



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

2nd SOD

PRINTED: 04/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/26/2015
NAME OF PROVIDER OR SUPPLIER  TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823	
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F 000  F 155 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted on 03/24-26/15. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p><b>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</b></p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart l of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure one (1) of fifteen (15) sampled residents (Resident #12) was afforded the right to formulate an advance directive. A review of the</p>	F 000  F 155	<p>Tri-Cities Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.</p> <p>Tri-Cities Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tri-Cities Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p><b><u>ID Prefix Tag F155</u></b></p> <p>The facility will continue to maintain written policies and procedures regarding advance directives including providing written information to all adult residents concerning the right to</p>	

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

TITLE

(X6) DATE

04/20/2015

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 155	<p>Continued From page 1</p> <p>record revealed no evidence the facility offered/reviewed advance directives with Resident #12 or the resident's family upon admission to the facility.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Advance Directives," dated January 2009, revealed upon admission the facility will determine whether the resident had advance directive documents. If so, the resident/family will provide a copy to the facility. Documentation of the existence of any advance directive will occur in the resident's medical record by the social worker or designated staff member, as indicated.</p> <p>Review of the medical record for Resident #12 revealed the resident was admitted to the facility on 02/14/07 with diagnoses that included Chronic Airway Obstruction, Hypertension, Retention of Urine, Acute Cerebrovascular Disease, Anemia, Acute Kidney Failure, Anxiety, Congestive Heart Failure, Degenerative Disc Disease, Depression, Diabetes without complications Type 2, Lumbosacral Spondylosis without Myelopathy, Morbid Obesity, Muscle Weakness, Neurogenic Bladder, Chronic Bronchitis, Osteoarthritis, Psoriasis, Gastritis, Chronic Pulmonary Heart Disease, and Constipation. Further review of the record revealed no evidence that the facility provided written instructions for advance directives to the resident or the resident's family.</p> <p>Interview with the Admissions Coordinator on 03/26/15 at 3:25 PM revealed that the advance directive information was not in the resident's record as required. The Admissions Coordinator stated she was not working on the day Resident</p>	F 155	<p>accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive.</p> <p>On 04-15-2015, resident #12 was given the facility's advance directive information and the resident signed acknowledgement of receiving such information.</p> <p>A 100% audit was completed by the admissions director on 04-15-2015 checking for the signed acknowledgement of receiving such information in their medical record. Those found without signed acknowledgements were provided with the written information and new acknowledgements signed. An in-service was provided by the administrator to the admissions and social services personnel on 4-15-2015 regarding documenting that the facility provided written information on advance directives. The documentation will include the facility's "Receipt Acknowledgement" form and documentation in the chart.</p> <p>The Medical Records clerk will audit new admissions for signed "Receipt Acknowledgements" for two months to ensure compliance.</p>		

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F 155	Continued From page 2 #12 was admitted and did not know if it was done or not. The Admissions Coordinator stated that it should have been in the record, but facility staff was unable to locate the information.	F 155	Audit results will be forwarded to Administrative/Executive Committee for follow up as appropriate and to determine the frequency and/or need for continued monitoring.  <u>ID Prefix Tag F 315</u>  The facility will continue to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections (UTI) and to restore as much normal bladder function as possible.  Resident #4 was admitted to facility on 9-4-2014 with diagnoses of Congestive Heart Failure, Esophageal Reflux, Hyperlipidemia, Anxiety, and End Stage Renal Disease. Review of the Care Plan 9-5-2014 dated revealed the resident required an indwelling catheter with routine catheter care. Residents BMP on 1-8-2015 revealed GFR 11, BUN 111 and Crea 4.2. Resident does not desire labs, has	4-24-15	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure appropriate treatment and services were provided to prevent infections of the urinary tract for one (1) of fifteen (15) sampled residents (Resident #4). During observations of catheter care for Resident #4, facility staff was observed to clean the catheter tubing toward the urethra (urinary opening to pass urine outside the body), which was not acceptable according to facility policy.  The findings Include:  Review of the facility's policy titled "Perineal Care" (dated April 2013) revealed staff would clean around the meatus (opening of the urethra) and				

