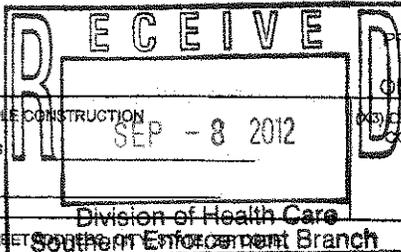


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 09/30/2012
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 _____	(X3) DATE SURVEY COMPLETED 09/16/2012
NAME OF PROVIDER OR SUPPLIER STANTON NURSING CENTER			STREET ADDRESS 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		
F 164 SS=D	<p>A standard health survey was conducted on 08/14-16/12. Deficiencies were identified with the highest scope and severity at "D" level.</p> <p>483.10(e), 483.75(j)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 164	<p>F 164</p> <p><u>Corrective Actions for Targeted Resident(s):</u></p> <p>Resident # 7 was evaluated for any adverse psycho/social issues related to her dignity being violated and none were determined. CNA #1 and LPN #1 were both counseled and inserviced by the Education Training Director regarding the dignity violation and how to maintain, promote, enhance and respect the resident's dignity and individuality.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u></p> <p>All residents have the potential to be affected. An audit was conducted by the Unit Managers for North and South wings, Education Training Director, and the Director of Nursing on all residents receiving personal care to insure that dignity and complete privacy were maintained while they received either a skin assessment or incontinence care. The audit will be completed on or before September 14, 2012.</p>	

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

[Signature]

TITLE

Administrator

(X6) DATE

9/8/12

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

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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and review of the Bill of Resident Rights, the facility failed to ensure personal privacy was provided for one of sixteen sampled residents (Resident #7). Observation on 08/15/12, at 10:00 AM, revealed Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #1 closed the door but failed to close the privacy curtain when they performed a skin assessment and provided incontinence care to Resident #7. Observation revealed Resident #7's incontinence brief and lower extremities were visible/exposed when the CNA left the room to obtain linens and when a staff member opened the door to respond to the call light.</p> <p>The findings include:</p> <p>Review of the facility's Resident's Bill of Rights (effective July 2009) revealed residents had the right to personal privacy during personal care and medical treatment. The Resident's Bill of Rights also revealed each resident had the right to receive care in a manner and in an environment that promoted, maintained, or enhanced the resident's dignity and respect in full recognition of his/her individuality.</p> <p>Observation of a skin assessment of Resident #7 was conducted on 08/15/12, at 10:00 AM. LPN #1 and CNA #1 were observed to enter Resident #7's room and close the door to the room in order to conduct a skin assessment. Staff failed to provide complete privacy for Resident #7 during the skin assessment by failing to ensure the privacy curtain was positioned around Resident #7's bed. During the skin assessment, Resident #7 had an incontinence episode that soiled the</p>	F 164	<p>Systemic Changes: Education Training Director (ETD) will in-service and re-educate all licensed personnel and CNAs regarding the regulation of maintaining privacy and how to maintain, promote, enhance and respect the resident's dignity and individuality. The Unit Managers for North and South Wings, or ETD or DON will audit at least one skin assessment and one incontinence care per week for 4 weeks beginning 10/17/2012.</p> <p>Monitoring: All audit findings 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 September and October 2012 meetings and continued audits will be conducted if recommended by the Quality Performance Improvement Committee.</p>	09/29/2012	

