entitled "Do Not Crush" revealed Prilosec (anti-ulcer) was included on the list. A medication pass was observed on 02/22/12, at 9:40 AM, and revealed the Certified Medication Technician (CMT) crushed and administered medications for unsampled Resident B. Observation revealed the medications administered included Prilosec OTC.	F 332	Committee for further recommendations and monitoring for continued compliance for four months.	

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F 332	Continued From page 16 An interview with the CMT on 02/22/12, at 1:45 PM, revealed the CMT "thought" Prilosec was not supposed to be crushed but since the resident required a pureed diet, the CMT stated she was afraid the resident would choke on the pill so she crushed it. An interview with the facility's Consultant Pharmacist on 02/23/12, at 10:40 AM, revealed the Pharmacist had not identified any concerns with medication administration. The Pharmacist acknowledged Prilosec should not be crushed. The Pharmacist further stated she had not considered residents who required crushed medications and who were receiving medications that were not crushable.	F 332		

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1938, 1988 Facility type: SNF/NF Type of structure: Type III Protected (1988) Type III Unprotected (1938) Smoke Compartments: 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 sprinkler system (dry) installed 1988 Generator: Type II powered via propane installed 2003 A standard Life Safety Code survey was conducted on 02/22/12. South Shore Nursing and Rehabilitation Center 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 57. The facility is licensed for 60 beds. The highest scope and severity was at "F" level. The following demonstrate noncompliance:	K 000	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 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.	
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018	South Shore Nursing & Rehabilitation	4/7/2012

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

Sarah Willis — Administrator — 3/15/12

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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SOUTH SHORE NURSING & REHABILITATION CENTER	JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41175

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K 018 SS=D	Continued From page 1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would latch according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of four smoke compartments, six residents, staff, and visitors. The findings include: Observation on 02/22/12, at 11:56 AM, revealed resident room doors 5, 13, and 19 would not latch	K 018	Center strives to ensure compliance with NFPA 101 Life Safety Code Standards requiring that there is no impediment to the closing of the doors and that doors are provided with a means suitable for keeping the door closed. The Maintenance Director will repair resident room doors 5, 13, and 19 to ensure proper latching by April 7, 2012, according to National Fire Protection Association standards. All doors were audited by the Maintenance Director on 3/14/2012 to ensure proper latching according to National Fire Protection Association Standards. The Maintenance Director was educated on 3/14/2012 on the requirements for doors in the National Fire Protection Association Standards as in the National Fire Protection Association 101 19.3.6.3.2. The Maintenance Director or designee will audit all doors monthly to ensure proper latching according to the National Fire Protection Association	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185282	A. BUILDING 02 - MAIN BUILDING B. WING	02/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE NURSING & REHABILITATION CENTER	JAMES E. HANNAH DRIVE SOUTH SHORE, KY 41175

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K 018	Continued From page 2 when shut. Corridor doors must latch to prevent smoke from entering the room in the event of a fire. The observation was confirmed by the Maintenance Director and Regional Maintenance Director. Interview on 02/22/12, at 11:56 AM, with the Maintenance Director, revealed he had performed an audit of the doors approximately one month ago and was aware of the doors not latching. He further indicated the facility had ordered new doors to replace the doors not latching. Reference: NFPA 101 (2000 Edition). 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018	Standards. Results will be forwarded to the CQI Committee for further recommendations and continued monitoring for compliance.	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or	K 051	South Shore Nursing and Rehabilitation Center strives to comply with NFPA 101 Life Safety Code Standard that ensures that fire alarms systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available.	4/7/2012

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	185282	A. BUILDING 02 - MAIN BUILDING B. WING	02/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 051	Continued From page 3 extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure the fire alarm system was inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of four smoke compartments and staff working in the basement. The findings include: Observation on 02/22/12, at 12:53 PM, with the Maintenance Director and Regional Maintenance Director, revealed a heat detector located in the basement area. Record review of the quarterly	K 051	The heat detector located in the basement area was inspected on 2/29/12 by Sentry Fire, the facilities contractor for fire safety. The Maintenance Director was educated by the Administrator on 2/22/12 regarding maintaining fire alarm systems and record maintenance. The Maintenance Director or designee will audit fire alarm inspection records quarterly to ensure that fire alarm systems are maintained and maintenance is recorded as indicated in NFPA 72 7-2.2. Results will be forwarded to the CQI Committee for further recommendations and continued monitoring for compliance	

