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PRINTED: 07/24/2013
FORM APPROVED
OMB NO. 0938-0391

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

RECEIVED
JUL 30 2013
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
	185352		05/30/2013

NAME OF PROVIDER OR SUPPLIER: STANTON NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 31 DERICKSON LANE, STANTON, KY 40380

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	A standard health survey was conducted on 05/28-30/13. Deficient practice was identified with the highest scope and severity at "E" level.			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	**F 253** **Corrective Actions for Targeted Resident(s):** The wheel chairs for residents D, E, F, and H have been repaired. The bedside table in room 101-2 has been replaced. The door to room 109 has been repaired and no longer has rough edges. The feeding pumps in rooms 118-1 and 118-2 were cleaned and no longer have dried tube feeding on them.	
	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, and review of the facility policy, it was determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior. Observation on 05/30/13 revealed wheelchairs for four residents (Residents D, E, F, and H) with torn armrests and in need of repairs. A bedside table had rough edges in room 101-2. The door to room 109 had rough jagged edges, and gastric feeding pumps for the residents in rooms 118-1 and 118-2 had dried tube feeding on the pumps and poles. The findings include: Review of the facility's Maintenance Service policy (undated) revealed the Maintenance Department was responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. Interview with the Consultant Nurse on 05/30/13 at 4:25 PM revealed there was no policy related		**Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. An audit is being conducted by the Administrator, Environmental Service Director and the Interim Maintenance Director of all resident rooms and resident equipment to ensure we are maintaining a sanitary, orderly, and comfortable environment. The audit will be completed on or before July 13, 2013. **Systemic Changes:** The Education Training Director, Environmental Services Director and Interim Maintenance Director, will in-service all nursing staff and department heads on identifying areas in need of repair or replacement, and how to communicate via work orders for the items to be corrected. Additionally, the Department Head round sheets have been modified to address	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T. B. D. TITLE: Administrator (X6) DATE: 7/30/13

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 253	Continued From page 1 to who was responsible for cleaning the gastric feeding poles. Observation on 05/30/13 at 9:45 AM revealed Resident D, Resident E, Resident F, and Resident H had wheelchair armrests that were torn and in need of repair. In addition, resident H had a tear in the wheelchair backrest in need of repair. The bedside table in room 101-2 had rough edges. The door to room 109 was splintered, and the gastric feeding pumps/poles in rooms 118-1 and 118-2 had dried tube feeding on the pumps and poles. Interview with RN #1 on 05/30/13 at 4:20 PM revealed the RN was unaware that nursing staff was to clean the gastric pumps and poles. The RN stated the nurses were not cleaning the poles or pumps as far as she knew. Interview with the Housekeeping Supervisor on 05/30/13 at 4:30 PM revealed the Maintenance Director had resigned one week earlier and the facility was in the process of hiring a new Maintenance Director. The Housekeeping Supervisor stated the housekeepers were not responsible for gastric feeding pumps or poles but the nursing staff was responsible. The Housekeeping Supervisor monitored daily for any housekeeping issues and had not identified the gastric pumps or poles. Interview with the Administrator on 05/30/13 at 2:45 PM revealed the Maintenance Director had plans to replace the floors for all "green tiled" rooms, and rooms that had plaster on the walls were scheduled to be painted. The Administrator said the facility was in the process of hiring a	F 253	specific environmental issues to ensure items like wheel chairs, doors, and feeding tubes are viewed, documented and reported in our daily stand up meetings. **Monitoring:** All audit findings and Department Head round sheets rounds will be presented to Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July and August 2013 meetings and continued audits will be conducted if recommended by the Quality Performance Improvement Committee.	07/14/2013

