

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

PRINTED: 09/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	<div style="border: 2px solid black; padding: 5px; text-align: center;"> R E C E I V E D OCT - 3 2011 09/08/2011 </div>		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380 Division of Health Care Southern Enforcement Branch			
(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				
F 252 SS=D	<p>A standard health survey was conducted on 09/06-08/11. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide a clean, comfortable, and homelike environment. During the survey conducted on 09/06-08/11, a strong, persistent urine odor was present in room 100 and the immediate hallway adjacent to room 100.</p> <p>The findings include:</p> <p>Observations of room 100 on 09/06/11 at 2:45 PM and 3:50 PM, on 09/07/11 at 9:30 AM, 10:30 AM, and 2:40 PM, and on 09/08/11 at 9:40 AM, revealed a pervasive strong urine odor in the room and the immediate hallway area outside the room.</p> <p>Interview conducted with Certified Nurse Aides (CNAs) #1 and #2 on 09/07/11 at 2:45 PM and 2:55 PM, revealed Resident #9 required assistance with toileting and was frequently incontinent of urine. Both CNA #1 and CNA #2</p>	F 252	<p>F 252</p> <p><u>Corrective Actions for Targeted Resident(s):</u> Room 100 was deep cleaned immediately by housekeeping. The tile was replaced in the room and bathroom. The floors were bleached before tile was replaced. The walls were painted. All furniture was cleaned and sanitized. The heating and air unit was cleaned.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> An audit was conducted on all resident rooms and bathrooms in the center to observe for urine odor. No other rooms with odor was found.</p> <p><u>Systemic Changes:</u> Beginning 9/30/2011, certified nursing assistants will monitor Room 100 every hour. In addition, housekeeping staff will monitor the room three times a day. All staff will document on a flow sheet. Beginning 10/10/2011, Director of Maintenance and/or Housekeeping Supervisor will audit Room 100 and verify flow sheet three times a week.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Th B D

Administrator

10/3/11

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 252	Continued From page 1 stated the resident was able to ambulate independently to the bathroom to urinate but frequently did not make it to the bathroom in time or would "miss" the commode and urinate around/near the commode area. CNA #1 and CNA #2 stated the urine odor had been present for "a while" in room 100. CNA #1 and CNA #2 also stated the odor had been reported to the Housekeeping Department. An interview with the Maintenance Supervisor (MS) on 09/08/11 at 3:00 PM, revealed he was aware of the persistent urine odor in room 100 and the hallway. The MS stated the room was cleaned daily and as needed by the Housekeeping Department. In addition, the MS stated he had replaced the floor tiles with a linoleum rug and painted room 100 three months ago but this had not corrected the urine odor in the room.	F 252	Monitoring: All audit findings to 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 and revision of plan if needed weekly for 4 weeks and bi monthly for next 4 weeks beginning 10/31/2011.	10/20/2011	
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 applicable.	F 431	F 431 Corrective Actions for Targeted Resident(s): No specific resident was identified. All residents have the potential to be affected.		

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F 431	Continued From page 2 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: The facility failed to ensure biologicals stored in the South Hall medication room did not exceed the manufacturer's recommended expiration dates. The findings include: A review of the facility's policy (dated May 2010) related to Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles revealed the facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other applicable law, and in accordance with Policy 8.2. An observation on 09/07/11 at 5:00 PM, of the	F 431	Identification of Other Residents with Potential to Be Affected: Director of Nursing(DON) to complete a one time audit of all medication rooms, all medication/treatment carts and all medication refrigerators to identify any medication opened and not dated per policy by 10/10/2011. Any medication opened and not dated will be discarded, reordered and dated by the UM upon arrival from pharmacy. Systemic Changes: Education Training Director to re educate licensed personnel regarding p/p for storage of biologicals, dating of opened liquids/medications and following manufactures recommendation for all opened medications by 10/14/2011. Regional Director of Clinical Services to re educate DON and UM regarding p/p for storage of biologicals, dating opened medications and following manufactures recommendation for all opened medications by 10/14/2011. Pharmacy representative to audit at least all three(3) medication rooms and	