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F 315	Continued From page 3 then the catheter tubing.  Review of the medical record revealed Resident #4 was admitted to the facility on 09/04/14 with diagnoses of Congestive Heart Failure, Esophageal Reflux, Hyperlipidemia, Anxiety, and End Stage Renal Disease. Review of the Care Plan dated 09/05/14 revealed the resident required an indwelling catheter with routine catheter care.  Observation of catheter care for Resident #4 on 03/25/15 at 10:10 AM with State Registered Nurse Aide (SRNA) #1 revealed the SRNA cleaned the catheter tubing approximately six inches toward the meatus rather than away from the meatus.  Interview with SRNA #1 on 03/25/15 at 3:30 PM revealed staff had been trained to clean the perineal area from front to back and clean catheter tubing four inches away from the urinary meatus. The SRNA further stated she knew she had cleaned the catheter tubing using the wrong technique.  Interview with the Director of Nursing (DON) on 03/26/15 at 4:45 PM revealed competency checks were done yearly with all SRNAs for catheter care. She further revealed staff was trained on catheter care to wash from dirty to clean and to clean the catheter tubing away from the urinary meatus. The DON also stated no problems had been identified with catheter care.	F 315	refused dialysis, transportation to hospital if needed and refused follow-up appointments with urologist. Resident is aware of her medical condition and elects to stay at facility until kidney function ceases completely. Resident has history of UTI's and has not displayed any symptoms of UTI since admission. Resident refused to have any urinalysis done because she knows nothing much can be done for her condition and just wants to stay here until the end of her life.  Resident has order for Foley catheter changed as needed for dislodgement, occlusion and encrustation. After the observation was noted on 3-25-2015 at 10:10 am, the resident received proper Foley catheter care by SRNA.  The toileting program was reviewed by ADON to see if any other residents had potential to have Foley catheters removed and have bladder function restored. No residents were identified as having a potential to have Foley catheters removed and toileting program initiated.		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from	F 329	The infection control percentage for residents in the facility has not noted any increase with UTI's during the past		

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F 329	<p>Continued From page 4</p> <p>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, record review, and review of facility policies, it was determined the facility failed to ensure three (3) of fifteen (15) sampled residents (Residents #5, #9, and #11) were free from unnecessary drugs. Resident #5's Lexapro (antidepressant medication) 10 mg (milligrams) was increased on 01/08/13 from 10 mg daily to 20 mg daily. On 01/24/14, Resident #5's Lexapro was decreased back to 10 mg every day. There was no evidence the facility attempted Gradual Dose Reductions (GDRs) since 01/24/14. Resident #9 was admitted to the facility on</p>	F 329	<p>Quarter and 100% audit done by DON noted all residents with Foley catheters had diagnoses for catheter and notation on the residents care plan for Foley catheter care.</p> <p>On March 27, 2015, an in-service was provided by the Staff Development Nurse on proper perineal care and Foley catheter care to male and female residents with visual observation and skills checklist. 100% attendance by SRNA's was completed on 4-6-2015. The two SRNA's who were observed providing Foley catheter care by the surveyor were in-serviced on March 27, 2015.</p> <p>The facility will continue with Annual skills checklist for all SRNAs. The Staff Development Nurse will delegate which SRNA's are to be audited for Foley catheter/perineal care. Licensed Charge Nurses will observe and complete the skills check list for Foley catheter care/perineal care for the 10 selected SRNAs weekly x 1 month, then five SRNA's weekly x1 month.</p> <p>The facility will add to the Treatment Administration Records sign-offs that Foley catheters are secured, and the insertion site is free of encrustations, redness and drainage. This will be done daily on 7-3 shift and as needed.</p>	

