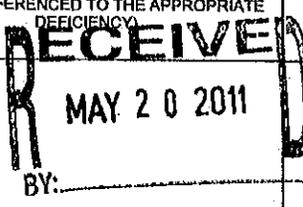


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID

STATEMENT OF DEFICIENCIES AND PLAN OF ACTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185181	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01-Main Building 01 B. WING	(X3) DATE SURVEY COMPLETED 04/27/2011
NAME OF PROVIDER OR SUPPLIER <b>KINGS DAUGHTERS MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 LEXINGTON AVE ASHLAND, KY 41101</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 000	INITIAL COMMENTS  A recertification Survey was conducted on 04/26/11 thru 04/27/11. A Life Safety Code Survey was conducted on 04/26/11. Deficiencies were cited with the highest scope and severity of an "F".	F 000		
F 323 SS=D	<p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible for one (1) of five (5) sampled residents, (Resident #4). Facility staff was unaware if Resident #4's bed was locked or unlocked as they attempted to sit the resident on the bed on 04/19/11, resulting in the bed sliding from underneath the resident. Resident #4 sustained a laceration to the lower right leg that required eleven (11) stitches.</p> <p>The findings include: Review of the facility's policy "Administrative Policy: Fall Reduction Program", dated 11/01/06 revealed for universal fall precautions, the beds are to be locked and in low position.</p>	F 323		An environmental scan of the effected resident's room as well as all resident rooms in the facility was completed and the bed locking mechanisms were checked for functionality and to ensure they were in the locked position, by the facility administrator, on 4/27/11. The team member disciplinary process (performance improvement conversation) was implemented on 5/12/11 for the appropriate team members for failure to follow facility policies and procedures during resident transfers. Team member re-education with a special emphasis on the facility "Universal Fall Reduction Program", locking of beds prior to transfers and the use of gait belts during transfers as well as other appropriate interventions was developed on 5/10/11 by the facility administrator and the therapy coordinator and was initiated on 5/10/11. The education will be completed for all nursing, therapy, and environmental team members by the facility administrator and the therapy coordinator in an effort to ensure that the deficient practice will not recur. This unit-specific education module will be required for all new hires that provide patient care on the Transitional care Unit.
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE		TITLE		DATE
		Director of Accreditation & Regulatory Affairs		5/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF ACTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:  186181	(X2) MULTIPLE INSTRUCTION A. BUILDING 01 MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED  04/27/2011
NAME OF PROVIDER OR SUPPLIER  KING'S DAUGHTERS MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2201 LEXINGTON AVE ASHLAND 41102		
(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 323	<p>Continued From page 1</p> <p>Record review revealed the facility admitted Resident #4 on 04/18/11 with diagnoses that included Acute Renal Failure, Atrial Fibrillation, Hypertension, Congestive Heart Failure and General Debility.</p> <p>Interview with Certified Occupational Therapy Aide (COTA) #1 on 04/27/11 at 2:20 PM revealed on 04/19/11, she and an unnamed nursing student went to get Resident #4 up on a shower chair for a shower, as part of therapy. Further interview revealed as they stood Resident #4 to transfer from the bed to the shower chair, the resident had a large bowel movement and urinated on the floor. Interview further revealed they attempted to lower the resident back to the bed, prompting the bed to scoot away from them. Then they lowered Resident #4 to the floor. Further interview revealed it was at this time that Resident #4 swung his/her leg out to the side and sustained the laceration to the right leg, presumably on the side of the recliner. COTA #1 stated she had transferred Resident #4 by herself before, without problems but did not check the bed to ensure the wheels were locked. She further stated she did not use a gait belt as per protocol.</p> <p>Interview with the Occupational Therapy Director on 04/27/11 at 3:35 PM revealed each resident's assistance needs was determined through the assessment. It also depends how comfortable the therapist is providing the assistance. Maximum assist is usually (1) therapist providing seventy five percent (75%) effort and the resident providing twenty five percent (25%) effort. He further stated all staff is encouraged to ask for</p>	F 323	<p>Five random audits will be performed bi-weekly until four consecutive months of 100% compliance has been reached by the therapy coordinator/clinical coordinator to monitor compliance with proper bed locking and use of gait belts with transfers. The rate of compliance will be calculated as the number correct over the total number audited each month.</p> <p>Compliance will be reported to and monitored quarterly by the performance improvement committee to ensure sustained compliance with the Universal Fall Prevention program.</p>	05/19/11

