

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

PRINTED: 05/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2013
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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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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 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.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY A Recertification Survey was initiated on 04/17/13 and concluded on 04/19/13. Deficient practice was identified with a scope and severity of a "D." The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide care in a manner that maintained dignity for one (1) of thirteen (13) sampled residents(Resident #4). Observations, on 04/17/13 and 04/18/13, revealed Resident #4's indwelling catheter bag was uncovered and not in a privacy bag when the resident was in a public area. The findings include: Review of the facility's "Resident Handbook", dated March 2007, revealed the facility strived to promote care in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. Review of the medical record revealed Resident #4 was re-admitted to the facility, on 01/28/13.	F 241	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. South Shore Nursing and Rehabilitation Center strives to ensure that the facility promotes care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The catheter bag of resident #4 was placed in a privacy bag by the Director of Nursing on 4/19/2013. On 4/19/13, the Director of Nursing visually reviewed all residents with a catheter to ensure that dignity was maintained via a cover or fig leaf brand catheter bag. Front	5-11-2013

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Berita Adkins</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5-7-13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 Continued From page 1
with diagnoses which included Multiple Sclerosis and Urinary Retention. Review of an Admission Minimum Data Set (MDS), dated 02/04/13, revealed the facility assessed Resident #4 as being severely cognitively impaired and utilized an indwelling catheter. Review of the Care Area Assessment Summary (CAAs), dated 02/04/13, revealed Resident #4 utilized an indwelling catheter due to urinary retention.

Observation, on 04/17/13 at 2:40 PM, revealed Resident #4 was sitting in a reclining Geri-chair in the hallway outside of the resident's room. Further observation revealed an uncovered indwelling catheter bag contained yellow urine was anchored to the chair. Additional observation revealed staff, visitors and other residents were in the hallway.

Additional observation, on 04/18/13 at 2:45 PM, revealed State Registered Nursing Assistant (SRNA) #1 pushed Resident #4 in his/her Geri-chair from the entrance of the facility to the resident's room. Further observation revealed Resident #4's indwelling catheter bag which contained yellow urine was not covered as SRNA #1 pushed Resident #4 in his/her Geri-chair and passed by visitors, staff and other residents in the entrance way and hallways.

Interview with State Registered Nurse Assistance (SRNA) # 1, on 04/18/13 at 2:50 PM, revealed Resident #4's catheter bag should have been in a privacy bag before leaving the facility to go to an outing; however, the resident had left prior to her coming on duty.

Interview with Licensed Practical Nurse (LPN) #1,

F 241 5/7/13 thru 5/10/13, the Director of Nursing will conduct at least 2 random audits per day on various shifts to ensure that the facility promotes care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Any identified areas of concern will be immediately corrected.

On 5/7/13, a resident council meeting was held by the Administrator-In-Training and the Social Service Director to review resident rights and dignity issues and to ensure that the facility is providing care in a manner and in an environment that maintains each resident's dignity and respect in full recognition of his or her individuality. No issues were identified.

All nursing staff will receive additional education by the DON no later than 5-10-13 regarding the importance of maintaining dignity and respect by ensuring that all catheter bags are covered, either by a pre-covered bag or be placed in a privacy bag. All staff will receive additional education by the Administrator-in-Training no later than 5-10-13 regarding ensuring dignity of all residents and to ensuring that the facility promotes care for residents in a manner and environment that maintains or enhances each

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F 241 Continued From page 2
on 04/18/13 at 3:35 PM, revealed Resident #4's indwelling catheter bag should have been placed in a privacy bag before he/she went out of the facility. LPN #1 Indicated a privacy bag should be on at all times even in the facility to promote dignity.

F 241 resident's dignity and respect in full recognition of his or her individuality.

The charge nurses will check patients each shift to ensure that the catheter bags are covered, either by a pre-covered bag or are placed in a privacy bag.

The Director of Nursing and the Administrator-In-Training will audit during daily rounds, Monday through Friday, for two weeks, then monthly for three months, that care is delivered in a way that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This will include, but is not limited to, the dignity of any resident that requires a foley catheter.

Results of these audits will be forwarded to the monthly Continuous Quality Improvement (CQI) Committee meeting for further recommendations and continued compliance.