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F 253	Continued From page 2 Maintenance Director. The Administrator said supervisors made environmental rounds every week and filled out slips for needed repairs. The Administrator stated the tube feeding pumps/poles, the jagged door edge for room 109, the rough edges on room 101-2's bedside table, and whaelchair armrests for Residents D, E, F, and G had not been identified by the facility as needed repairs.	F 253		
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, and record review, the facility failed to ensure services provided met professional standards of quality for two of nineteen sampled residents (Residents #5 and #12). Resident #5 had a physician's order for oxygen to be administered at 2 liters per minute and Resident #12 had physician's orders for oxygen to be administered at 3 liters per minute; however, observations conducted on 05/28-30/13 revealed facility staff failed to ensure the oxygen was administered as ordered by the physician. The findings include: A review of the facility policy related to following physician's orders (dated 05/30/13) revealed nursing staff was responsible to administer oxygen as ordered by the physician.	F 281	F 281 **Corrective Actions for Targeted Resident(s):** Resident #5's physician was contacted and he visited on 5/30/2013, and determined there were no adverse reactions to the resident. Resident #5's physician also discharged the order for 2 liters per nasal cannula and issued an order for oxygen to be administered PRN. Resident #12 was care planned for her non-compliance with leaving the oxygen on 3 liters per minute. Resident #12's physician was contacted about the oxygen being on 1.5 liters per minute and the resident's non-compliance with keeping the setting at 3 liters. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. The Director of Nursing and the two Unit Managers are conducting audits of all resident Physician orders this includes residents with oxygen orders to indentify if any other residents have been affected, and to ensure services are provided that meet professional standards of quality. The audits will be completed for July and August, 2013. **Systemic Changes:** All licensed nursing staff will be in-serviced by the ETD regarding the monitoring of Physician orders (i.e., orders for tube feedings, safety devices, treatments, etc.) and the	

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F 281	Continued From page 3 A review of the medical record revealed the facility admitted Resident #5 on 02/28/12 with diagnoses that included Cerebral Vascular Accident, Stage III Chronic Kidney Disease, Congestive Heart Failure, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. A review of the May 2013 physician's orders revealed the physician ordered oxygen to be administered at 2 liters per nasal cannula for Resident #5. Observations conducted on 05/28/13 at 4:20 PM, 4:50 PM, and 6:05 PM, revealed Resident #5 was lying in bed. An oxygen concentrator was observed beside the resident's bed but was not in use. Further observations conducted on 05/29/13 at 8:45 AM, 9:10 AM, 10:30 AM, 11:55 AM, 12:55 PM, and 4:00 PM, revealed the oxygen was not in use. On 05/30/13 at 9:20 AM and 1:30 PM, Resident #5 continued to be in bed with the oxygen concentrator at bedside. No oxygen was observed to be administered to Resident #5. Resident #5 was not interviewable due to cognitive status. Interview conducted with Licensed Practical Nurse (LPN) #1 on 05/30/13 at 1:40 PM, revealed she was assigned to Resident #5 on 05/28/13 and 05/30/13. LPN #1 stated nurses were responsible to check the resident's oxygen setting whenever they were in and out of the resident's room. LPN #1 stated she could not recall administering oxygen to Resident #5 on 05/28/13. LPN #1 stated she had not administered oxygen on 05/30/13 to the resident. LPN #1 stated she believed the oxygen was ordered on an as needed basis for Resident #5.	F 281	carrying out of these orders including oxygen orders and how to actually monitor the liters ordered are being administered at the concentrator. The Director of Nursing and Administrator will in service Department Heads on a change to the Department Head round sheets – that have been modified to ensure physician orders (i.e., O2, safety devices, tube feeding, treatments, etc.) are reviewed and checked once per week to ensure the orders are being provided that meet professional standards of service and quality. The Central Supply Manager or the Oxygen aide will check the orders and the concentrators weekly when changing out tubing to ensure the actual orders and liters are correct. All new physician orders including oxygen orders will be brought to daily triage meeting and reviewed to ensure there accuracy in the daily clinical review meeting. All professional staff (Dietary Manager, Therapist, Social Services, Activities, etc.) will be in-serviced on following professional standards for their respective disciplines. The Administrator, the Director of Nursing or the Regional Clinical Nurse Consultant will make and document at least one weekly observation of a professional providing service to our residents to ensure they meet their specific disciplines professional standards of practice.	