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F 164	<p>Continued From page 2</p> <p>linens on the resident's bed. CNA #1 was observed to open the door and exit the room to obtain linens and as a result Resident #7's lower extremities and incontinence brief were exposed to anyone outside the resident's door. Further observation revealed CNA #1 re-entered the room and Resident #7's lower extremities and incontinence brief remained exposed to anyone that passed by the door. Continued observation revealed Resident #7's call light had been accidentally activated during turning of the resident with the linen change. Staff was observed to knock on the door and open the door and as a result, staff had a direct view of Resident #7's incontinence brief and lower extremities.</p> <p>Interview on 08/15/12, at 4:00 PM, with LPN #1 revealed she should have pulled the privacy curtain around Resident #7's bed before she began the skin assessment. LPN #1 stated she always kept residents covered during any treatment but just failed to pull the privacy curtain for the skin assessment.</p> <p>Interview on 08/16/12, at 12:30 PM, with CNA #1 revealed she was knowledgeable of the requirement to ensure privacy during any care to residents. CNA #1 stated the privacy curtain should have been closed to ensure Resident #7 was not exposed when she left and re-entered the room or if the door was opened.</p> <p>Interview on 08/16/12, at 12:45 PM, with the Director of Nursing (DON) revealed staff was required to provide privacy by closing the door and pulling the privacy curtain around the bed for any treatment or when providing care to residents. The DON stated staff should always</p>	F 164			

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F 164 F 312 SS=D	Continued From page 3 respect residents' dignity. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one of sixteen sampled residents (Resident #3). The facility failed to provide nail care for Resident #3. Observations on 08/15/12, during a skin assessment, revealed Resident #3 had excessively long toenails. The findings include: The facility failed to provide a policy to direct staff related to providing nail care. According to the facility's Regional Nurse Consultant, staff was required to provide nail care to residents as needed. Review of the medical record revealed Resident #3 was admitted to the facility on 05/16/12, with diagnoses of Seizure Disorder, Cerebral Vascular Accident with left sided Hemiparesis, and Schizophrenia. Review of the monthly physician's	F 164 F 312	F 312 <u>Corrective Actions for Targeted Resident(s):</u> Resident #3 received nail care the evening of 8/15/2012. Resident #3 has been referred to the Podiatrist for follow up. The Podiatrist saw and treated resident #3 on 08/23/2012, with no negative outcomes. The Inter Disciplinary Team has revised Resident #3's Care Plan to ensure his nail care and other ADLs are being provided. LPNs #3, and #4, are being counseled regarding initialing the TAR without verifying the care was provided. CNA #3 has also been counseled for failing to provide the toe nail care for resident #3. <u>Identification of Other Residents with Potential to Be Affected:</u> All residents have the potential to be affected. An audit will be completed by the Unit Managers for North and South wings, Education Training Director, and the Director of Nursing on all dependent residents receiving ADL care. This audit reviewed the ADLs of dependent residents to ensure services were being provided from good nutrition, grooming, and personal and oral	

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F 312	<p>Continued From page 4</p> <p>orders for August 2012 revealed Resident #3 would receive podiatry, eye, dental, and psychiatric consultations as needed. Further review of the monthly physician's orders revealed staff was to trim Resident #3's fingernails and toenails every Sunday. Further review of the medical record revealed Resident #3 had not had a podiatry consultation since admission to the facility. Review of the initial admission Minimum Data Set (MDS) assessment completed on 05/24/12, revealed Resident #3 required extensive assistance of two staff members for personal hygiene needs. Review of the comprehensive care plan for activities of daily living (ADL) revealed Resident #3 would receive nail care as needed. Review of the weekly skin assessment revealed no documentation of the condition of Resident #3's toenails. Review of the August 2012 Treatment Administration Record (TAR) revealed staff had initialed the TAR to indicate that Resident #3 received nail care on 08/05/12 and 08/12/12.</p> <p>Observation during a skin assessment provided by the wound care nurse, Licensed Practical Nurse (LPN) #2, on 08/15/12, at 2:30 PM, revealed Resident #3's toenails were excessively long. Interview with LPN #2 during the skin assessment revealed the resident needed to be seen by the podiatrist and she would inform the nurses to add Resident #3 to the podiatry list. LPN #2 revealed she was responsible for wound care/treatments and was not required to cut residents' nails.</p> <p>Interview on 08/15/12, at 3:00 PM, with LPN #1, who was assigned to provide care for Resident #3, revealed Certified Nurse Aides (CNAs) were</p>	F 312	<p>hygiene. This audit will be completed on or before 9/14/2012.</p> <p>Systemic Changes: The Wound Care Nurse will routinely observe nail care when completing a skin assessment and immediately report any adverse findings to the Unit Manager and DON. Nursing Staff will be re-educated by the ETD, or DON or Unit Managers on the Policies and Procedures (P/P) regarding ADL care with a specific emphasis on nail care. The Unit Managers for North and South Wings, or ETD or DON will audit at least one resident dependent for ADLs per week for 4 weeks beginning 10/17/2012. Audit findings that are adverse will be corrected immediately and counseling will be performed with the staff involved.</p> <p>Monitoring: All audit findings 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 September and October 2012 meetings and continued audits will</p>		

