

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

PRINTED: 11/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/28/2013
NAME OF PROVIDER OR SUPPLIER MILLS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066		
(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/25/13 as alleged.	{F 000}			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066
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F 000	INITIAL COMMENTS A recertification survey was conducted on 10/02/13 through 10/04/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of an "E".	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's "Cart Order and Times", it was determined the facility failed to provide a homelike environment related to the excessive wait time for meals in the dining room for eleven (11) residents. A review of the facility Census and Condition, dated 10/03/13, revealed there was eighty-two (82) residents. The findings include: A review of the facility's "Cart Order and Times" revealed: Lunch: 12:00 - Hall Carts 12:10 - Fine and DRT Dining 12:20 - RTA & CNA Table 12:30 - U Tables.	F 252	F 252 1. The 11 residents were assessed immediately and no negative consequences were found in any of the 11 residents as a result of the residents arriving in the dining room early. 2. The dining locations and arrival times of other residents were reviewed to verify that they were provided with a homelike environment at meal times by not having to wait an excessive amount of time for their meals. This was completed by the Staff Development Nurse, night shift Nursing Supervisor, and DON. 3. Staff responsible for escorting/transporting residents to the dining room were inserviced by the Staff Development Nurse, DON and nursing supervisor beginning on 10/7/13 regarding providing a	

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David K. Lutz

TITLE

Administrator

(X6) DATE

10/25/13

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F 252	Continued From page 1 An observation of the lunch meal in the U-table dining room, on 10/03/13 from 12:15 PM through 1:00 PM, revealed when the surveyor entered there were eleven (11) residents at the U-Tables without a meal tray. The cart came out and the first resident in the U-table dining room was served at 1:00 PM. Attempts to interview the residents were unsuccessful. An interview with Certified Nurse Aide (CNA) #1 and #2, on 10/03/13 at 1:00 PM and 1:30 PM, respectively, revealed, each day the CNAs worked, the CNAs would bring the residents from his/her room to the U-Table dining room for lunch beginning at 11:30 AM. An interview with Kentucky Medication Aide (KMA) #1, 10/03/13 at 1:45 PM, revealed he began taking residents to the dining room for lunch at 11:30 AM. An interview with the Director of Nursing (DON), on 10/04/13 at 2:10 PM, revealed she expected the residents to be in the dining room no more than 30 minutes prior to meal service.	F 252	homelike environment at mealtimes for residents by escorting/transporting residents to the dining areas no earlier than 30 minutes prior to meal arrival. Training was completed by 10/23/13. Dietary staff were inserviced by the Administrator beginning on 10/21/13 on the importance of delivering meal carts at the designated times. Training was completed on 10/23/13. 4. The Staff Development Nurse and DON will monitor the escorting/transporting residents to all dining areas to ensure arrival times are not in excess of 30 minutes prior to meals weekly for the next for 1 month and then monthly thereafter. Weekend observations will be conducted by the Weekend Administrative Designee. The dietary manager/assistant dietary manager will monitor the delivery of meal carts to verify timeliness in accordance to set schedules weekly for the next month and monthly thereafter Results will be reported to the administrator and reviewed by the QA committee during the monthly QA meeting. Any irregularities will be corrected immediately.	10/25/13	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure that the resident environment remains as free of accident hazards as is possible for one (1) of seventeen sampled residents (Resident #13), and for one (1) unsampled resident (Resident B). Observations, on 10/03/13, revealed both residents' medications, as well as the medication cart, were left unsupervised during a medication pass. The findings include: A review of the facility's policy/procedure, "General Dose Preparation and Medication Administration", dated January 2013, revealed "facility staff should not leave medications or chemicals unattended" and "facility staff should ensure that medication carts are always locked when out of sight or unattended." Observation during a medication pass for Resident #13, on 10/03/13 at 10:15 AM, revealed Kentucky Medication Aide (KMA) #1 left unopened packages of medications unsupervised inside the medication administration record book while he went inside the resident's room to speak to him/her. Afterward, he came back to the cart, pulled the unopened medications from inside the medication book, opened the medications, and put the pills in a cup on top of the medication cart. Again, he went inside the resident's room to speak to the resident, leaving the pills in the medication cup unsupervised on top of the medication cart.	F 323	F 323 1. Resident #13 and resident B were assessed immediately and not found to be adversely effected during this medication pass. 2. Other residents receiving medications in this area from KMA#1, were identified and found to have no adverse effects of having access to meds left unsupervised. 3. KMA #1 was pulled immediately from passing medications and inserviced by the Staff Development Nurse and DON covering proper medication administration policies and practices which included not leaving medications unattended and not leaving the medication cart unlocked unattended. KMA #1 was then observed by the Staff Development Nurse to administer medications safely in accordance to facility policies and procedures. A medication pass audit was done by the consultant pharmacist on 10/16/13 to ensure compliance. All nurses and KMAs were inserviced by the Staff Development Nurse and DON on 10/7/13 covering proper medication administration policies and procedures which included never leaving medications unattended and		