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	185282		02/22/2012

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K 051	Continued From page 4 fire alarm inspection records for a complete year revealed the heat detector had not been inspected. Heat detectors must be inspected semi-annually. Interview on 02/22/12, at 12:54 PM, with the Maintenance Director, revealed he was not aware the heat detector had not been inspected as required. Reference: NFPA 72 (1999 Edition). 7-2.2* Fire alarm systems and other systems and equipment that are associated with fire alarm systems and accessory equipment shall be tested according to Table 7-2.2.	K 051		
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 observation and interview, it was determined the facility failed to ensure proper documentation of the monthly inspection for the main sprinkler control valve according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four of four smoke compartments, sixty residents, staff, and visitors. The findings include:	K 062	South Shore Nursing & Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standards requiring that automatic sprinkler systems are continuously maintained and in reliable operating condition and are inspected and tested. The sprinkler systems main control valve was inspected on 2/22/12and was documented according to NFPA 25 9-3.3.2 by the Maintenance Director. The Maintenance Director was educated on 2/22/12 by the Administrator on NFPA 25 regarding the requirements for records of inspections, tests, and maintenance of	4/7/2012

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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	Continued From page 5 Observation on 02/22/12, at 1:23 PM, with the Maintenance Director, revealed the facility's sprinkler system had one main control valve. Interview on 02/22/12, at 1:23 PM, with the Maintenance Director, revealed he inspected the sprinkler system's main control valve monthly but does not document the monthly inspection. Documentation must be maintained by the facility to prove the required inspection was conducted according to NFPA standards. Reference: NFPA 25 (1998 Edition). 1-8* Records. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 9-3.3.2* The valve inspection shall verify that the valves are in the following condition: (a) In the normal open or closed position	K 062	the sprinkler system and its components. A monthly audit was added on 3/13/2012 by the Administrator, adding the monthly valve inspection to TELS, an electronic system used to track and record maintenance related tasks. Effective 3/13/2012, this will require the Maintenance Director to document specific information required in NFPA 25 which includes the following: if the valve is in the normal open or closed position, if the valve is properly sealed, locked, or supervised, if the valve is accessible, if the valve is provided with appropriate wrenches, and if the valve is free from external leaks. This monthly audit will be audited by the Administrator monthly for two months. Results will be forwarded to the CQI Committee for further recommendations and continued monitoring.	

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NAME OF PROVIDER OR SUPPLIER: SOUTH SHORE NURSING & REHABILITATION CENTER

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K 062	Continued From page 6 (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification	K 062		
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 observation and interview, it was determined the facility failed to ensure the facility had an adequate number of electrical receptacles to meet the needs of residents without the use of extension cords or multiple outlet adapters according to National Fire Protection association (NFPA). The deficiency had the potential to affect one of four smoke compartments, two residents, staff, and visitors. The findings include: Observation on 02/22/12, at 11:54 AM, with the Maintenance Director and Regional Maintenance Director, revealed an oxygen concentrator was plugged into a multiple-outlet adapter located in resident room 22. A facility must provide an adequate number of electrical receptacles to meet the needs of residents.	K 147	South Shore Nursing and Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standard which ensures that electrical wiring and equipment is in accordance with NFPA 70, National Electrical code 9.1.2. The multiple-outlet adapter located in room 22 was removed by the Maintenance Director on 2/22/2012. Facility staff was able to rearrange room 22 on 2/22/2012 to ensure adequate number of electrical receptacles were available for the resident. The Maintenance Director audited the facility on 2/27/2012 to ensure there were no additional multiple-outlet adapters and to ensure adequate number of electrical receptacles were available to meet the needs of the residents. The Maintenance Director found that no	4/7/2012

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K 147	Continued From page 7 Interview on 02/22/12, at 11:54 AM, with the Maintenance Director, revealed the facility prohibited medical equipment from being plugged into a multiple-outlet adapter. Reference: NFPA 99 (1999 Edition). 3-3.2.1.2 D 2. Minimum number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	additional receptacles were needed. The Maintenance Director received education by the Administrator on 2/22/2012 regarding NFPA 70, National Electrical Code 9.1.2 electrical wiring and equipment. All residents and family members will also receive notification by the Administrator regarding the prohibition of multiple outlet adapters/extension cords by April 7, 2012. An audit will be conducted by the Maintenance Director or designee monthly for six months to ensure compliance with NFPA 70, national Electrical Code 9.1.2. Results will be forwarded to the monthly CQI Committee Meeting for further recommendations and continued monitoring.	

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