

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

PRINTED: 02/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/19/2012
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40392
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(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  F 279 SS=D	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted 01/16/12 through 01/19/12. Deficiencies were cited with the highest Scope and Severity of an "E".</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to develop a Comprehensive Plan of Care based on the residents' Comprehensive Assessment which include measurable objectives and individual</p>	F 000  F 279		

RECEIVED  
FEB 15 2012  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Duffy Backman TITLE: TCU Administrator (X6) DATE: Feb 15-2012

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 279	<p>Continued From page 1</p> <p>Interventions to meet resident needs for one (1) of eight (8) sampled residents (Resident #1). Resident #1 sustained falls on 10/23/11 and 12/08/11; however, there was no Plan of Care to address this resident's risk for falls in order to implement interventions to prevent further falls.</p> <p>The findings include:</p> <p>Review of the facility "Comprehensive Care Plans" Policy, dated 07/09, revealed, "Based upon the assessments of the interdisciplinary team and information from residents, families and/or representatives care plan objectives are developed to reach measurable outcomes. Care Plans are reflective of steps for the interdisciplinary team to take to promote positive outcomes. Care Plans should include the resident's needs, strengths and preferences so residents can be cared for based upon residents history and functional level".</p> <p>Review of the facility "Guidelines for Falls-Transitional Care Unit" Policy, dated 11/09, revealed proper actions following a fall include: revise resident's Care Plan as appropriate to reduce future falls.</p> <p>Review of Resident #1's medical record revealed diagnoses which included Alzheimer Dementia, and Macular Degeneration. Review of the facility Fall Investigation Report revealed Resident #1 sustained a fall on 10/23/11 at 8:45 PM. According to the report the resident sat in the floor while ambulating with a Certified Nursing Assistant (CNA). Further review, revealed the resident was ill and not showing symptoms, and the Physician was notified. Review of the</p>	F 279	<p>POLICY AND PROCEDURE FOR CARE PLANS ANNUALLY REVIEWED DATED 6-11 - POLICY ORIGINATED 7-09</p> <p>POLICY AND PROCEDURE FOR GUIDELINES FOR FALLS ANNUALLY REVIEWED DATED 6-11 ORIGINATED 11/09</p>	

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F 279	<p>Continued From page 2</p> <p>Physician's Orders dated 10/26/11 revealed orders for a Urinalysis. Further review revealed orders dated 10/26/11 for Bactrim DS (antibiotic medication) twice a day for ten (10) days.</p> <p>Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 11/16/11 revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making, as requiring total assistance with transfers, and as non-ambulatory. Review of the Comprehensive Plan of Care dated 11/16/11, revealed there was no Plan of Care to address this resident's risk for falls with interventions to prevent further falls, although the resident sustained a fall on 10/23/11. Review of the Care Area Assessment Summary (CAAS), dated 11/21/11, revealed the resident was no longer weight bearing or ambulatory, was weak, unable to maintain balance without support while sitting, and was a high risk for falls.</p> <p>Review of the Fall Risk Assessment dated 12/08/11, revealed the resident was assessed to be at high risk for falls with a score of seventy (70). According to the Assessment, a score of forty-five (45) or higher was considered high risk.</p> <p>Further review of the facility Fall Investigation Reports, revealed the resident sustained a fall on 12/08/11 at 8:30 AM and was noted to be sitting on the floor mat next to the bed. According to the Report, the care givers were to get the resident up and out of the room.</p> <p>Review of the Comprehensive Plan of Care revealed no documented evidence the the facility developed a Plan of Care to address this</p>	F 279	<p>ALL RESIDENT CARE PLANS HAVE BEEN REVIEWED /REVISED TO DETERMINE IF ANY CHANGES WERE NEEDED TO CARE PLANS TO ADDRESS OBJECTIVES, GOALS AND TIMELINES TO CARE FOR EACH RESIDENT, FOR COMPLIANCE WITH F-279</p>	2/8/12

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F 279	<p>Continued From page 3</p> <p>resident's risk for falls with interventions to prevent further falls, although the resident sustained another fall on 12/08/11.</p> <p>Observation of Resident #1, on 01/16/12 at 3:00 PM, revealed the resident was in the bed with fall mats on the floor on both sides of the bed.</p> <p>Interview, on 01/18/12, at 10:15 AM, with the MDS Nurse, revealed the resident was a fall risk and that was why there were mats on the floor next to the bed. She further stated the resident's room was purposely next to the nurses station where the nurses could see her/him when she/he was up in the recliner chair. Continued interview revealed she would have been the one responsible for initiating a Care Plan related to falls due to the MDS triggering for falls. She further stated, it should have been recognized that there was no falls Care Plan in place, because after a resident sustained a fall, the administrative nurses were to have an informal meeting to discuss the falls at the nurses station, and the Care Plan would need to be updated at that time.</p>	F 279	<p>RESIDENT #1 CARE PLAN HAS BEEN REVIEWED AND INTERVENTIONS THAT CAREGIVERS WERE PROVIDING WERE ADDED TO CARE PLAN. ON 1-18-2012.</p> <p>THE FALLS POLICY AND PROCEDURE HAS BEEN REVISED PROCEDURE #11 HAS BEEN REVISED TO ADD DISCIPLINARY TEAM TO REVIEW RESIDENT AFTER A FALL TO IMPLEMENT INTERVENTIONS TO FURTHER PREVENT FALLS OR MAINTAIN CURRENT INTERVENTIONS. REVISE CARE PLANS AS APPROPRIATE.</p> <p>MDS/RN WILL REVIEW CARE PLANS QUARTERLY TO MONITOR COMPLIANCE</p>	2/1/12
F 323 SS-D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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>	F 323	<p>CARE PLAN MTS WILL BE CONDUCTED MONTHLY IN COORDINATION WITH MDS SCHEDULE TO REVIEW/REVISE CARE PLANS, FOR COMPLIANCE.</p> <p>UPDATED POLICY + PROCEDURE ATTACHED - CHANGES MADE PG. 2 #11.</p> <p>EDUCATION TO ALL TCU STAFF BY RN/MDS + ADMINISTRATOR</p>	2/1/12

CLARK REGIONAL MEDICAL CENTER  
TRANSITIONAL CARE UNIT

**TITLE :** Guidelines for Falls – TCU 11/09

**PURPOSE :**

To ensure the Transitional Care Unit addresses the occurrences of falls/accidents through identification of Resident/Patients at risk and environmental hazards. The importance of supervision, implementing interventions, educating employees, patients, Residents and families, the use of assistive devices, modifying the environment and evaluating/monitoring falls and unexpected events.