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F 281	Continued From page 4 Interview conducted with the Director of Nurses (DON) on 05/30/13, at 4:45 PM, revealed an oxygen concentrator should not be in the resident's room if the resident's oxygen was ordered as needed. The DON stated nurses were responsible to check the oxygen settings daily and during each medication administration pass. 2. Observation conducted for Resident #12 on 05/30/13 at 1:30 PM and 2:40 PM, revealed the resident was sitting in a personal recliner chair with oxygen being administered at 1.5 liters per minute via nasal cannula. Resident #12 was not interviewable due to cognitive status. Review of the medical record revealed the facility admitted Resident #12 on 06/21/12 with diagnoses that included Senile Dementia, Hypertension, Syncope, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. Review of the May 2013 physician's orders revealed oxygen was to be administered at 3 liters per minute. Interview conducted with LPN #2 on 05/30/13 at 2:50 PM, revealed she was assigned to Resident #12 on 05/30/13. LPN #2 stated the nurses were supposed to check the resident's oxygen setting at least one time a day. LPN #2 stated she had not checked Resident #12's oxygen setting on 05/30/13 because she was too busy.	F 281	**Monitoring:** The Director of Nursing and the two Unit Managers will conduct another audit in August of all physician orders including Oxygen orders. Any orders found to not meet the professional standards of service and quality will be immediately addressed, corrected, when audited and presented to QPI. The weekly documented observations of a professional providing service to our residents to ensure they meet their specific disciplines professional standards of practice will be presented along with all audit findings and Department Head round sheets to the Quality Performance Improvement (QPI) Committee (Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July and August 2013 meetings and continued audits will be conducted if professional standards are not sustained as recommended by the Quality Performance Improvement Committee.	07/14/2013
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282	F 282 **Corrective Actions for Targeted Resident(s):** Resident #1's physician was notified regarding the plan of care not being followed for the orthotic device to the left upper extremity. The physician	

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F 282	Continued From page 5 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to ensure staff provided care to residents in accordance with the resident's written plan of care for one of nineteen sampled residents (Resident #1). The plan of care directed a left-hand orthotic device be utilized twenty-three of twenty-four hours daily and to be removed for bathing/hygiene needs for Resident #1. However, the orthotic device was not observed to be used consistently during the survey conducted on 05/28-30/13. The findings include: Review of the Care Plan policy (no date) revealed a comprehensive care plan would be developed and maintained to identify the highest level of functioning the resident may be expected to attain. The policy noted the care plan was designed to aid in preventing or reducing declines in the resident's function or status levels. Review of the medical record revealed the facility admitted Resident #1 on 12/12/12 with diagnoses that included Cerebral Vascular Accident with Hemiplegia, Dysphagia, Dementia, Aneurysm, and Chronic Obstructive Pulmonary Disease. A review of the quarterly assessment for Resident	F 282	determined there were no adverse reactions to the resident and changed resident #1's orders to RHO on during AM and off at HS as resident allows release Q 4 hours to check for skin integrity. Resident #1's Plan of Care has been updated. The AccuNurse system now prompts the SRNA's for the plan of care for resident #1 to place the RHO on in the AM and release every 4 hours and check for skin integrity. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. The Director of Nursing and the two Unit Managers are conducting audits of all written plans of care and comparing the same with what is on the AccuNurse Care voice assistant system. The DON and Unit Managers will compare or audit the current written plan of care with what the residents have in place. Additionally, the DON and Unit Manager will monitor and document at least five staff members per week to determine they are providing care in accordance with the written plan of care. (i.e., Orthotic devices are in place, safety devices in place, assist levels are followed, etc.) The audits will be completed for July, August, and September 2013. **Systemic Changes:** The ETD, DON and Unit Managers will in-service all Nursing Staff on how to access each residents Plan of Care	