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F 312	<p>Continued From page 5</p> <p>responsible for Resident #3's nail care and licensed staff was to cut the toenails of residents who had a diagnosis of Diabetes. Upon review of the TAR and observation of Resident #3's excessively long toenails, LPN #1 acknowledged staff had not trimmed Resident #3's toenails as indicated on the TAR</p> <p>Interview on 08/15/12, at 3:15-3:30 PM, with LPN #3 and LPN #4 revealed they initialed the TAR on 08/05/12 and 08/12/12, but stated they had not checked to ensure the CNA assigned to provide care to Resident #3 had performed the nail care. LPN #3 stated she should have checked and made sure the CNA had trimmed Resident #3's nails before initialing the TAR. LPN #4 stated she failed to check Resident #3's nails before initialing the TAR and acknowledged she should not sign/initial the TAR unless the treatment was done.</p> <p>Interview on 08/15/12, at 4:10 PM, with the Unit Coordinator (UC) revealed nail care is generally conducted on Sunday. The UC stated CNAs are responsible for resident's nail care if the resident does not have a diagnosis of Diabetes. The UC stated she had worked on 08/05/12, and nail care was provided for residents. Upon observing the condition of Resident #3's toenails, the UC confirmed the nails had not been trimmed as indicated on the TAR. The UC confirmed Resident #3 had not been evaluated by the podiatrist on the 06/20/12 or 07/09/12 visit.</p> <p>Interview on 08/16/12, at 8:20 AM, with CNA #3, who was assigned to provide care to Resident #3 on 08/05/12, revealed she failed to trim Resident #3's toenails and should have communicated that</p>	F 312	be conducted if recommended by the Quality Performance Improvement Committee.	09/29/2012	

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F 312	Continued From page 6 to the nurse. CNA #3 stated she had a heavy assignment and clipped Resident #3's fingernails but did not clip the toenails as assigned.	F 312	<p>F 329 <u>Corrective Actions for Targeted Resident(s):</u> Resident #9 had the Imodium discharged on 8/15/2012 at 6 PM. There were no adverse outcomes related to the unnecessary medication. <u>Identification of Other Residents with Potential to Be Affected:</u> All residents have the potential to be affected. The DON, Unit Managers and Education Training Director will audit all records by 09/23/2012, to ensure all medications have diagnosis and all medication regimes are free of unnecessary medications – any issue identified will be immediately corrected. The Pharmacy Consultant will complete a 100% audit of all records to ensure all resident's medication regime is free from any unnecessary drug and all drugs have the appropriate diagnosis by 09/25/2012 – any issue identified will be immediately corrected.</p> <p><u>Systemic Changes:</u> All licensed nursing staff will be re educated by the ETD regarding the writing of orders for anti-diarrheal medications to ensure they have a "stop date".</p>		
F 329 SS=D	<p>483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS:</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure medications were not administered without adequate indications for their use, for an</p>	F 329			