**DEFINITIONS:**

- **Fall** – When a Resident/Patient makes contact with the floor due to medical condition, medication side effects, cognitive – functional impairment, environmental hazards and other circumstances that cause the Resident/Patient to have contact with the floor with or without injury.
- **Risk assessments** – Resident/Patients are assessed upon admission, monthly or if a fall occurs by a RN/LPN to assess for fall potential and preventive measures. Resident/Patients are considered high risk for falls. Resident/Patient care plans are implemented, revised and reviewed.
- **Environment** – The Resident/Patient's surroundings.
- **Supervision** – Employees of TCU observe visually and physically, the Resident/Patients based on assessed needs to improve safety and reduce risks.
- **Interventions** – A variety of solutions implemented to reduce falls/unexpected events through interdisciplinary care plans, verbal Nursing/SRNA shift to shift report, Resident/Patient and family education, identification of hazards, reduction of physical risks, provide assistance, supervision, completion of work orders and environment modifications.
- **Assistive Devices** – Employees are educated to encourage Resident/Patients to use assisted devices for mobility, visual and hearing devices, proper foot wear, environmental adaptations and elimination of restraints.

CLARK REGIONAL MEDICAL CENTER  
TRANSITIONAL CARE UNIT

- **Modification of the Environment** – Physical changes made to improve safety and reduce risks. Hallways clear, equipment placed on one side of corridor, utilization of cord organizers, chair/bed alarms, safety mats, walking rounds to identify and resolve maintenance risks that include equipment, lighting, noise levels, etc. Modifications are individualized for each resident.

**PROCEDURE:**

These guidelines are in effect for any Resident/Patient on the Transitional Care Unit who has a fall or accident.

Proper actions following a fall include:

- 1) Assess Resident/Patient for injuries
- 2) Provide treatment as necessary
- 3) Contact physician as appropriate to inform physician of Resident/Patient's fall
- 4) Obtain treatment orders if necessary, and document appropriately
- 5) If Resident/Patient is alert/oriented ask Resident/Patient if they would like family contacted or POA/guardian.
- 6) Assess environment for possible cause of fall
- 7) Correct environment concern if needed (clean spilled liquids, move furniture, etc.)
- 8) Complete work order request for maintenance department for environment/equipment repair as appropriate
- 9) Complete incident report
- 10) Submit incident report to administrators mailbox
- 11) The Interdisciplinary team will review resident's care plan to revise and review interventions to prevent further falls.
- 12) Discuss in shift report to implement communication among care givers of TCU.
- 13) Referral to Physical Therapy to screen patients/residents to improve physical abilities.

***\*Order of above action may vary as appropriate.***

Guidelines for Falls  
Formulated by: Kathy Glass, TCU Administrator  
Formulation Date: 03/2008  
Revision Date(s): 10/10, 02/12  
Review Date(s): 11/09, 10/10, 06/11  
Reviewed by: Kathy Bachman, Administrator  
Approved by: TCU Administrator and Medical Director

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F 323	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure an environment free of accident hazards and adequate supervision to prevent accidents. Observation revealed there was a hot pot of coffee; which tempted at one hundred seventy-two (172) degrees Fahrenheit, on the coffee maker in the clean utility room which was accessible to residents.</p> <p>The findings include:</p> <p>Observation, on 01/16/12 at 5:30 PM, revealed a hot pot of coffee on the coffee maker was in the clean utility room. One entrance to the room had no door to the hallway and one entrance had a door to the hallway which was unlocked. A temperature of the coffee taken by the Dietary Manager, at 5:40 PM, revealed the coffee temperature was 172 degrees Fahrenheit.</p> <p>Interview, on 01/16/12 at 5:30 PM and 01/17/12 at 12:15 PM, with Registered Nurse (RN) #1/Charge Nurse, and the Administrator, revealed the only confused resident who may possibly come into the utility room was Resident #4. Further interview, revealed this resident was watched closely when out of bed and was mobile per wheelchair. However, there were some residents who would come into the room to get their own ice.</p> <p>Further interview revealed the staff would get the residents' coffee from the coffee pot in the clean utility room and would put ice, milk or water in it to cool it down. However, there was no actual</p>	F 323		

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F 323	Continued From page 6 assessment done to assess residents for safety with hot beverages and no system in place to test the temperatures of the coffee from the coffee pot to ensure safe temperatures at the point of service. Continued interview, revealed they had not thought about the possibility of a hot coffee spill which could burn the residents and they would remove the coffee maker from the clean utility room which was accessible to the residents.	F 323	COFFEE POT AND COFFEE MARKER REMOVED IMMEDIATELY AT THE TIME THE LEAD SURVEYOR EXPRESSED SAFETY CONCERN. A FRAMED SIGN WAS PLACED FOR RESIDENTS / VISITORS TO ASK FOR ASSISTANCE FOR COFFEE.	1-16-12
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure that it was free of medication error rates of five percent or greater for one (1) of eight (8) sampled residents (Resident #5) and one (1) unsampled resident (Unsampled Resident B). Observation of medication administration, on 01/17/12 at 2:05 PM for Resident #5, revealed thirty (30) milliliters of water was not administered prior to the administration of medications per gastric tube resulting in a medication error. Further observation of medication administration, on 01/18/12 at 8:10 AM, for Unsampled Resident B revealed medications were not administered as per the Physician's orders. There were forty-four (44) medication attempts observed, with three (3) medication errors observed, resulting in an error rate of 6.8 percent.	F 332	A WORK ORDER WAS SUBMITTED FOR REPLACEMENT OF THE DOOR TO CLEAN UTILITY ROOM TO DECREASE ANY OTHER POTENTIAL SAFETY CONCERNS. WORK ORDERS GIVEN TO LEAD SURVEYORS AND DOOR WAS REPLACED BY 7:36AM - ON 1-17-12  ADMINISTRATOR REMOVED COFFEE POT AND COFFEE MAKER AT 5:46 PM ON 1-16-2012	1-16-12  1-17-12  1-16-2012