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F 282	Continued From page 6 #1, dated 03/06/13, revealed the resident required extensive assistance of staff persons for all transfers, bed mobility, and locomotion. The assessment revealed the resident exhibited bilateral impairment of range of motion of upper and lower extremities. Review of the care plan for Resident #1 revealed staff was to utilize an orthotic device to the left upper extremity 23 hours each day. Resident #1 was observed to be lying in bed on 05/28/13 at 4:15 PM, 4:45 PM, and 6:10 PM; no orthotic device was observed to be in place. Observation conducted on 05/29/13 at 8:45 AM, 9:50 AM, and 10:30 AM, revealed Resident #1 was in bed; however, there was no evidence the orthotic device was utilized. On 05/29/13 at 11:55 AM, Resident #1 was observed to be up in a broda chair with the left orthotic device in place on the resident's left upper extremity. However, at 2:50 PM on 05/29/13, a skin assessment was conducted and the device was no longer in use. Further observations revealed the resident was in bed on 05/30/13 at 9:30 AM; the orthotic device was observed to be lying on the overbed table. Interview with Certified Nurse Aide (CNA) #1 on 05/29/13, at 1:10 PM, revealed she was assigned to Resident #1 on 05/29/13. CNA #1 stated the CNAs utilized a "headset" to identify the residents' specific care needs. CNA #1 stated she had not applied the orthotic device because the information was not in her headset. The CNA stated CNA #2 had told her to apply the orthotic device to Resident #1 when she had transferred the resident to the broda chair. CNA #1 stated CNA #2 told her the device was supposed to be used for 23 hours each day.	F 282	on AccuNurse and in the resident's medical record either by printing it, viewing in the medical record, on the computer or through the AccuNurse head sets. This will ensure the nursing staff is qualified to provide care per the resident's written plan of care. A systemic change will be for the Unit Managers and Director of Nursing to ensure all Plans of Care are updated through the Inter Disciplinary Team meeting daily and updated on the AccuNurse system. To ensure the deficient practice does not recur, the DON and Unit Manager will monitor and document at least five staff members per week to determine they are providing care in accordance with the written plan of care. (i.e., Orthotic devices are in place, safety devices in place, assist levels are followed, etc.). This weekly monitoring will continue through September 2013. **Monitoring:** The written Plan of Care audits from July, August and September will be presented to the QPI committee. Additionally, the weekly documented monitoring of five staff members per week to determine they are providing care in accordance with the written plan of care. (i.e., Orthotic devices are in place, safety devices in place, assist levels are followed, etc.), will also be presented to the Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing,	

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F 282	Continued From page 7 Interview with CNA #2 on 05/30/13 at 9:35 AM, revealed she was assigned to Resident #1 on 05/30/13. CNA #2 stated she knew the resident was supposed to have the orthotic device on for 23 hours each day, but she had removed the device during the breakfast meal and was planning to reapply the device. Interview conducted with Unit Manager #1 on 05/30/13 at 9:40 AM, confirmed that the information related to the application of the left orthotic device was in the information on the CNA's headset. The UM stated she looked under positioning in the headset data and the CNA was responsible to conduct periodic rounds throughout the day to monitor for care plan interventions. The UM stated she observed the resident at 6:00 AM on 05/30/13 and the device was in place at that time. Interview conducted with the Director of Nurses (DON) on 05/30/13 at 4:45 PM, revealed she made rounds each morning and periodically throughout the day to monitor to ensure care plan interventions were implemented per each resident's plan of care. The DON stated no problems had been identified related to the application of orthotic devices.	F 282	Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July, August and September 2013 meetings. Continued audits will be conducted if recommended by the Quality Performance Improvement Committee to ensure the solutions are sustained and care is provided in accordance with each resident's plan of care	07/14/2013
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by:	F 369	F 369 **Corrective Actions for Targeted Resident(s):** Resident #3 was interviewed to see if she experienced any adverse affects from not receiving the divided plate for lunch on 5/29/2013. Resident #3 indicated she did not have any adverse affects from not receiving the divided plate (Assistive device). Resident #3 has received the divided plate for meals since the incident of 5/29/13.	