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F 329	<p>Continued From page 7</p> <p>excessive duration, and without adequate monitoring for one of sixteen sampled residents (Resident #9). Facility staff administered 2 milligrams of Imodium to Resident #9 three times a day from 03/26/12 through 08/15/12, without adequate indications for its use.</p> <p>The findings include:</p> <p>Interview with the Regional Nurse on 08/16/12, at 4:18 PM, revealed the facility did not have a policy related to unnecessary drugs, pharmacy reviews of medications, or the monthly changeover of orders.</p> <p>Review of Resident #9's medical record revealed the facility admitted the resident on 04/20/07, with diagnosis to include Aspiration Pneumonia, Hypertension, Non-Insulin Dependent Diabetes Mellitus, Dementia, GERD, Malnutrition, and Constipation. Review of Resident #1's physician's orders revealed an order written on 03/26/12, for 2 milligrams (mg) of Imodium (an anti-diarrrhea) to be administered three times per day for diarrhea. In addition, 100 mg of Colace (stool softener) had been ordered on 08/11/11, to be administered every morning. A review of Resident #9's Medication Administration Record (MAR) revealed facility staff had administered 2 mg of Imodium every day, three times per day as ordered, since 03/26/12 until 08/15/12. A review of Resident #1's bowel record from March 2012 through August 2012 revealed the resident had only experienced a few episodes of diarrhea.</p> <p>Interview with Registered Nurse (RN) #3 on 08/16/12, at 10:05 AM, revealed the RN had administered the Imodium and the Colace to</p>	F 329	<p>Additionally, all licensed nursing staff will be re-educated on the use of Unnecessary Drugs.</p> <p>Monitoring: The DON, Unit Managers and ETD will audit at least 10 records randomly each week for 4 weeks beginning October 1, 2012, then at least 20 records monthly for two months beginning November 2012. The Pharmacy Consultant is to review all records monthly for use of unnecessary medications beginning September 2012.</p>	09/29/2012	

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F 329	Continued From page 8 Resident #9 as ordered by the physician. RN #3 stated that she had not paid attention to the types of medication she administered to Resident #9 and acknowledged she should have contacted the resident's physician to have the Imodium discontinued or changed to as needed for diarrhea. Interview with Unit Manager (UM) #1 on 08/15/12, at 4:38 PM, revealed the Imodium prescribed for Resident #9 should have been ordered for 2-3 days to treat a stomach virus the resident had at the time the order was written, and stated a "stop date" should have also been noted for the medication. The UM acknowledged that based on a review of documentation Resident #9 had not experienced diarrhea on a daily basis and stated the order for the Imodium should have been identified when the pharmacist conducted the monthly review of the resident's medication and/or by the resident's physician. Interview the Consultant Pharmacist on 08/16/12, at 10:20 AM, revealed the Imodium order should have included a stop date of "2-3 days," and stated the administration of the Imodium administered with the Colace should have been identified and questioned by the pharmacist at the time the monthly drug review was conducted.	F 329		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356	F 356 <u>Corrective Actions for Targeted Resident(s):</u> No specific resident was identified. All residents have the potential to be affected. The Corrected Posted Nurse Staffing Information (including census) was posted on 8/15/2012 at approximately 5:30 PM in a prominent place – in the front lobby. The Posted Nurse Staffing has been posted each shift and day since 08/15/2012. <u>Identification of Other Residents with Potential to Be Affected:</u> All residents have the potential to be affected.	