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F 332	<p>Continued From page 6</p> <p>The findings include:</p> <p>Review of the Administration of Medications Policy, dated 05/11, revealed medications were to be administered following the five (5) R's of medication administration: Right patient, Right drug, Right dose, Right route, and Right time.</p> <p>1. Observation of medication administration, on 01/17/12 at 2:05 PM for Resident #5, revealed Registered Nurse (RN) #1 crushed medications to be administered including Gabapentin 100 milligrams (mg's), and Sinemet 25/100- two (2) tablets, and mixed with water in a cup. She then mixed Ativan 2 mg's per milliliter liquid in a cup with water. Further observation revealed the nurse checked for placement of the gastric tube and administered the medications per the gastric tube. The nurse failed to administer thirty (30) milliliters of water prior to the administration of medication. This was medication error #1.</p> <p>Interview with RN #1, immediately after the administration of medications to Resident #5, revealed she would normally flush the gastric tube with five (5) to ten (10) milliliters of water prior to administration of medications and was unaware of the need to flush the tube with at least 30 ml's of water prior to administration of medication.</p> <p>2. Observation of medication administration, on 01/18/12 at 8:10 AM, for Unsamped Resident B, revealed Licensed Practical Nurse (LPN) #1 verbally called out the name of the medications and handed the medication bottles to the surveyor as she was pouring the medications into</p>	F 332	<p>① RN#1 REVIEWED REGULATION AFTER SURVEY -(1-19-12) GABAPENTIN 100 MGS WAS NOT GIVEN -RESIDENT ADMINISTRATION RECORDS REVIEWED BY ADMINISTRATOR AND 2 RN'S ON 2-2-2012. SINAMET 25-100-ZTAB ADMINISTERED @14:13 ATIVAN 2MG/ML ORAL CONC PER TUBE</p> <p>EDUCATION FOR 30 MILLILITERS OF WATER PRIOR TO ADMINISTRATION AND AFTER MEDICATION ADMINISTRATION WILL BE COMPLETED BY ALL NURSING CAREGIVERS BY RN BY 2.17.2012</p> <p>RN ASSESSED. ONLY 1 OTHER RESIDENT HAS FEEDING TUBE - DR. ORDERS STATE 30 MILLILITERS. MEDICATION AUDITS ON</p>	2/17/12

ALL NURSES UNTIL 100% COMPLIANT - COMPLETED BY RN OBSERVATION TOOL ATTACHED 3/1/12





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F 332	<p>Continued From page 7</p> <p>the medication cups during medication pass.</p> <p>Reconciliation of the medications with the Physician's orders, on 01/19/12 at 10:00 AM, revealed orders for Aspirin EC 325 mg's and Amlodipine 10 mg's to be administered at 8:00 AM. However, the nurse was not observed to administer these medications on 01/18/12. This was medication error #2 and #3.</p> <p>Phone interview, on 01/19/12 at 10:45 AM with LPN #1, revealed she thought she had administered the Aspirin and Amlodipine to the resident as ordered on 01/18/12.</p> <p>Observation of the medication cart, on 01/19/12 at 10:50 AM, revealed there was no bottle of Amlodipine in the drawer for the resident and the bottle of Aspirin was empty.</p> <p>Interview, on 01/19/12 at 11:00 AM with RN #2, who had administered medications to Unsampled Resident B on 01/19/12 at 8:00 AM, revealed she thought she had administered the Amlodipine that morning; however could not find the bottle. She further stated she had made out a list of prescription numbers from the bottles of medications which needed to be reordered while administering medications that morning and possibly she had thrown away the bottle after writing down the prescription number. However, when pharmacy was called and questioned by RN #3 with the surveyor on 01/19/12 at 11:15 AM, the prescription list which RN #2 had completed did not include the Amlodipine.</p> <p>Interview, on 01/19/12 at 12:00 PM, with the Administrator revealed pharmacy did not observe</p>	F 332	<p>② A REDESIGNED MEDICATION TRACKING FORM REVISED AND IMPLEMENTED TO TRACK MEDICATIONS ORDERED FROM OUTSIDE SOURCES/SUPPLIERS. EMPTY MEDICATION BOTTLES RETAINED UNTIL ORDERED MEDICATIONS DELIVERED. EDUCATION TO ALL NURSES 1-27-2012 BY ADMINISTRATOR. COPY OF FORM ATTACHED THIS PROCESS WILL ELIMINATE THIS CONCERN FROM OCCURRING WITH OTHER RESIDENTS. RNS REVIEWED MEDICATIONS ADMINISTRATION OF MEDICATION POLICY AND PROCEDURE DEVELOPED TO PROVIDE CONSISTENCY AND SAFETY AMONG ALL</p>	1/27/12



## **CLARK REGIONAL MEDICAL CENTER**

**TITLE:       ADMINISTRATION OF MEDICATION  
              TRANSITIONAL CARE UNIT**

### **PURPOSE:**

To assure medications are administered to patients and residents safety and documented appropriately.

### **PROCEDURE:**

- 1) Log into HMS and enter password.
- 2) Click on HMS clinical.
- 3) Login and password.
- 4) Click on my patient list.
- 5) Choose patient/resident.
- 6) Click on HMS tab EMAR worklist.
- 7) Highlight individual medication to be given.
- 8) Find medication in patient/resident drawer.
- 9) Verify the 5 R's – Right patient/resident, drug, dose, route and time.
- 10) Go to next medication.
- 11) Repeat steps #7 through #9.
- 12) Inpatient/resident room – identify patient with armband or residents with picture identification.
- 13) Give medications.
- 14) Return to EMAR and highlight medications given.
- 15) Right click to document administered medications or missed does if appropriate.
- 16) Parameters must be checked prior to administering medications – monitor blood pressure medications and Lanoxin (Digoxin). Add blood pressure or pulse to comment section when administering medications.