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F 329	<p>Continued From page 5</p> <p>10/03/14 with Lexapro 10 mg daily. There was no evidence the facility attempted a GDR since admission to the facility. Resident #11 was admitted to the facility on 06/11/13 with Wellbutrin SR (antidepressant medication) 150 mg every day and there was no evidence a GDR had been attempted since admission to the facility.</p> <p>The findings include:</p> <p>Review of facility policy entitled "Psychopharmacological Drug Therapy," (not dated) revealed GDRs would be attempted with residents who receive psychopharmacological medications, unless clinically contraindicated.</p> <p>1. Review of the medical record revealed the facility admitted Resident #11 with diagnoses of Dementia, Altered Mental Status, Anxiety State, Diabetes, Depressive Disorder, and Congestive Heart Failure. Review of the Medication Administration Record (MAR) revealed Resident #11 started Wellbutrin SR (Antidepressant) 150 mg 1 tablet every day on 06/11/13, when Resident #11 was admitted to the facility. Review of the Drug Regimen Sheet that is reviewed/signed by the Pharmacist monthly, revealed there had not been any GDRs since 06/11/13.</p> <p>2. Review of the record for resident #5 revealed that resident was admitted to the facility on 12/08/08 and then readmitted on 11/23/14 with diagnoses that included Depressive Disorder not elsewhere classified, Dementia - unspecified with behavior disturbances, Anxiety state, and Alzheimer's Disease. Review of the consultant pharmacist notes revealed Resident #5 was on Lexapro (antidepressant medication) daily.</p>	F 329	<p>The Staff Development Nurse will bring her audit list to the DON and this will be reviewed monthly and presented to the Administrator and the Executive QI Members. If any problems are noted before the Executive QI Meeting monthly the DON will be taking immediate action to correct any problems occurring with residents Foley/perineal care.</p> <p>The Treatment Nurses were in-serviced on 4-10-15 to inform the DON immediately if any issues noted with Foley catheters.</p> <p><b><u>ID Prefix Tag F 329</u></b></p> <p>The facility will continue to ensure that resident who have not used antipsychotic drug therapy 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 (GDRs), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Resident #5's psychotropic medications were reviewed by the ADON and the MD was notified about the need for a GDR. The Nurse Practitioner discontinued Xanax 1mg po qday prn</p>	4-14-15

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F 329	<p>Continued From page 6</p> <p>Further review of consultant pharmacist notes revealed a recommendation for a GDR of Lexapro on 12/22/13 from 20 mg daily to 10 mg daily. Consultant pharmacist notes dated 01/24/14 revealed that Lexapro was decreased as recommended. Further review of the consultant pharmacist notes revealed no further GDRs were attempted.</p> <p>3. Review of the record for Resident #9 revealed that the resident was admitted on 10/03/14 with diagnoses that included Major Depressive Disorder and Senile Dementia. Review of consultant pharmacist notes revealed Resident #9 was on Lexapro (antidepressant medication) daily. Further review of the consultant pharmacist notes revealed no recommendation for a GDR and no evidence in the record that a GDR had been attempted.</p> <p>Interview with the Director of Nursing (DON) on 03/26/15 at 4:45 PM revealed Social Services and Minimum Data Set (MDS) nurses were responsible for auditing charts and checking for GDRs. She further revealed the Pharmacist visits monthly, checks all the charts, and makes the final recommendations. She stated she had not identified any problems with GDRs.</p> <p>Interview with the facility's Pharmacist on 03/26/15 at 5:00 PM revealed she was out of her office and was unable to obtain any resident information at that time. She further stated she would fax any information on the GDRs for Residents #5, #9, and #11. No information was received from the Pharmacist regarding GDRs.</p>	F 329	<p>for agitation. A request to the attending physician for further GDR's on Lexapro medication changes on 3-24-2015 &amp; 3-25-2015 were refused by the physician and a Psychopharmacological Medication Dose Reduction Request was done.</p> <p>Resident #9 psychotropic medications were reviewed by the ADON on 3-30-2015 and MD was notified about the need for a GDR and Lexapro was reduced to Lexapro 5mg po qday as GDR.</p> <p>Resident #11 psychotropic medications were reviewed by ADON on 3-30-2015 and MD was notified about the need for a GDR and Wellbutrin SR 150mg was reduced to Wellbutrin 100mg po q day.</p> <p>A 100% audit was conducted by the DON, MDS and Second MDS nurse on 4-8-2015 and 4-9-2015. These recommendations were given to the facility's pharmacy consultant. Pharmacy team reviewed charts on 4-12-2015 with further GDR's noted. Attending physicians were provided recommendations and Pharmacological Dose Reduction signed as indicated.</p> <p>The DON and Second MDS nurse will do a review of each resident's chart when their quarterly, significant changes</p>	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	Continued From page 7  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure physician ordered medications were available for resident use. During observation of the morning medication pass on 03/25/15, an LPN (Licensed Practical Nurse) was observed to take/borrow a Ferrous Sulfate 325 mg (milligram) tablet from one resident's medications and administer the medication to another resident, Resident A.  The findings include:  Review of the facility policy titled "Ordering	F 425	and annual assessments are due and review for GDR's. The list will be given to the attending physicians/Pharmacy Team and Psychopharmacological Medication Dose Reduction Form will be completed and signed by physician as indicated.  This list will be reviewed monthly by the Administrator, DON, MD, Pharmacy Team and Executive QI Committee with recommendations and changes as indicated.  <u>ID Prefix F 425</u>  The facility will continue to ensure physician ordered medications are available for resident use.  Pharmacy was notified of licensed nurse borrowing ferrous sulfate 325mg po and medication was replaced by pharmacy to the resident from which medication was initially borrowed. Resident received new box of ferrous sulfate 325mg the evening of occurrence. Through a 100% audit completed by ADON on 4-13-15, all residents were identified as being at risk for medications being borrowed by licensed staff who give medications. All resident	4-14-15	