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1938, 1988</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type III (211) 1988 Type III (200) 1938</p> <p>Smoke Compartments: 4</p> <p>Fire Alarm: Complete fire alarm with smoke detectors in corridors and electrical room. Heat detector located in basement. New panel installed 2011.</p> <p>Sprinkler System: Complete sprinkler system (dry) installed 1988</p> <p>Generator: Type II powered via propane installed 2003</p> <p>A standard Life Safety Code survey was conducted on 04/18/13. 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 48. The facility is licensed for 60 beds. The highest scope and severity was an "E".</p> <p>The following demonstrate noncompliance:</p> <p>K 038: NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 000	<p>To the best of my knowledge and belief, as an agent of South Shore Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements.</p> <p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or 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.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Berita Adkins TITLE: Administrator (X6) DATE: 5-7-13

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K 038
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Continued From page 1
Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview it was determined the facility failed to ensure exit doors that had a magnetic locking device with delayed egress hardware had letters on the sign that indicated PUSH UNTIL ALARM SOUNDS and DOOR CAN BE OPENED IN 15 SECONDS was not less than 1 in. (2.5 cm) high for two (2) of five (5) exterior exit doors with delayed-egress locks.

The findings include:

Observation, on 04/19/2013 at 10:00 AM, revealed the exterior exit door for the Ambulance exit had a magnetic locking device with delayed egress hardware. Further observation revealed a sign on the door indicated a delayed function operation (PUSH UNTIL ALARM SOUNDS and DOOR CAN BE OPENED IN 15) had lettering that measured less than 1 in. (2.5 cm) high.

Observation, on 04/18/13 at 10:15 AM, revealed the exterior exit door from the Dining Room had a magnetic locking device with delayed egress hardware. Further observation revealed a sign on the door indicated a delayed function

K 038

South Shore Nursing and Rehabilitation Center strives to ensure compliance with NFPA 101 Life Safety Code Standards requiring that exit doors are readily accessible at all times in accordance with section 7.1 19.2.1

The Maintenance Director, in conjunction with Sentry Fire Protection, on 4/19/13, installed two signs with letters of one inch in height.

The Maintenance Director was reeducated on 4/19/13 by the Administrator-in-Training regarding the requirements for signage in the National Fire Protection Association Standards as in the National Fire Protection Association 101 7.2.1.5.4.

An audit of all exterior exit doors was completed on 4/19/13 by the Maintenance Director. The Maintenance Director will continue to perform this audit monthly for 6 months to ensure signs with letters of one inch in height are present on all exterior exit doors and signs are present and in good repair.

Results of the exterior exit door sign audit will be forwarded to the Continuous Quality Improvement (CQI) Committee for further recommendations and continued monitoring for compliance.

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K 038 Continued From page 2
operation (PUSH UNTIL ALARM SOUNDS and DOOR CAN BE OPENED IN 15) had lettering that measured less than 1 in. (2.5 cm) high.

Interview, on 04/19/2013 at 10:00 AM, with the Maintenance Director revealed the facility was not aware that all doors equipped with delayed locking devices required a sign with letters that had a minimum height of 1 in. (2.5 cm).

Reference: NFPA 101 (2000 edition)
7.2.1.6.1. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.

(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released

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K 056	<p>Continued From page 4</p> <p>systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were free from corrosion for one (1) of four (4) smoke compartments in the facility. Observations, on 04/19/13, revealed three (3) sprinkler heads in the Kitchen smoke compartment were corroded.</p> <p>The findings include:</p> <p>Observation, on 04/19/13 at 10:40 AM, revealed two (2) sprinkler heads in the Dish Washing room was corroded.</p> <p>Further observation, on 04/19/13 revealed one (1) sprinkler head near the Kitchen Hood was corroded.</p> <p>Interview, on 04/19/2013 at 10:40 AM, with the Maintenance Director revealed he was not aware the sprinkler heads in the Dish Washing Room and near the Kitchen Hood were corroded.</p> <p>Reference: NFPA 25 (1998 edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted,</p>	K 056	<p>The Maintenance Director was reeducated on the importance of ensuring all sprinkler heads in the building are free from corrosion, foreign materials, paint, and physical damage by the Administrator-In-Training on 4-19-13.</p> <p>The Maintenance Director and Administrator-In-Training conducted an audit of all the building's sprinkler heads on 4/19/2013 and replaced all sprinkler heads that were not free from corrosion, foreign materials, paint, and physical damage.</p> <p>All sprinkler heads will be audited monthly to ensure that all sprinkler heads are free from corrosion, foreign materials, paint, and physical damage.</p> <p>Results of the sprinkler head audit will be forwarded to the Continuous Quality Improvement (CQI) Committee monthly for further recommendations and continued monitoring for compliance.</p>	
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K 056	Continued From page 5 corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 056		
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