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(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 332  F 441 SS=E	<p>Continued From page 8 medication pass and only the new hire nurses were observed on medication pass by a RN.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of</p>	F 332  F 441	<p>NURSES PASSING-MEDICATION POLICY ATTACHED</p> <p>RE-EDUCATION OF POLICY CONSISTENT MEDICATION PASS COMPLETED BY RN FOR COMPLIANCE. TO ALL NURSES</p> <p>MEDICATION AUDITS COMPLETED BY RN WITH AUDIT TOOL AND DOCUMENTION WITH EACH NURSE UNTIL 100% COMPLIANCE ACHIEVED WITH NO ERROR MED PASS. AUDITS WILL CONTINUE UNTIL NURSE IS 100% COMPLIANT AND THEREAFTER ANNUALLY</p>	2/17/12  3/1/12

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

PRINTED: 02/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/19/2012
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40392
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F 441	<p>Continued From page 9 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of Centers for Disease Control and Prevention (CDC) guidelines, review of the U.S. Food and Drug Administration guidelines for cleaning blood glucose monitors, and review of facility's policy, it was determined the facility failed to establish and maintain an infection control program to ensure a safe environment and to help prevent the development and transmission of infection for one (1) sampled resident (Resident #3) and one (1) unsampled resident (Unsampled Resident B). The facility failed to ensure staff was knowledgeable of CDC guidelines and U.S. FDA guidelines regarding blood glucose monitor cleaning. In addition, the facility failed to develop a policy related to cleaning blood glucose monitors which would comply with current CDC guidelines and U.S. FDA guidelines.</p> <p>On 01/17/12, staff failed to disinfect the blood glucose monitor according to CDC guidelines and U.S. FDA guidelines after testing the blood sugar for Resident #3, and on 01/18/12 staff failed to disinfect the blood glucose monitor according to CDC guidelines and U.S. FDA guidelines after testing the blood sugar between Unsampled Resident B and Resident #3. The facility identified six (6) residents who required blood glucose monitoring and for which this failure had a likelihood to affect which included one (1) of</p>	F 441	<p>GLUCOMETER TRAINING AND POLICY REVIEW TO BE COMPLETED BY 2-27-2012 BY INFECTION CONTROL NURSE COMPETENCY ASSESSMENT DEVELOPED - ATTACHED</p> <p>POLICY FOR WHOLE BLOOD GLUCOSE CARE MAINTENANCE REVISED DURING SURVEY (1-18-12) ATTACHED</p>	2/27/12

## Glucometer Training

### Competency Assessment

Name: \_\_\_\_\_

Department: \_\_\_\_\_

Validations: RD = Return Demonstration; I = Inservice; T = Testing; O = Observation

Skills	Satisfactory Performance		Validation (Initial as appropriate)				Date
	Yes	No	RD	I	T	O	
Quality control							
Handling and dating of control solution							
Patient identification (name, date of birth, scanning)							
Patient testing							
Reportable range for Precision Xceed Pro							
Critical values and process							
Care and cleaning							

Person(s) validating skills:

Initials

Print Name

Signature

\_\_\_\_\_

Action Plan for skills not satisfactorily performed:

Date to be completed

\_\_\_\_\_

I have read and understand the updated (January 2012) Whole Blood Glucose policy, including the sections "Patient Testing" and "Care and Maintenance" of the glucometer.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**TITLE: Whole Blood Glucose**

Whole blood glucose is a point of care test that is used as a screening test to detect the level of glucose in whole blood collected primarily by a finger stick.

**PRINCIPLE**

- A. The Precision Xceed Pro Point of Care System for Blood Glucose Testing is intended for in vitro diagnostic use for the quantitative measurement of glucose in fresh capillary whole blood. The Precision Xceed Pro System is not for use in diagnosis or screening of diabetes mellitus, but is to be used as an aid in monitoring the effectiveness of diabetes control programs. The Precision Xceed Pro System may also be used by healthcare professionals for the quantitative measurement of glucose in venous, arterial or neonatal whole blood, provided the sample is used within 30 minutes.
  
- B. Intended Use  
The Precision Xceed Pro System meter is used with the Precision Xceed Pro Blood Glucose Test Strips to provide a glucose result using whole blood in approximately 20 seconds.

**SPECIMEN**

Specimen Collection

- 1. A fresh whole blood sample collected by finger stick is the preferred specimen.
- 2. A fresh whole blood sample collected in an EDTA (lavender) top or heparin (green) top tube is acceptable. See Specimen Collection Procedure for correct method to collect an EDTA or Heparin tube.

Unacceptable Specimens

- 1. A specimen collected in another type of tube or an old sample.
- 2. A specimen other than whole blood is unacceptable.

**REAGENTS/MATERIALS NEEDED**

Precision Xceed Pro Blood Glucose Meter  
Precision Xceed Pro Glucose Meter Test Strips  
Precision Xceed Pro Linearity Test Kit  
Precision Xceed Pro Glucose Controls (2 Levels-Low and High)  
LIS Computer System interface at corporate office  
Precision Xceed Pro download stations

**REAGENT STABILITY AND STORAGE**

- A. Precision Xceed Pro Glucose Meter Test Strips are individually packaged and are to be used immediately after opening and expire based on manufactures expiration date on vial.
- B. Precision Xceed Pro Linearity Tests expire 90 days after opening or by manufactures expiration date on vial, whichever comes first.
- C. Precision Xceed Pro Glucose Controls expire 90 days after opening or by manufactures expiration date on vial, whichever comes first.

**QUALITY CONTROL MATERIALS AND PROCEDURES**

Quality control is performed on each meter, each day that patient samples are performed. The Precision Xceed Pro has a built in program which requires Quality Control to be performed every 24 hours. Two levels of quality control reagents are used each day. A low and a high level is performed on each meter each day patient samples are performed. Quality control is to be performed based on the following procedure: The Quality Control results are to Pass or patient testing can not be performed. If meter is set to numerical result for Quality Control, refer to acceptable range on Precision Xceed Pro strip package for acceptable range for Quality Control. Linearity is to be performed every six months or when a new lot number of glucose reagent strips are placed into use. The linearity kits along with the quality control kits are to be Precision Xceed Pro brand. The Quality Control results will be reviewed monthly by Point of Care/ Laboratory Supervisor or designee.

**QUALITY CONTROL PROCEDURE**

1. Press On/Off to turn on the monitor.
2. Press 2 to select Control Test
3. Press Scan to scan the Operator ID barcode or manually enter the Operator ID via the keypad, and then press enter.
4. Scan or manually enter the low control solution lot number via the keypad, then press Enter.

Note: If the Unexpected Level screen appears, you may either:

- a. Enter 1 to Re Enter the expected level.
- b. Enter 2 to Continue.

5. Press Scan to scan the test strip barcode or manually enter the test strip lot number via the keypad, then press Enter.