STATEMENT OF DEFICIENCIES AND PLAN OF ACTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:  <b>185181</b>	(X2) MULTIPLE CONSTRUCTION C. BUILDING _____ D. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>KING'S DAUGHTERS MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 LEXINGTON AVE. ASHLAND, KY. 41101</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 323	Continued From page 2  help if they feel they need help.  Record review of the occupational therapy evaluation dated 04/19/11 revealed Resident #4 would be a maximum assist. Per Interview with the Occupational Therapy Director this indicates a (1) person assist.  Interview with the Unit Director on 04/27/11 at 4:00 PM revealed the staff would be re-education on resident safety.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY The facility must- (1) Procure food from sources approved or considered satisfactory by federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to prepare and serve food under sanitary conditions, as evidenced by staff not having hair completely covered with hair nets. The facility's failure had the potential to effect eight (8) of nine (9) residents living at the facility. The findings include:  Review of the facility's policy titled "King's	F 371	On 4/26/2011 Lora Pullin, Food Service Supervisor, verbally reminded Food Service Team Members to properly restrain hair away from food by containing all hair, including bangs, at all times within a hair net/restraint.  On 05/11/2011 a read and sign in-service sheet was implemented for completion by all Food Service Team Members regarding the Proper use of Hair Net/Restraint. Daily hair restraint audit will be conducted by a Food Service Supervisor to ensure compliance. All new hires will receive a Food Services Orientation and Training Checklist of items that must be covered by a Supervisor or designee of the department. These items will be in-serviced to the Team Member during the first duty day. Once all items are covered, the new hire and the Supervisor must sign and date the form. A copy of the signed checklist will be filed in the Team Members departmental file.	05/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF ACTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:  <b>185181</b>	(X2) MULTIPLE CONSTRUCTION E. BUILDING _____ F. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/27/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>KING'S DAUGHTERS MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 LEXINGTON AVE. ASHLAND, KY. 41101</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)	(X6) COMPLETE DATE
F 371	Continued from page 3  Daughter's Medical Center. Infection Control Manual, Section 7 C-food service department", revealed hair nets, scarves, harts of similar hair coverings that effectively restrain head and facial hair are worn by all employees working in food preparation areas. Observation on 4/26/11 at 7:30 AM revealed eight (8) different dietary staff, as well as the Dietary Supervisor, with full bangs that were not covered by their hair nets. Interview with Dietary Supervisor on 04/26/11 at 7:45 AM revealed it is policy that all staff in the kitchen area have all of their hair completely covered with a hair net or a hat. She stated t did not matter if they were working in the kitchen or not, if they were in the kitchen area, their hair had to be completely covered. interview with the Infection Control Nurse on 04/26/11 at 8:00 AM revealed upon hire, all staff had infection control in=service and department specific infection control training.	F 371	Daily hair restraint audit will be conducted by the 6:00a.m. Patient Services Food Service Supervisor to ensure proper compliance of hair net/restraint. If a hair net/restraint is not properly utilized findings along with date, Team Member, and Supervisor conducting audit will be noted in the comments box on the audit sheet as well as action taken in DWP process. The completed audit will be sent to Accreditation & Regulatory Affairs on or before the 10 <sup>th</sup> day of each following month.	05/19/2011

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/26/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINGS DAUGHTERS MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2201 LEXINGTON AVENUE ASHLAND, KY 41101</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)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS  A standard Life Safety Code survey was conducted on April 26, 2011. The facility was found to be in substantial compliance with Title 42, Code of Federal Regulations, 483.70(a) relating to NFPA 101 Life Safety Code 2000 Edition, with no regulatory violations identified on the date of the survey.	K 000		

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**MAY 20 2011**  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X8) DATE  
*Theresa Ann Burdette, Director of Accreditation & Regulatory Affairs* 5/20/2011

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.