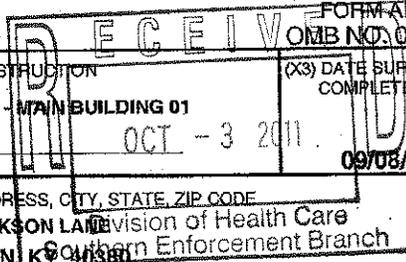
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F 431	<p>Continued From page 3</p> <p>South Hallway medication storage room revealed one Blood Culture Collection Kit, expiration date June 2011; one bottle of Hep-Lock Solution 30 milliliters, expiration date 11/12/10; two Enteral feeding tubes, Ross 10 French 45-inch, expiration date September 2009; and two Enteral Nutrition Bags, expiration date August 2010.</p> <p>An interview on 09/07/11 at 5:00 PM, with the Unit Manager for the South Hallway revealed pharmaceutical supplies were restocked with each use and the nurse was required to restock the medications and look at the expiration date.</p> <p>An interview with the Administrator on 09/08/11, revealed the staff had been rotated and it had been the supply clerk's responsibility to check the medication storage room and check dates for expiration monthly. The Administrator further revealed the identified supplies had been for a resident that no longer resided in the facility.</p>	F 431	<p>medication refrigerators for expired or undated opened medications by 10/14/2011. DON to audit all medication refrigerators 2 x week x 4 weeks to ensure all medications are dated if opened and discarded per manufactures recommendation beginning 10/10/2011. UM to audit medication and treatment carts to ensure opened liquids are dated and discarded per manufactures recommendation 1 x week x 4 weeks beginning 10/10/2011.</p> <p>Monitoring: All audit findings to 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 and revision of plan if needed weekly for 4 weeks and bi monthly for next 4 weeks beginning 10/31/2011.</p>	10/20/2011

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Six smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p>	K 000	<p>K 052</p> <p>Corrective Actions for Targeted Resident(s):</p> <p>The fire doors are being fixed by a Certified Fire Alarm Company to ensure they no longer can be placed in the open position while the system is still showing fire conditions. The Middle Corridor Zone and zone displays are being fixed by a Certified Fire Alarm Company to ensure the display shows the correct zones on the display panel.</p> <p>Identification of Other Residents with Potential to Be Affected:</p> <p>All fire doors were checked by the Director of Maintenance (DOM) on 10/10/11 to ensure they could not be placed in the open position while the fire alarm was still showing fire conditions. All fire zones were checked on the display board 10/10/11 by the DOM to ensure the proper zones displayed when tested.</p>	
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K 052	<p>GENERATOR: Type II generator. Fuel source is LP gas.</p> <p>A life safety code survey was initiated and concluded on 09/08/11. 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.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 052	<p>Systemic Changes:</p> <p>The DOM will check and record the results of the fire alarms doors and display zones with his</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator _____ (X6) DATE 10/3/11

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 052 SS=F	Continued From page 1. A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 81 beds with a census of 78 on the day of the survey. The findings include: During the Life Safety Code tour on 09/08/11 at 10:00 AM, with the Director of Maintenance (DOM) a test of the facility fire alarm system revealed the fire doors would close when the alarm was activated but could be reset while in the silent mode to the open position while the system was still showing fire conditions. The silence button on the fire alarm control panel	K 052	monthly Fire Alarm drills for the next three months beginning in October 2011. Monitoring: The Quality Assurance Committee will review the DOM's record of checking the Fire doors and fire zone check monthly beginning in October 2011 and ending December 2011, unless the committee sees it is necessary to continue the review.	10/20/11

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K 052	Continued From page 2 would keep the alarm silenced for a few seconds; however, the reset button would silence the system. The middle corridor zone was tested but the display read as the physical therapy zone on the fire alarm panel. An interview with the DOM on 09/08/11 at 10:15 AM, revealed the DOM was not aware fire doors should not be able to be reset while the fire alarm system was still showing fire conditions. The DOM was not aware of incorrect zones displaying on the fire alarm panel. The DOM was not sure if staff on all shifts could operate the fire alarm system as intended in an emergency situation. Reference: NFPA 72 (1999 Edition). 3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.	K 052			