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F 369	Continued From page 8 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to provide one of nineteen sampled residents (Resident #3) with special dining equipment as recommended by a Speech Therapist and prescribed by the resident's physician. The findings include: Review of the facility's Special/adaptive equipment policy (undated) revealed adaptive equipment for dining will be provided on the resident's meal tray as appropriate. Review of Resident #3's meal tray card revealed Resident #3 was required to have a divided plate for meals. Observation of the noon meal on 05/29/13 at 12:30 PM revealed Resident #3 received the meal on a regular plate. Resident #3's tray card indicated the resident was to receive a divided plate for meals. Interview with Resident #3 on 05/29/13 at 12:30 PM revealed the resident could eat better when food was on a divided plate. Resident #3 stated he/she was supposed to have a divided plate and usually received the plate with meals. Interview with CNA #1 on 05/29/13 at 12:30 PM revealed Resident #3 was supposed to receive a divided tray but did not have one for the lunch meal on 05/29/13. CNA #1 said the CNAs were to check the meal tray cards for accuracy when the tray was passed to the resident.	F 369	**Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. The Dietary Manager audited (5/31/2013) all resident tray cards for Assistive Devices. Additionally, the DON is obtaining and auditing a report from pharmacy listing all residents with adaptive equipment orders. The audits will be completed by July 13, 2013. **Systemic Changes:** The ETD, and Dietary Manager will in service all Dietary workers on identifying the adaptive equipment on the tray cards. A tray card audit will be conducted by the Dietary Manger for adaptive equipment in June, July and August of 2013 and a list of all residents to receive adaptive equipment will be reviewed/in serviced with dietary staff. Any new residents or existing resident in need of adaptive equipment will be reviewed in the daily IDT meeting for their need and if appropriate the Dietary Manager will in service her staff on the new or existing resident's specific adaptive equipment to be included on the resident's tray and tray card. The ETD, DON and Unit Managers will in service all Nursing staff on how to review the resident's tray card and tray to identify and ensure any appropriate adaptive equipment is available or immediately corrected. The weekend Department Head Managers or the weekend nurse supervisor will be provided with	

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STANTON NURSING AND REHABILITATION CENTER	31 DERICKSON LANE STANTON, KY 40380

(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 369	Continued From page 9 Interview with RN #1 and LPN #1 on 05/29/13 at 2:30 PM revealed the divided plate should come from the kitchen and the CNAs should check tray cards when passing meal trays. The nurses said Resident #3 should have a divided plate. Interview with the Dietary Cook on 05/30/13 at 10:20 AM revealed Resident #3 was supposed to have a divided plate but did not receive the plate for the lunch meal on 05/29/13. The Dietary Cook did not know why the divided tray was missed for Resident #3. Interview with the Dietary Manager on 05/30/13 at 10:15 AM revealed Resident #3 had a divided plate and should receive the plate for all meals. The Dietary Manager said the tray line was observed daily and the Dietary Manager performed test trays one time weekly. According to the Dietary Manager, she had not identified any problems with adaptive equipment.	F 369	a list from the Dietary Manager of all residents receiving adaptive equipment and they will audit at least one meal per day on their tour of duty to ensure all residents on the list receive their respective adaptive device(s). **Monitoring:** The tray card audits from May 31, 2013, June, July and August along with the weekend Department Manager or the weekend nurse supervisor audits will be presented to Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July and August 2013 meetings and continued audits will be conducted if recommended by the Quality Performance Improvement Committee.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431		07/14/2013

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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
	185352		05/30/2013

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F 431	Continued From page 10 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to ensure narcotic records were accurately maintained for one of nineteen sampled and five unsampled residents (Resident G). Observation of the narcotic count on 05/30/13 at 3:30 PM for the North Hall "short hallway medication cart" revealed resident G's controlled drug record was inaccurate. The findings include: Review of the policy "Inventory Control of Controlled Substances" (dated 12/01/07) revealed narcotics were to be accounted for by facility staff with a separate individual controlled	F 431	F 431 **Corrective Actions for Targeted Resident(s):** After Resident G awoke on 5/30/2013, LPN #2 assessed the resident for pain and Resident G denied any pain or discomfort at the time. Resident G's physician was contacted on 05/30/2013 to report the missed dose and he said she should be just fine and have no adverse affects. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. The Director of Nursing and the two Unit Managers are conducting an audit of all drugs to ensure residents are receiving their medications as ordered and the drugs are accurately reconciled and drug records are in order. The audit will be completed on or before July 13, 2013. **Systemic Changes:** The ETD, DON and Unit Managers will in service all licensed nursing staff and medication aides on the proper distribution and reconciliation of drugs. The ETD, DON and Unit Managers will conduct at least one audit per week beginning the week of July 13, 2013, this audit will reconcile medications from the time of the audit back to the change of the shift and ensure the counts were correct at the end and beginning of the shift.	