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F 356	<p>Continued From page 9</p> <p>unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the nurse staffing or the resident census was in a prominent place and readily accessible to residents and visitors.</p> <p>The findings include:</p> <p>Observations of the facility on 08/14/12 and 08/15/12, revealed the nurse staffing and the resident census had not been posted in a prominent place that was accessible to residents</p>	F 356	<p>Systemic Changes:</p> <p>The DON, Unit Managers and Weekend Managers are now responsible for posting the Nurse Staff Information, on a daily basis at the beginning of each shift. The DON, Unit Managers or Human Resource Specialist will file the previous day(s) Posted Nurse Staffing Information Sheet in a binder to be maintained for a minimum of 18 months.</p> <p>Monitoring:</p> <p>The Administrator or Human Resource Specialist will inspect the daily posting at least three times a week for four weeks beginning 09/05/12 and then one time a week for the next two months beginning October 2012. The Posted Nurse Staffing Information sheet binder will be brought to QPI meeting for the next two months beginning September 2012.</p>	09/29/2012

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

PRINTED: 08/30/2012
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 _____	(X3) DATE SURVEY COMPLETED 08/16/2012
NAME OF PROVIDER OR SUPPLIER STANTON NURSING 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 356	Continued From page 10 and visitors. Observations of the North and South nurses' station revealed a list of staff working on each unit posted behind the nurses' station, but the list was not in view of the public and did not include the facility census. Interview with the Director of Nursing (DON) on 08/15/12, at 4:15 PM, revealed the DON had never posted the number of nursing staff responsible for resident care or the resident census sheet in the facility and was not aware of the requirement. The interview further revealed the DON posted the staffing for each day at each of the nurses' stations but it was kept behind the desk and did not contain the census of the facility. The Regional Nurse acknowledged in interview conducted on 08/15/12, at 4:18 PM, that the staffing and census were not posted in a prominent place as required. The Regional Nurse stated she was not aware the signage had not been posted. Interview with the Administrator on 08/15/12, at 4:20 PM, revealed although nurse staffing was posted at each nurses' station, the posting was not in view of the public and did not contain the resident census.	F 356		
F 431 SS=D	463.60(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	F 431	F 431 <u>Corrective Actions for Targeted Resident(s):</u> No specific resident was identified. All residents have the potential to be affected. <u>Identification of Other Residents with Potential to Be Affected:</u> The Director of Nursing (DON) and North and South Unit Managers are 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 09/21/2012. Any medication opened and not dated will be discarded, reordered and dated by the UM upon arrival from pharmacy.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2012
NAME OF PROVIDER OR SUPPLIER STANTON NURSING 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 431	<p>Continued From page 11 reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of manufacturer's guidelines, and review of facility policy/procedure, it was determined the facility failed to ensure medication for resident use was not expired. A multi-dose vial of Tuberculin Purified Protein Derivative (PPD) was available for use and had not been dated when opened as required.</p>	F 431	<p>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 09/21/2012. Consultant 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 09/21/2012. A Pharmacy representative will be required to audit all medication rooms and medication refrigerators for expired or undated opened medications by 09/28/2012. 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 09/10/2012. 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 09/10/2012.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2012
NAME OF PROVIDER OR SUPPLIER STANTON NURSING 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 431	<p>Continued From page 12</p> <p>The findings include:</p> <p>Review of the facility policy/procedure, "Storage and Expiration Dating of Drugs, Biologicals, Syringes and Needles," dated as effective 12/01/07, revealed once any drug or biological package was opened, the facility should follow manufacturer or supplier guidelines with respect to expiration dates for opened medications.</p> <p>Review of the manufacturer's guidelines on the label of the Tuberculin Purified Protein Derivative (PPD) revealed "once entered the vial should be discarded after 30 days."</p> <p>Observation of the medication refrigerator on the North Hall on 08/15/12, at 2:12 PM, revealed an open vial of PPD. The vial was not dated to indicate when the vial was first entered.</p> <p>Interview on 08/15/12, at 2:12 PM, with Licensed Practical Nurse (LPN) #1 revealed staff was required to date all vials when opened to ensure they would be discarded on the expiration date.</p>	F 431	<p>Monitoring:</p> <p>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 09/28/2012.</p>	09/29/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2012
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	
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: SNF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: 6</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II generator. Fuel source is LP gas.</p> <p>A life safety code survey was initiated and concluded on 08/16/12, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 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.