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F 425	Continued From page 8 Medications from the Pharmacy," not dated, revealed that routine medication refills were to be ordered from the pharmacy using the "automatic reorder sheet." Further review of the policy revealed the policy did not address the "borrowing" of resident medication.  Review of Resident A's medical record revealed the resident had a physician's order to receive Ferrous Sulfate 325 mg once daily. Observation of the morning medication pass on 03/25/15 revealed the LPN borrowed a Ferrous Sulfate 325 mg tablet from another resident and administered the medication to Resident A.  Interview with the LPN on 03/25/15 at 9:42 AM revealed Resident A was out of Ferrous Sulfate and she would call the pharmacy to reorder. The LPN stated she borrowed the medication from another resident to give to Resident A. The LPN stated that it was acceptable to borrow resident medications as long as the medication was not a narcotic.  Interview with the Director of Nursing (DON) on 03/26/15 at 4:45 PM revealed that the facility policy did not address borrowing medications. However, the DON stated nursing staff was not permitted to borrow medications from one resident to another.	F 425	refill tabs had been removed and sent to pharmacy.  All medication nurses were in-serviced on 3-27-15 for correct procedure to follow if residents do not have their medications available and on our back-up measures and which pharmacy's the facility uses for back-up.  A missing medication QI form will be filled out if residents do not have medications available.  Staff in-serviced they can contact the attending physician for a substitution in the emergency medication box if the medication initially ordered is not available.  ADON will check medication carts weekly to ensure labels for reordering have been pulled. This audit will be for three months.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463	Results from the QI's completed by licensed staff and ADON audits will be discussed by the administrator/QI Executive Committee monthly for three months for any trends with facility not having medications for residents. Results will also be shared with the consulting pharmacist and facility pharmacy as needed.	4-15-15

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PRINTED: 04/28/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/26/2015
NAME OF PROVIDER OR SUPPLIER  TRI-CITIES NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823	
(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 463	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy it was determined the facility failed to ensure a functioning communication/call system was in place for one (1) of three (3) resident shower rooms. Observations on 03/25/15 revealed the communication system utilized by residents was not functioning properly for the (Rail Road Crossing) shower room.</p> <p>The findings include:</p> <p>Interview with the Administrator on 03/26/15 at 3:25 PM revealed there was no call light policy.</p> <p>Observation of the Rail Road Crossing shower room on 03/25/15 at 10:42 AM revealed four separate call activation cords in the shower room. When all four of the call light cords were activated, the light above the outside of the shower room door did not illuminate and there was no audible alarm. Therefore, staff did not respond to the activated call light.</p> <p>Interview with the Maintenance Supervisor on 03/25/15 at 1:25 PM, revealed the nursing staff performed audits on the call lights randomly. He stated he was unaware the call light was not working in the Rail Road Crossing shower room and had not received a work order for the non-functioning call light. Further interview with the Maintenance Supervisor revealed when a call light is activated there is a light above the door that should be illuminated as well as an alarm that should sound at the nurses' station.</p>	F 463	<p><b><u>ID Prefix Tag F 463</u></b></p> <p>The facility will continue to ensure a functioning communication/call system is in place for resident shower rooms.</p> <p>On 03-25-2015, the other two resident shower rooms in the facility were checked and in working order. In addition, on 3-27-15 the DON and QI nurse audited all call bells in the facility to ensure proper working order.</p> <p>On 3-26-2015, the facility contractor for the call bell system was on sight and determined that the due to the age of the system, there were no parts for repair. The shower room was placed out of order with a barrier to prevent residents from entering. The shower room remained out of service until repairs were made on 4-29-15 and it was placed back in service.</p> <p>The facility will continue to use the "Maintenance Work Order" to ensure that call bells functioning properly. Staff was inserviced on 4-27-15 on filling out work orders and reporting non-functioning call bells.</p> <p>"Maintenance Work Orders" regarding call bells will be forwarded to Administrative/Executive Committee</p>	