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

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F 431	Continued From page 11 substance record on all Schedule II drugs in the form of a declining inventory. The facility should reconcile all current inventory to the controlled drug declining inventory record and to the resident's medication administration record. Observation of the narcotic count on 05/30/13 at 3:30 PM revealed LPN #2 had signed for a Lortab 5/500 mg to be administered to Resident G at 10:00 AM; however, the narcotic had not been administered and the narcotic count had one extra Lortab 5/500 mg. Interview with LPN #2 revealed the Lortab 5/500 mg had not been administered to Resident G. LPN #2 said the count was correct at the beginning of the shift at 7:00 AM when the medications were counted. LPN #2 said she just missed giving Resident G's medication. LPN #2 said Resident G's medication was scheduled but the resident did not complain of pain. Resident G was unable to be interviewed on 05/30/13 at 3:45 PM as the resident was asleep and did not awaken prior to the surveyors exiting the facility. There were no visible signs of pain on 05/30/13 at 3:45 PM. Interview with the DON on 05/30/13 at 3:45 PM revealed the facility staff was to count narcotics at the end of every shift with the offgoing and oncoming staff. The DON said Unit Managers checked the narcotic counts to ensure no discrepancies and that the counts were being performed. Interview with the Consultant Pharmacist on 05/30/13 at 3:50 PM revealed the Pharmacist	F 431	**Monitoring:** The weekly medication reconciliation audits will be presented to Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July and August 2013 meetings and continued audits will be conducted if recommended by the Quality Performance Improvement Committee.	07/14/2013

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F 431	Continued From page 12 came in once each quarter and checked medication carts. No discrepancies had been identified by the pharmacy with any narcotics.	F 431	**F 441** **Corrective Actions for Targeted Resident(s):** Resident A and resident B have been monitored for signs and symptoms of infection or sickness. Resident A and B have not had any adverse affects from the improper handling of the slice of bread and feeding performed by SRNA #3.	
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	**Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. The DON is conducting an audit of all infections in the building from 5/28/13 through 6/12/13, to determine if any infections were a result of not following the facility Infection Control Plan. **Systemic Changes:** The ETD, DON and Unit Managers will in service all staff on the Infection Control Plan, proper hand washing, handling of food, linens and other items to ensure the spread of infections are prevented. The Administrator or DON or another Department Head will observe and document at least one meal service per week beginning the week of July 13, 2013, to ensure the facility food handling policy is being followed. Additionally, the ETD, DON, Unit Managers will document/audit weekly observations beginning the week of July 13, 2013, of Peri-care, hand washing, linen storage to ensure the Infection Control Plan is being	

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F 441	Continued From page 13 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy it was determined the facility failed to maintain an effective infection control program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection. Observation during the dinner meal on 05/28/13, revealed facility staff touched the bread of one unsampled resident (Resident A) with their bare hands when serving the bread to the resident, when applying butter to the resident's bread, and during feeding of another unsampled resident (Resident B). The findings include: A review of the facility's Handling Food policy (dated 05/30/13) revealed bare hand contact with food was prohibited. The policy noted gloves must be worn when directly handling foods. Observation during the evening meal in the facility dining room on 05/28/13 at 5:45 PM, revealed Certified Nurse Aide (CNA) #3 delivered the dinner tray to Resident A. The resident's bread was noted to be in a plastic bag when served to the resident. CNA #3 was observed to pick up the bread with her bare hands and place it on top of the other food items on the resident's tray. CNA #3 was then observed to deliver a tray to Resident B and began feeding this resident. CNA	F 441	followed. The DON will track infections for June, July and August to ensure we are not having patterns of infection developing as a result of not following our infection control plan. **Monitoring:** The weekly meal service documented observation, as well as the ETD, DON, Unit Managers weekly audit to observe Peri-care, hand washing, linen storage, and the DON tracking of infections for June, July and August to ensure we are not having patterns of infection will be presented to the Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July and August 2013 meetings and continued audits will be conducted if recommended by the Quality Performance Improvement Committee.	07/14/2013