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F 323	Continued From page 3 Observation during a medication pass for Resident B, on 10/03/13 at 10:25 AM, revealed KMA #1 pulled medications for the resident. While the surveyor was documenting the medications to be administered to Resident B, KMA #1 walked away from the medication cart to obtain a blood pressure cuff and then went in the room with the resident. The medications, which the surveyor documented for the medication pass, were left on top of the medication cart unsupervised while KMA #1 was still in the resident's room. Additionally, KMA #1 left the medication cart unlocked and unsupervised while in Resident B's room. An interview with KMA #1, on 10/03/13 at 12:30 PM, revealed he had not been observed during a medication pass before, and stated he did not realize there was an issue regarding the unsupervised medications/medication cart. He revealed "I was just nervous." An interview with the Director of Nursing (DON), on 10/03/13 at 12:50 PM, revealed she expected staff to follow the facility's policies/procedures.	F 323	the medication cart unlocked unattended. All nurses and KMAs will be inserviced covering proper medication administration policies and procedures including never leaving medications unattended and never leaving medication cart unlocked at least annually. Nurses and KMAs responsible for delivering medication were observed to verify understanding and adherence to the training by the DON, ADON, SDC and Nursing Supervisors. Inservices were completed on 10/23/13. 4. The Staff Development Nurse and DON will do random medication pass audits on 3 different nurses/KMAs weekly for 1 month and then monthly thereafter to ensure compliance. Results will be reported to the administrator and reviewed by the QA committee during monthly QA meetings. Any irregularities will be corrected immediately. If any areas of concern are identified the frequency and duration of audits will be increased. Re-education will be provided on an individual basis if indicated.	10/25/13	
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 review of the facility's policy/procedure, it was	F 332			

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F 332	<p>Continued From page 4</p> <p>determined the facility failed to ensure it was free of medication error rates of 5% or greater involving one (1) of seventeen (17) sampled residents (Resident #13) and two (2) unsampled residents (Resident A and B). Observation of a medication pass on 10/03/13 revealed there were twenty-eight (28) opportunities with eight (8) medication errors resulting in a 28% medication error rate related to timing.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "General Dose Preparation and Medication Administration", dated January 2013, revealed "verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct time, for the correct resident," and "administer medications within timeframe specified by facility policy."</p> <p>1. A review of Resident A's physician's orders, dated October 2013, revealed "Artificial Tears eye drops, three times daily in both eyes at 8:00 AM, 1:00 PM, and 8:00 PM."</p> <p>Observation of a medication pass for Resident A, on 10/03/13 at 10:00 AM, revealed Kentucky Medication Aide (KMA) #1 administered Artificial Tears eye drops, one drop into each eye.</p> <p>2. A review of Resident #13's physician's orders, dated October 2013, revealed "Lopressor (anti-hypertensive) 50 milligram (mg) tablet, give one tablet orally (po) two times a day at 8:00 AM and 8:00 PM; Cefitin (antibiotic) 250 mg po twice daily times 10 days at 9:00 AM and 9:00 PM; Timoptic (decrease aquas pressure) 0.5% eye</p>	F 332	<p>F 332</p> <p>1. Resident A, resident #13, and resident B were assessed by the ADON and DON to ensure residents did not have any adverse effects related to the medication error. Resident A, resident #13, and resident B's physician was notified of medication error and no new orders were received.</p> <p>2. Residents on the unit receiving meds from KMA#1 have been reviewed by the ADON and DON to ensure no resident has been effected adversely from the untimely administration of medications.</p> <p>3. KMA #1 was pulled immediately from passing medications and inserviced by the Staff Development Nurse and DON covering proper medication administration policies and practices which included the importance of timeliness.</p> <p>The medication delivery process for that unit was reviewed and a portion was re-assigned to expedite the delivery process. KMA #1 was observed by the Staff Development Nurse to administer medications timely in accordance to facility policies and procedures. A medication pass audit was done by the consultant pharmacist on 10/16/13</p>		