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F 463	Continued From page 10  Interview with Registered Nurse (RN) #1 (who is also the Quality Improvement Nurse) on 03/25/15 at 1:16 PM, revealed she performed monthly and random call light audits but had not checked the shower rooms. Interview with RN #1 revealed she was not aware the call light was not properly working. RN #1 stated to her knowledge no other staff was monitoring the functioning of the call light system in the Rail Road Crossing shower room. According to RN #1, she had not received complaints related to the shower room call light not functioning properly.  Interview with the Director of Nursing (DON) on 03/26/15 at 4:37 PM, revealed there was no policy on monitoring call lights. Further interview with the DON revealed the Quality Improvement Nurse performs random call light audits to ensure the call lights are in working order. Further interview with the DON revealed she was not aware the call light in the Rail Road Crossing shower room was not functioning properly.	F 463	for follow up as appropriate and to determine the frequency and/or need for continued monitoring. A monthly audit to check for non-functioning call bells will be performed by maintenance.	5-4-15	

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NAME OF PROVIDER OR SUPPLIER  <b>TRI-CITIES NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823</b>	
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1998</p> <p>SURVEY UNDER: 2000 Existing (using 2786S Short Form)</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (111)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Natural gas generator</p> <p>A life safety code survey was initiated and concluded on 03/24/15. 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 for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000	<p>Tri-Cities Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.</p> <p>Tri-Cities Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tri-Cities Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p><b>ID Prefix Tag K 045</b> The facility will continue to maintain emergency lighting at exits.</p>	
K 045 SS=E	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>	K 045		

RECEIVED  
APR 20 2015  
Division of Health Care  
Southern Enforcement Branch

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



TITLE



(X8) DATE

4-17-15

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 045	<p>Continued From page 1</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain emergency lighting at exits according to NFPA (National Fire Protection Association) standards. This deficient practice affected three (3) of six (6) smoke compartments, facility staff, and approximately forty (40) residents. The facility has the capacity for eighty-five (85) beds with a census of sixty-five (65) on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 03/24/15 at 2:00 PM with the Director of Maintenance (DOM), an exterior exit light fixture located at the north wing of the facility was observed to be a single bulb lighting fixture. Further observations revealed exterior exits located on the south wing and service hall wing were also observed to have a single bulb fixture. An exterior light fixture is required to have more than one bulb so that if one bulb burns out, the exit will not be left in darkness. An interview with the DOM on 03/24/15 at 2:00 PM revealed the fixture had a single bulb. The DOM stated he was not aware that exterior lighting should contain more than one bulb.</p> <p>The findings were revealed to the administrator</p>	K 045	<p>The facility has contracted with our electrical supplier on 4-17-15 to replace the lights installed and certified when the facility opened in 1997 with new fixtures with more than a single bulb.</p> <p>Once the new fixtures are received, the facility's contracted electrician will install the new fixtures.</p> <p>The facility will continue to use the "Maintenance Work Order" to ensure that exterior exit lights are functioning properly. "Maintenance Work Orders" regarding exterior exit lights will be forwarded to Administrative/Executive Committee for follow up as appropriate and to determine the frequency and/or need for continued monitoring.</p>	5-4-15

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K 045	Continued From page 2 during the exit conference.  Reference: NFPA 101 (2000 Edition).  7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. A.7.8.1.4 An example of the failure of any single lighting unit is the burning out of an electric bulb.	K 045			