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F 441	Continued From page 14 #3 was then observed to reach over to Resident A's tray and pick up the slice of bread with her bare hands, apply butter to the bread, and then place the bread in Resident A's hand. CNA #3 was observed to continue feeding Resident B. Interview conducted with CNA #3 on 05/30/13 at 3:00 PM, revealed the CNA had been trained not to touch food with bare hands when feeding or delivering food to the residents. The CNA stated she knew she should not have touched the resident's bread with her bare hands and during feeding the other resident. Interview conducted with the Director of Nurses (DON) on 05/30/13 at 4:45 PM, revealed the DON had conducted a verbal training regarding proper handling of foods a "couple of weeks ago." The DON stated she could not recall if CNA #3 was present during the training. The DON stated the staff should not handle residents' food with their bare hands.	F 441	**F514** **Corrective Actions for Targeted Resident(s):** Resident #8's Medical Record was corrected on 5/30/2013, by removing the Kentucky Emergency Medical Services Do Not Resuscitate Order with Resident #8's name on it. **Identification of Other Residents with Potential to Be Affected:** The Medical Records Director, Unit Managers and DON are auditing all medical records to ensure they are complete, accurate and accessible.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	**Systemic Changes:** The Unit Managers, DON and Medical Records Director will ensure the Medical Records are complete, accurate, accessible, maintained in accordance with accepted professional standards and practices by auditing all residents during monthly change over. Each record will be checked for physician's orders, code status and advanced directives, any discrepancies will be corrected immediately. **Monitoring:** The initial Audit and monthly audits conducted during change over will be presented to Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing, Social Services,	

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F 514	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure clinical records were maintained in accordance with accepted professional standards and practices for one of nineteen sampled residents (Resident #8). Resident #8 had physician's orders for full code status. Although nursing staff was aware of Resident #8's code status, there was a "Do Not Resuscitate" form on Resident #8's record with the incorrect code status. The findings include: Review of the facility's "Advance Directives" policy (undated) revealed information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record. A review of Resident #8's medical record revealed physician's orders dated May 2013 that indicated Resident #8 was to receive Cardio Pulmonary Resuscitation (CPR). A review of the front cover of Resident #8's chart revealed "full code" status. Further review of the medical record revealed a Kentucky Emergency Medical Services Do Not Resuscitate Order with Resident #8's name and signed by the former Director of Nursing and witnessed by two other facility nurses. An interview with RN #1 and LPN #1 on 05/30/13 at 2:30 PM revealed all code statuses were to be	F 514	Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July and August 2013 meetings and continued audits will be conducted if recommended by the Quality Performance Improvement Committee.	07/14/2013

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F 514	Continued From page 16 checked by the physician's orders. The nurses said Resident #8 was considered a "full code." The nurses said the social worker gets the code information if the resident is admitted during the week. If the resident is admitted on a weekend or holiday the nurses obtain the code information. The nurses said the Daily Clinical Review (DCR) meeting performed spot audits of the clinical records for accuracy related to code status. The nurses said there were no issues related to code status from any of the audits performed by the DCR committee. Interview with the Nurse Consultant, Director of Nursing, and the Administrator on 05/30/13 at 2:50 PM revealed the code status for a resident was filled out upon admission with the family. The DNR form for Resident #8 was filled out inaccurately, the DNR status was in regards to another resident, and the wrong name was placed on the form. According to the DON and Nurse Consultant, Resident #8 had a "full code" status.	F 514		

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Division of Health Care
Southern Enforcement Branch

