

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

PRINTED: 12/10/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>335344</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/22/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHASE MEMORIAL NURSING HOME CO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>ONE TERRACE HEIGHTS NEW BERLIN, NY 13411</b>	
(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 282 SS=D	<p>483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon staff interviews and record reviews conducted during the annual survey, it was determined that for 1 of 16 sampled residents, the comprehensive care plan was not implemented as written for Resident #3. Specifically, facility staff did not counsel Resident #3 on a periodic basis regarding exceeding his 1500cc (cubic centimeter) fluid restriction. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>1) Resident #3 has a diagnosis of end stage renal disease. The August 8, 2007 current physician orders noted the resident received dialysis treatments three times a week and was on a 1500 cc fluid restriction. The facility's fluid plan for the resident was to provide 1080 ccs of fluid during meals, 240 ccs of fluid during medication passes and 120 ccs of fluid during a nighttime snack, for a total 1440 ccs in a 24 hour period. The resident's Intake and Output record from June 11, 2007 through August 20, 2007 showed the resident periodically exceeded the 1500 ccs fluid restriction. Specifically, for the period August 1, 2007 through August 20, 2007, the resident exceeded his 1500 cc fluid restriction on 10 of the 20 days. When the resident exceeded his</p>	F 282		10/12/07

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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F 282	<p>Continued From page 1</p> <p>1500 cc fluid restriction, the resident's intake ranged from 1580 to 2070 ccs of fluid per day.</p> <p>The June 21, 2007 Comprehensive Care Plan noted that the resident exceeded the fluid restriction 1 to 2 times per week. Among the Comprehensive Care Plan approaches was to alert the resident "when he request fluids that exceed his fluid restriction". A review of the nursing notes from June 11, 2007 through August 20, 2007 did not record any instances in which facility staff counseled the resident about the risks of exceeding his 1500 cc fluid restriction.</p> <p>During an August 21 , 2007 interview with the registered nurse manager and the diet technician at 1:15 PM, they stated the resident requested additional fluid and, at times, took extra fluid without the staff 's knowledge. They agreed that there was no documentation of any counseling of the resident regarding exceeding the fluid restriction.</p> <p>In summary, facility staff did not have evidence the resident was counseled on a periodic basis regarding exceeding his 1500 cc fluid restriction.</p> <p>10NYCRR 415.11 (c)(3)(ii)</p>	F 282			

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K 029 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based upon observation and staff interviews during the annual survey, it was determined that the facility did not ensure that all hazardous areas were appropriately constructed and separated from other spaces. Specifically, the facility did not ensure that the door to one clean utility room containing oxygen cylinders was equipped with a self-closing device. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:</p> <p>1) During the building inspection on August 22, 2007 between 11:00 AM - 12:15 PM, the door to the 1st floor clean utility room containing portable oxygen cylinders lacked a self-closing device as required. The room measured approximately 15' x 6'.</p> <p>The director of maintenance interviewed on August 22, 2007 at 11:00 AM stated that this room used to contain the autoclave, and had only</p>	K 029		10/12/07
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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K 029	Continued From page 1 recently been used for storing oxygen cylinders.	K 029		
K 211 SS=F	2000 LSC 19.3.2.1 NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623  This STANDARD is not met as evidenced by: Based on observations and staff interviews conducted during the annual survey, it was determined that the facility did not ensure that alcohol-based hand sanitizer dispensers were not installed in carpeted areas of the corridor since the building was not fully sprinklered. Specifically, two alcohol-based hand rub dispensers were installed above carpeted areas in the two nursing unit corridors. This resulted in no actual harm with	K 211		10/12/07

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K 211	<p>Continued From page 2</p> <p>potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>1) During the building inspection on August 22, 2007 between 11:00 - 12:15 PM, alcohol based sanitizers were hung on the two nursing unit corridor walls, which is prohibited unless the building is fully sprinklered.</p> <p>According to the maintenance director interviewed on August 22, 2007 at 11:00 AM, the building was not fully sprinklered as he stated there were only five sprinklered locations within the building. He believed the installations were acceptable because the corridors were sprinklered.</p> <p>In summary, the facility did not ensure that alcohol based sanitizers were installed in compliance with all six of the conditions specified by the Life Safety Code to allow their use in corridors.</p> <p>2000 LSC 19.3.2.7(6)&amp;(7), (temporary interim amendment 00-1(101) effective 4/04)</p>	K 211			

**Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 335344	<b>(Y2) Multiple Construction</b> A. Building _____ B. Wing _____	<b>(Y3) Date of Revisit</b> 10/31/2007
<b>Name of Facility</b> CHASE MEMORIAL NURSING HOME CO		<b>Street Address, City, State, Zip Code</b> ONE TERRACE HEIGHTS NEW BERLIN, NY 13411

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <b>F0282</b>	Correction Completed 08/27/2007	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <b>483.20(k)(3)(ii)</b>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 8/22/2007	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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ID Prefix _____ Reg. # <b>NFPA 101</b> LSC <b>K0029</b>	Correction Completed <b>10/12/2007</b>	ID Prefix _____ Reg. # <b>NFPA 101</b> LSC <b>K0211</b>	Correction Completed <b>08/27/2007</b>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
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CMS RO				

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YES	NO		