**Note: Place monitor on a flat surface while running control tests.**

6. Open the foil test strip packet at the notch and tear down to remove the test strip.
7. With the contact bars facing up, insert the test strip into the test strip port until it stops and Strip Inserted is displayed.
8. Gently invert the required control solution bottle 3-4 times. Remove the cap of the control solution bottle and wipe the nozzle with a clean gauze or tissue. Apply a small drop of solution to the test strip target area, allowing the target area to fill completely. Wipe the nozzle of the control solution bottle before replacing the cap.
9. Wait for the monitor to analyze the sample and display the test result. (Approximately 20 seconds)

**Note: Do not move the monitor while it is analyzing a sample.**

10. Note the test result and whether it falls within the acceptable range. If required, scan or manually enter the comment code, and press Enter. You will see Pass or Fail.

**Note: Patient samples will not be able to be performed until 2 levels of Quality Control has been performed and within acceptable range on each day of testing.**

11. Remove the test strip from the monitor and discard it when finished testing.
12. You may select one of the following:
  - a. Press 1- Next Level
  - b. Press 2- Repeat Test
13. Press Menu to return to the Menu Mode menu or Press On/Off to turn off the monitor.

#### **LINEARITY TESTING**

1. Press On/Off to turn on monitor.
2. Press the Menu button
3. Press 4 to select Linearity Test.
4. Press Scan or manually enter the Operator ID via the keypad, then press Enter.

5. Scan or manually enter the CVC kit lot number via the keypad, then press Enter.
6. If the new Panel screen appears you may either:
  - a. Press 1 - Re Enter Kit Lot.
  - b. Press 2 - Replace Panel.
7. Select the number of the level of the next test to be run. If you press 6 for a New Panel, the monitor will prompt you to confirm that you wish to replace the existing panel.
8. Press Scan to scan the test strip barcode or manually enter the test strip lot number via the keypad, then press Enter.
9. Open the foil test strip packet at the notch and tear down to remove the test strip.
10. With the contact bars facing up, insert the test strip into the test strip port until it stops and Strip Inserted is displayed.
11. Follow the instructions in the CVC kit package insert. Then apply a drop of the sample to the target area.
12. Wait for the monitor to analyze the sample and display the test result. (Approximately 20 seconds)

**Note: Do not move the monitor while it is analyzing a sample.**

13. Note the result. If required, scan or manually enter the comment code, and press Enter. The monitor may be enabled to scan or enter a 1 to 2 digit comment code. If there is no prompt to enter a comment code, skip to next step.
14. Remove the test strip from the monitor and discard it when finished testing.
15. You can do one of the following options:
  - a. Press 1 - New Level.
  - b. Press 2 - Same Level,
16. Press Menu to return to the Menu Mode menu or Press On/Off to turn off the monitor.

**UNKNOWN SOLUTION TEST (PROFICIENCY TESTING)**

1. Press On/Off to turn on monitor.
2. Press the Menu button
3. Press 3 to select Proficiency Test.

4. Press Scan or manually enter the Operator ID via the keypad, then press Enter.
5. Scan or manually enter the Sample ID via the keypad, then press Enter.
6. Press Scan to scan the test strip barcode or manually enter the test strip lot number via the keypad, then press Enter.
7. Open the foil test strip packet at the notch and tear down to remove the test strip.
8. With the contact bars facing up, insert the test strip into the test strip port until it stops and Strip Inserted is displayed.
9. Bring proficiency survey specimens to room temperature. Mix each specimen well according to instructions from the survey provider. Wipe away any specimen on the tip of the vial before squeezing the vial and applying a drop to the test strip target area, covering the entire area. After applying the sample, recap the vial tightly.
10. Wait for the monitor to analyze the sample and display the test result. (Approximately 20 seconds)

**Note: Do not move the monitor while it is analyzing a sample.**

11. If you are prompted to enter a comment code, continue to next step, otherwise skip to step 13.
12. Scan or manually enter the comment code via the keypad, then press Enter.
13. Remove the test strip from the monitor and discard it when finished testing.
14. You may select one of the following options:
  - a. Press 1 - Next Test.
  - b. Press Menu - to return to the Menu Mode.
15. Press On/Off to turn off the monitor.

#### **REAGENT/SPECIMEN PREPARATION**

All Precision Xceed Pro test strips, quality control solution and linearity solutions are stored at room temperature therefore reagent preparation is not necessary.

#### **PROCEDURE**

##### **Performing a Patient Test**

1. Press On/Off to turn on the monitor
2. Press 1 to select Patient Test.
3. Press Scan to scan the Operator ID barcode or manually enter the Operator ID via the keypad, then press Enter
4. Press Scan to scan the Patient ID barcode on the Patient's armband or manually enter the Patient ID via the keypad, then press enter.

Note: If manually entering the Patient ID, you must enter it twice.

5. Confirm the Patient ID (if prompted). You may see one of the following four options on the screen:
  - a. Re-enter the ID using the keypad.
  - b. Press 2 to Confirm the information and continue testing or 1 to Re Enter the ID.
  - c. Enter the year of birth (e.g. 63) and press Enter.
  - d. Press 2 to Continue testing or 1 to Re Enter the ID.
6. Press Scan to scan the test strip barcode or manually enter the test strip lot number via the keypad, then press Enter.
7. Open the foil test strip packet at the notch and tear down to remove the test strip.
8. With the contact bars facing up, insert the test strip into the test strip port until it stops and Strip Inserted is displayed.
9. Select the finger that is to be used for the fingerstick.
10. Clean finger with alcohol and allow finger to dry completely.
11. Using the lancet, make an incision using appropriate technique.
12. Wipe away the first drop of blood.
13. Apply a drop of blood from the patient's finger, transfer pipette or syringe to the target area of the test strip allowing the entire target area to fill with blood. If necessary, blood can be collected in a capillary tube coated with heparin or EDTA, or a properly filled tube containing heparin or EDTA, and may be applied to the test strip within 30 minutes of collection.
14. Wait for the monitor to analyze the sample and display the test result. (Approximately 20 seconds)
15. If required, scan or manually enter the comment code, and press Enter.
16. If prompted, scan or manually enter the free text information and press Enter.
17. For results that fall in the Action or Critical range, repeat to verify, then notify nurse or physician and request a

laboratory collection by veni-puncture to confirm on chemistry analyzers in laboratory.

**Note:** If the blood glucose result appears to be inconsistent (lower or higher than expected), there may be a problem with the test strip. Repeat the test using a new test strip. Results that are incorrect may have serious medical consequences. Consult the prescribing physician before making any changes to diabetes medication plans if:

- a. The blood glucose results are not consistent with the physical symptoms and you have ruled out common errors in technique.
- b. The blood glucose result is less than 50mg/dL or greater than 425 mg/dL.