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	185352	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/29/2013

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1990 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type V (000) SMOKE COMPARTMENTS: Six smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system GENERATOR: Type II generator. Fuel source is LP gas. A life safety code survey was initiated and concluded on 05/29/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation with Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050	**K 050** **Corrective Actions for Targeted Resident(s):** Second and third shift fire drills, are being conducted at unexpected times and under varying conditions. A 2nd shift fire drill was conducted 5/31/2013 at 3 PM. The previous 2nd shift drill was performed on 2/28/2013 at 8:05 PM. The next 2nd shift drill will be conducted at least an hour after 3 PM. The last 3rd shift fire drill was conducted on 03/28/2013 at 2:30 AM and the next third shift fire drill will be conducted one hour before or one hour after 2:30 AM on the week of June 24, 2013. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. The Interim	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6/22/13

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 050 SS=F	Continued From page 1 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility. The facility has the capacity for 82 beds with a census of 78 on the day of the survey. The findings include: During the Life Safety Code survey on 03/26/13 at 1:30 PM, an interview and record review with the Administrator revealed the facility had not been performing fire drills at unexpected times and varying conditions on the second and third shifts as follows: Three fire drills on the second shift from 08/31/12 thru 11/30/12 were conducted at 7:04PM, 6:42PM, and 7:05 PM. Two fire drills on the third shift from 09/17/12 thru 03/28/13 were conducted at 2:30AM and 3:02 AM.	K 050	Maintenance Supervisor, Administrator and Administrative Office Specialist have organized the Fire Drill Manual and established a flow chart showing fire drills by shift and ensuring no consecutive shift fire drill is conducted less than an hour before or an hour after the preceding fire drill. **Systemic Changes:** The Fire Drill Flow Sheet will be audited by the Administrator monthly to ensure the facility is maintaining fire drills at unexpected times under varying conditions. **Monitoring:** The Maintenance Director will bring the fire drills manual and fire drill flow sheet to the Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July and August 2013 meetings and continued audits will be conducted if recommended by the Quality Performance Improvement Committee.	07/13/2013

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K 050	Continued From page 2 The Administrator stated he was not aware fire drills should be conducted at unexpected times and under varying conditions.	K 050		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 82 beds with a census of 78 on the day of the survey. The findings include: During the Life Safety Code tour on 05/29/13 at 1:30 PM, an interview and record review with the Director of Maintenance (DOM) revealed the DOM was not aware that he should be manually testing the generator transfer switch on a monthly basis as required. This testing helps ensure the transfer switch is operating as intended. The findings were revealed to the Administrator	K 144	**K 144** **Corrective Actions for Targeted Resident(s):** The Interim Maintenance Director manually tested the generator transfer switch at 9 AM on 5/30/2013, under load. The Interim Maintenance Director will manually test the generator transfer switch under load again the week of June 24, 2013. **Identification of Other Residents with Potential to Be Affected:** All residents have the potential to be affected. The Administrator, Interim Maintenance Director and Administrative Office Specialist have reviewed, organized and placed in a manual all the generator tests both weekly and those tested manually under load and drafted a cover sheet outlining the requirements of NFPA 99. 3.4.4.1. **Systemic Changes:** All generator tests both weekly and those tested manually under load will be signed off on by the Administrator. The Administrator, Interim Maintenance Director and Administrative Office Specialist	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185352	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON NURSING AND REHABILITATION CENTER	31 DERICKSON LANE STANTON, KY 40380

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K 144	Continued From page 3 during exit. Reference: NFPA 110 (1999 Edition). 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144	have set up a manual organized to review all the generator tests both weekly and those tested manually under load and drafted a cover sheet outlining the requirements of NFPA 99. 3.4.4.1. **Monitoring:** All generator tests both weekly and those tested manually under load will be monitored to ensure they comply with NFPA 99. 3.4.4.1. and will be presented to the Quality Performance Improvement Committee (Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review in the July and August 2013 meetings and continued audits will be conducted if recommended by the Quality Performance Improvement Committee.	07/13/2013