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F 332	<p>Continued From page 5</p> <p>drops, instill one drop into each eye every 12 hours at 8:00 AM and 8:00 PM; and FML Forte (anti-inflammatory) 0.25% eye drops, instill one drop into the right eye every 12 hours at 8:00 AM and 8:00 PM."</p> <p>Observation of a medication pass for Resident #13, on 10/03/13 at 10:15 AM, revealed KMA #1 administered Lopressor 50 mg tablet po, Cefitin 250 mg tablet po, Timoptic 0.5% eye drops, one drop into each eye, and FML Forte 0.25% eye drops, one drop into the right eye.</p> <p>3. A review of Resident B's physician's orders, dated October 2013, revealed "Artificial Tears 1.4% drops, instill one drop into each eye four times a day at 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM; Mucinex ER (antihistamine) 600 mg tablet, give one tablet po two times a day at 9:00 AM and 9:00 PM; Metoprolol Tart (anti-hypertensive) 100 mg tablet, give one tablet po two times a day at 9:00 AM and 9:00 PM."</p> <p>Observation of a medication pass for Resident B, on 10/03/13 at 10:25 AM, revealed KMA #1 administered Artificial Tears 1.4% drops into each eye, Mucinex ER 600 mg tablet po, and Metoprolol Tart 100 mg tablet po.</p> <p>An interview with KMA #1, on 10/03/13 at 12:30 PM, revealed when the therapy hall was full it was very time consuming to pass medications. No further explanation was provided.</p> <p>An interview with the Administrator and the Director of Nursing (DON), on 10/03/13 at 12:50 PM, revealed they verbalized an understanding of the medication error rate due to timing of the medication pass. No further explanation was</p>	F 332	<p>to ensure compliance with timely medication pass. Other nurses and KMAs were inserviced by the Staff Development Nurse and DON on beginning on 10/7/13 covering proper medication administration policies and procedures which included the importance of timely medication administration. Training was completed on 10/23/13. Nurses and KMAs will be inserviced covering proper medication administration policies and procedures including the importance of timely medication administration at least annually. All nurses and KMAs were observed administering medication to validate compliance and understanding. Observations were conducted by the DON, ADON, Consultant Pharmacist and Nursing Supervisor and was completed on 10/23/13.</p> <p>4. The Staff Development Nurse and DON will do random medication pass audits on 3 different nurses/KMAs weekly for 1 month and then monthly thereafter to ensure compliance. Results will be reported to the administrator and reviewed by the QA committee during monthly QA meetings. Any irregularities will be corrected immediately. If any areas of concern are identified the</p>		

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F 332	Continued From page 6 provided.	F 332	frequency and duration of audits will be increased. Re-education will be provided on an individual basis if indicated.	10/25/13	

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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: 1976.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1976, upgraded in 1999 with 30 smoke detectors and 5 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1976.</p> <p>GENERATOR: Type II generator installed in 1977. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 10/03/13. Mills Health and Rehab Center was found in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Ninety-Eight (98) beds with a census of Eighty-Two (82) on the day of the survey.</p> <p>The findings demonstrate compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000			
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