18. The glucose meter is to be uploaded within 1 hour of performing the test to ensure the results are on the chart for the physician to review. Docking stations have been placed in Lab, ER, WCC, PACU, CCU, Outpatient Services (2<sup>nd</sup> Floor), Med Surg and TCU. If there is an issue with one of the docking stations, Laboratory is to be notified immediately and the glucose meter taken to another docking station.

**Note:** Docking stations are also located at PCC and CRICC. These meters will be uploaded weekly since the results are manually entered into the chart and the results from the meters are not interfaced for patients at these locations.

#### **CALCULATIONS**

No additional calculations are needed

#### **REPORTING RESULTS**

Normal Values: Based on Age Specific Normals.

Pediatric Glucose Range: 40 to 100 mg/dL (< 6 days old)

Child Glucose Range: 70 to 115 mg/dL (6 days to 12 years old)

Adult Glucose Range: 70 to 115 mg/dL (>12 years old)

Critical Values:

Critical Low: <50 mg/dL for patients >12 years old  
<40 mg/dL for pediatric patients 6 days to 12 years old  
<35 for pediatric patients <6 days old

Note: Precision Xceed Pro will only read to a level of 20 mg/dL based on Linearity Studies.

Critical High: >500 mg/dL for patients >12 years old  
>300 mg/dL for pediatric patients 6 days to 12 years old  
>150 mg/dL for pediatric patients <6 days old

Reportable Range:

20 mg/dL to 425 mg/dL

Note: All values <50 or >425 are to have a venous sample collected and sent to the laboratory for confirmation.

Results are initially obtained at the patient bedside and the nurse or doctor is notified of the results. The results are then uploaded daily to the computer system used to collect the results. Results may then be printed out of the system to enter into the LIS or may cross over via interface. This is performed within a reasonable time frame from the time the result is obtained. Critical values are not called to the nurse or doctor when entering results into the LIS since the patient was treated based on the results when initially obtained. The order is created in the LIS by laboratory staff based on the results obtained from the Computer system that is interfaced with the glucose meters or the order may be generated automatically by the interface (if available). Once the order is created, a laboratory staff member will then enter the result into the computer with the time the test was performed and operator initials. Orders created by the interface will have the results cross into the LIS automatically.

Results obtained using the Precision Xceed Pro glucose meter are linked to the patient by the identification number entered into the meter. If the identification number is not available at the time the glucose meter is performed, the Precision Xceed Pro operator is to enter the result along with the identification number used onto the glucose meter manual entry result form. This is then sent to the laboratory at least daily. This allows the results to be entered into the LIS.

## **CARE AND MAINTENANCE**

### **General Care**

The Precision Xceed Pro Monitor requires little routine maintenance. During testing, the sample remains outside the monitor, which significantly reduces the possibility of contamination.

To keep the meter in good operating condition, you must keep it clean and handle it with care.

Follow these simple rules:

- a. Clean the exterior surface with a hospital approved Sani-Cloth wipes between each patient after use. Do not use bleach or hydrogen peroxide based cleaners as they will fade the monitor keypad.
- b. Keep the meter dry and avoid exposing it to extremes in temperature.
- c. Do not take apart the meter.
- d. If you drop the meter, inspect it for obvious damage. Perform a quality control test prior to running a patient blood glucose test.
- e. Do not allow any liquid to enter the port protector area. The port protector is designed to minimize the possibility of liquid entering the monitor through the strip port. Should blood or control solution come in contact with the port protector, the monitor should be cleaned and the port protector replaced with a new, dry port protector. After cleaning the monitor, dry the area around the port protector thoroughly.

#### **Changing the Batteries**

The meter is powered by two size AA batteries.

1. Turn off the meter.
2. Turn the meter over and remove the battery door.
3. Pull the blue tab to remove the batteries.
4. Discard the used batteries in compliance with hospital regulations.
5. Insert the new batteries on top of the strap, using the + and - symbols in the battery compartment to position the new batteries with the correct polarity.
6. Align the battery compartment cover with the slots on the Precision Xceed Pro Monitor, then snap the cover into place.
7. Turn on the meter to verify power.

#### **PROCEDURE NOTES**

Refer to the Operator's Guide for error messages or questions with the Precision Xceed Pro glucose meters that are not addressed in this procedure.

**LIMITATIONS OF PROCEDURE**

1. Use only fresh whole blood. Do not use serum or plasma.
2. Use an adequate amount of blood- just enough to fill the target area.
  - a. Too little blood may cause the countdown not to start. If this occurs discard this strip and start over with a new strip.
3. Increased hematocrits can affect test results therefore it may be necessary to collect a venous sample to send to laboratory for testing.

**COMPETENCY:**

Competency will be assessed based on the requirements of the accrediting agency for the laboratory and the hospital,

**Whole Blood Glucose**

**Section:**

**Formulation Date:** 7/29/2010

**Formulated by:** Donnie Berry

**Revision Date(s):** 01/12

**Review Date(s):**

**Reviewed by:** CRMC Medical Director (1/12)  
Director of Laboratory (1/12)

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

PRINTED: 02/01/2012  
FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/19/2012
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40392
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(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 441	<p>Continued From page 10</p> <p>eight (8) sampled residents (Resident #3), and five (5) unsampled residents (Unsampled Resident A, B, C, D, and E).</p> <p>The facility failed to ensure proper infection control procedures were followed related to hand hygiene after obtaining a fingerstick blood sugar for Unsampled B.</p> <p>In addition, the facility failed to ensure infection control procedures were followed related to dressing changes for Resident #1.</p> <p>Also, the facility failed to ensure proper hand hygiene prior to administration of eye medication for Resident #4.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the Centers for Disease Control and Prevention guidelines revealed if blood glucose meters were shared, the device should be cleaned and disinfected after every use.</li> </ol> <p>Review of the facility Policy, dated 07/10, revealed the blood glucose monitor should be cleaned with a damp cloth or with alcohol or Sani-Cloth wipes if dirt, blood, or lint is present. Review of the blood glucose monitor manufacturer's instructions revealed cleaning the exterior surface of the blood glucose monitor daily was recommended. "Important: the Joint Commission recommends cleaning after each patient for infection control." Further review revealed it was recommended the monitor be cleaned only with a damp cloth or sponge and a mild detergent. Acceptable cleaning solutions included alcohol and ammonia based cleaners.</p>	F 441	<p>GLUCOMETER EDUCATION WILL ALSO OCCUR AT ANNUAL SKILLS FAIR BY LABORATORY EMPLOYEES AND STAFF EDUCATOR, RN. MONTHLY COMPLIANCE AUDITS, HANDWASHING POLICY AND PROCEDURE REVIEW AND HAND WASHING EDUCATION TO BE COMPLETED 2/27/12 BY INFECTION CONTROL RN.</p> <p>HAND WASHING AUDITS TO OCCUR MONTHLY TO ENSURE COMPLIANCE OF EMPLOYEES - AUDIT TOOL ATTACHED 2/27/12</p> <p>MEDICATION AUDIT WILL REVIEW AND CORRECT TECHNIQUES FOR ADMINISTRATION OF EYE DROPS/MEDICATION 3/1/12</p> <p>① GLUCOMETER TRAINING AND POLICY REVIEW TO BE COMPLETED 2-27-2012 POLICY ATTACHED</p>	8/20/12 2/27/12 2/27/12 3/1/12

MONTHLY AUDITS FOR CLEANING COMPLIANCE OF GLUCOMETER - ATTACHED AUDIT FORM

**MANDATORY INSERVICE FOR TCU**

TERESA DANIELS, RN, INFECTION  
CONTROL NURSE  
WILL BE PRESENTING ON:

**LONG TERM CARE INFECTION  
REQUIREMENTS AND HAND  
WASHING COMPLIANCE.**

DATE: MONDAY 2-27-2012

TIME: 7:15AM  
10:30AM  
2:00 PM

EVERYONE MUST ATTEND ONE  
SESSION.

IF THERE IS ANY CONFLICT YOU  
MUST SEE ME PRIOR TO THIS DATE.

KATHY BACHMAN  
ADMINISTRATOR

**Hand Hygiene and Precaution Compliance**

Name of auditor \_\_\_\_\_  
week of: \_\_\_\_\_

Unit \_\_\_\_\_

Healthcare Discipline	Hand Hygiene		Staff using PPE correctly	B/P cuff, glucometer etc cleaned with saniwipe b/n patients		Comments/ staff members name if known
	Before Contact	After Contact				
MD NSG TECH RT PT/OT ES DIETARY LAB OTHER: _____	Waterless <input type="checkbox"/> Soap & Water <input type="checkbox"/> None <input type="checkbox"/>	Waterless <input type="checkbox"/> Soap & Water <input type="checkbox"/> None <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
MD NSG TECH RT PT/OT ES DIETARY LAB OTHER: _____	Waterless <input type="checkbox"/> Soap & Water <input type="checkbox"/> None <input type="checkbox"/>	Waterless <input type="checkbox"/> Soap & Water <input type="checkbox"/> None <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
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MD NSG TECH RT PT/OT ES DIETARY LAB OTHER: _____	Waterless <input type="checkbox"/> Soap & Water <input type="checkbox"/> None <input type="checkbox"/>	Waterless <input type="checkbox"/> Soap & Water <input type="checkbox"/> None <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
MD NSG TECH RT PT/OT ES DIETARY LAB OTHER: _____	Waterless <input type="checkbox"/> Soap & Water <input type="checkbox"/> None <input type="checkbox"/>	Waterless <input type="checkbox"/> Soap & Water <input type="checkbox"/> None <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Number HH correct \_\_\_\_\_ Number PPE correct \_\_\_\_\_ Equipment correct \_\_\_\_\_

Compliance Rate \_\_\_\_\_ Compliance Rate \_\_\_\_\_ Compliance Rate \_\_\_\_\_



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

PRINTED: 02/01/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/19/2012
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40392
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(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 441	<p>Continued From page 12</p> <p>blood glucose monitors in the last annual health fair.</p> <p>Observation, on 01/18/12 at 5:50 AM, revealed LPN #2 cleaned the blood glucose monitor with an alcohol pad and took a bin containing gauze, lancets, test strips, and alcohol pads into Unsampled Resident B's room. After performing the finger stick, LPN #2 cleaned the blood glucose monitor with alcohol pads. She stated it was very important to clean the monitor after use, and they had training on cleaning the monitor during the last yearly Inservice.</p> <p>Further observation, on 01/18/12 at 6:00 AM, revealed RN #4 cleaned the same blood glucose monitor with alcohol pads and proceeded to obtain a finger stick blood sugar on Resident #3. Afterwards, she cleaned the blood glucose monitor with alcohol pads. She stated the nurses were instructed they could use either Sani-wipes, Sani-Cloths or alcohol to clean the blood glucose monitors after each use. Continued interview revealed there was only one blood glucose monitor on the unit.</p> <p>Interview, on 01/18/12 at 4:00 PM, with the Infection Control Nurse, revealed the glucometers were to be cleaned after each use with Super Sanicloth or Sani-wipes per the CDC guidelines. Continued interview revealed the Lab Director did the Annual Competency inservice related to cleaning glucometers and the Staff Development Nurse did Inservices for new hires. After reviewing the facility policy related to cleaning glucometers, she indicated the policy needed to be updated to "current best practices" and that alcohol would not be effective in cleaning the</p>	F 441	<p>GLUCOMETER AUDITS TO OCCUR MONTHLY FOR CLEANING COMPLIANCE.</p> <p>① GLUCOMETER TRAINING AND POLICY REVIEW TO BE COMPLETED BY ALL STAFF BY 2/27/12 WITH COMPETENCY ASSESSMENT BY INFECTION CONTROL NURSE (RN)</p> <p>① GLUCOMETER TRAINING AND POLICY REVIEW TO COMPLETED BY 2/29/12 WITH COMPETENCY ASSESSMENT BY INFECTION CONTROL RN</p> <p>① WHOLE BLOOD GLUCOMETER POLICY AND PROCEDURE REVISED DURING SURVEY (1-18-2012)</p>	2/27/12

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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40392
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F 441	<p>Continued From page 13 blood glucose monitors.</p> <p>Interview, on 01/18/12 at 3:00 PM, with the Clinical Nurse Coordinator/Staff Development Nurse revealed she taught general orientation for newly hired nurses. She stated she informed the nurses they needed to use Sani-wipes to clean the glucometers; however, did not teach the nurses to clean the glucometer's after each use.</p> <p>Interview, on 01/18/12 at 4:00 PM, with the Lab Director, revealed she had done teaching related to cleaning the blood glucose monitors at the Annual Competency for the nursing staff. She stated she taught the nurses to clean the monitor if it was visibly dirty with Saniwipes and to clean the electrode part of the monitor with alcohol pads. She stated she also had the nurses to demonstrate the cleaning procedure back to her. She stated she was unaware the blood glucose monitors needed to be cleaned after each use and did not teach this during the inservices.</p> <p>The Director of Nursing was unavailable for interview.</p> <p>2. Review of the facility's Standard/Universal Precautions Policy, dated 02/08, revealed hand hygiene should be performed after touching blood, body fluids, secretions, excretions, contaminated items, immediately after removing gloves, and between patient contacts.</p> <p>Review of the facility's Hand Hygiene Policy, dated 02/11, revealed hand hygiene with soap and water or hand sanitizer should be performed upon entering or exiting a patients room, before and after patient contact, before donning and</p>	F 441	<p>① WHOLE BLOOD GLUCOMETER POLICY AND GLUCOMETER TRAINING FOR CARE AND MAINTENANCE EDUCATION TO BE COMPLETED BY RN/INFECTION CONTROL 2/27/12</p> <p>① WHOLE BLOOD GLUCOMETER POLICY/PROCEDURE REVISED TO STATE CLEAN THE EXTERIOR SURFACE WITH HOSPITAL APPROVED SANI-CLOTH WIPES BETWEEN EACH PT/RESIDENT AFTER USE. DO NOT USE BLEACH OR HYDROGEN PEROXIDE BASED CLEANERS AS THEY WILL FADE THE MONITOR KEYPAD DURING THE SURVEY 1-18-2012 1/18/12</p>	

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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40392
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F 441	<p>Continued From page 14</p> <p>after removing gloves, before clean/aseptic techniques, after touching patient surroundings, before handling medication, and after body fluid exposure risk.</p> <p>Observation, on 01/18/12 at 5:50 AM, revealed LPN #2 obtained a finger stick blood sugar for Unsampled Resident B, and stated the monitor would need to be reprogrammed. She then removed her soiled gloves, opened the door, and went to the nurse's station to obtain test strips, alcohol pads, and lancets in order to perform another finger stick blood sugar. The nurse failed to wash her hands after removing the soiled gloves and prior to leaving the room to get supplies from the nurse's station.</p> <p>Interview, with LPN #2 on 01/18/12, immediately after she obtained the finger stick blood sugar, revealed she should have sanitized or washed her hands after removing the soiled gloves.</p> <p>3. Observation of a dressing change for Resident #1, on 01/17/12 at 2:20 PM, revealed LPN #1 cleansed the wound to the left heel with wound cleanser and gauze, and applied Vaseline gauze with a Telfa dressing and kerlex. Further observation, revealed with the same soiled gloves, the nurse applied Triple Antibiotic and gauze to abrasions on the right arm. She then picked up the bed control to lower the head of the bed, and picked up the call bell and placed it on the bed with the same soiled gloves.</p> <p>Interview, on 01/17/12 with LPN #1 immediately after the dressing changes, revealed she did not feel she needed to wash hands and change gloves between wound sites because neither</p>	F 441	<p>② HANDWASHING- SECRET AUDITS TO TAKE PLACE MONTHLY, ALSO GLUCOMETER CLEANING AUDITS MONTHLY</p> <p>HANDWASHING POLICY AND PROCEDURE AND EDUCATION INSERVICES SCHEDULED (INFECTION CONTROL) BY RN / INFECTION CONTROL NURSE</p> <p>③ DRESSING CHANGE INSERVICES SCHEDULED FOR TRANSITIONAL CARE UNIT NURSES TO COMPLY WITH INFECTION CONTROL PROCEDURES CONDUCTED BY RN</p> <p>LPN #1 - INDIVIDUAL EDUCATION PROVIDED R/T DRESSING CHANGES AND HAND HYGIENE</p> <p>ALSO EDUCATED DURING SURVEY (1-17-2012)</p>	<p>2/27/12</p> <p>2/27/12</p> <p>2/17/12</p> <p>2/17/12</p>
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40392
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F 441	<p>Continued From page 15</p> <p>wound was infected and there were no Physician's orders for sterile procedures with the dressings. Further interview revealed she was unaware of the need to remove gloves and wash hands before handling the items in the room such as the bed control and call bell.</p> <p>4. Observation of medication administration, on 01/18/12 at 8:40 AM for Resident #4, revealed RN #2 moved a mattress which was on the floor with gloved hands, and with the same gloved hands administered Artificial Tears eye drops, one (1) drop in each eye.</p> <p>Interview, on 01/18/12 at 8:55 AM, with RN #2 revealed she should have removed her soiled gloves and washed her hands prior to administration of the eye drops.</p>	F 441	<p>④ RN #2 INDIVIDUALLY EDUCATED - RN #2 AWARE OF INFECTION CONCERN AT THE TIME OF MEDICATION PASS. AWARE OF HAND WASHING + INFECTION RE-EDUCATION BY RN / INFECTION CONTROL NURSE</p> <p>MEDICATION AUDITS TO CORRECT TECHNIQUE BY RN AUDITOR. ALL NURSES WILL RECEIVE 100% COMPLIANCE WITH MED. PASS - IF DOT AUDIT WILL CONTINUE UNTIL NURSE RECEIVES 100% COMPLIANCE AND THERE</p>	<p>2/27/12</p> <p>3/1/12</p>

AFTER ANNUALLY CONDUCTED

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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40382
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(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	<p>INITIAL COMMENTS</p> <p>Building: 01 3rd Floor of an Accredited Hospital</p> <p>Plan Approval: 08/17/87</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type I (332) Protected</p> <p>Smoke Compartment: Two (2)</p> <p>Fire Alarm: Complete Fire alarm System</p> <p>Sprinkler System: Complete Sprinkler System (Dry)</p> <p>Generator: Two (2) Type I Diesel Generators One (1) installed in 1985 and One (1) installed in 2007.</p> <p>A standard Life Safety Code survey was conducted on 01/18/12. Clark Regional Medical Center was found to be in compliance with the requirements for participation in Medicare and Medicaid</p>	K 000	<p style="text-align: center;">RECEIVED FEB - 9 2012 BY: _____</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathy Bachman TCU Administrator</i>	TITLE <i>Feb 9 - 2012</i>
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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.