

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

PRINTED: 12/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/17/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 241 SS=D	<p>A Recertification and Abbreviated Survey were initiated on 11/14/11 and concluded on 11/17/11. The Abbreviated Survey investigating ARO #KY17349 was determined to be unsubstantiated without related deficiencies. Deficiencies were identified during the Recertification Survey, with the highest scope and severity of an "E".</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one (1) of five (5) sampled residents, (Resident #4). The facility failed to ensure Resident #4, who had a urinary drainage bag, had a Dignity Bag to cover the drainage bag.</p> <p>1. The facility was unable to produce a policy on Dignity or urinary drainage bag covers.</p> <p>Observation on tour, on 11/14/11 at 7:00 PM, revealed Resident #4 did not have urinary drainage bag covered with a Dignity Bag and the drainage bag was facing the doorway hanging on the bed rail.</p>	F 241	<p>Corrective Action: Dignity bags were ordered and received 11/21/11. A Dignity Bag was applied to the catheter drainage bag of Resident #4. All other current residents were checked for dignity bag needs, none were required.</p> <p>Policy # 14-0909-136 "Resident Dignity Pertaining to Urinary Catheters" was written and posted on staff communication board on 11/18/11. All new residents are assessed for dignity bag needs per policy. Dignity bags have also been added to the urinary catheter care plan. Care Plans are audited throughout the month currently.</p> <p>A Unit meeting is scheduled for 12/16/11 and the new policy will be discussed. Any nursing staff not in attendance are required to read and sign the policy by 12/23/11.</p> <p>The DON will ensure this is done.</p> <p>Any staff not complying will not be allowed to work until this has been completed.</p>	

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 241	Continued From page 1 Interview, on 11/15/11 at 3:00 PM, with Registered Nurse #4, revealed the urinary drainage bags should be covered with a Dignity Bag.	F 241	The activity therapist has a daily rounding checklist in which all catheters will be checked for presence of dignity bags, if there are any missing, the activity therapist will put one on. The checklist will be given to the Administrator weekly for inclusion into the QA data that is reviewed weekly by the DON and Administrator. If the Activity Therapist is absent, this will be completed by the unit secretary or the DON. Care Plan Audits are also carried out weekly, the Catheter Dignity bag has been added to this audit also. The outcomes will be added to the data that is submitted to the TCU QA committee that meets Quarterly. The QA committee consists of the Administrator, DON, Medical Director, RN, Activity Therapist, PT, Dietician, Social Worker, MDS Coordinator, Risk and Compliance Manager, pharmacist and Admissions Coordinator. All audit results are documented, analyzed and trended by TCU QA Committee to identify opportunities for improvement and take appropriate and immediate action. The TCU QA Committee will develop and implement appropriate plans of action to correct identified quality deficiencies.	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide a clean, comfortable, and homelike environment to residents. The walls in the hallway had numerous areas of damaged drywall and damaged wallpaper. In addition, a stained glass window near the entryway to the unit had numerous breaks in it. The findings include: Observation on the evening of 11/14/11 revealed extensive damage to the drywall in the hallway nearest residents' rooms. Most of the damage appeared to be between one (1) and three (3) feet from the floor, with the most severe of the damage measuring approximately five (5) centimeters in length and going through the drywall. The damage was noted to be centered in the areas between residents' rooms, with wallpaper at the same height further down the			

12/24/11

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F 252	Continued From page 2 hallway noted to be torn in several places. Observation, on 11/16/11 at 9:00 AM, revealed a stained glass window near the main elevators leading to the unit had several breaks in the glass. Closer examination revealed all the glass was present in the window, but sharp edges could be felt by running one's hands across the surface. An interview with the Director of Environmental Services, on 11/16/11 at 9:13 AM, revealed he conducted monthly rounds throughout the facility, with the focus of his monthly rounds being the identification of safety issues. He further stated that cosmetic damages were a lower priority than addressing safety concerns. The Director of Environmental Services went on to acknowledge he did receive regular work orders from the unit, primarily dealing with burned-out lightbulbs or plumbing issues. An interview with the Director of Nursing, on 11/16/11 at 2:20 PM, revealed she was not aware of the damage to the stained glass window, and believed the damage to have been recent. She acknowledged the damage to the walls, ciling bumps and gouges were caused by medical equipment, ranging from beds to medication carts to wheelchairs. She went on to reveal she put in work orders for damaged areas often. A review of work orders place by the unit from 09/03/11 through 11/09/11 revealed a total of six (6) work orders. Four (4) of the work orders dealt with plumbing issues, one (1) dealt with lighting issues, and one (1) dealt with heating issues. None of the work orders mentioned any concerns related to the "cosmetic" damages to the unit.	F 252	Corrective Action: All residents affected. Stained glass window repaired 12/9/11 Drywall damage and wallpaper - all repairs completed 12/9/11. An interior designer came in to the unit 12/12/11 and recommended color scheme and changes to enhance the unit to provide a clean, comfortable and homelike environment to our residents. Remodeling /updating of the unit is planned for early 2012. Staff have been instructed verbally and via postings to call and place work orders if they see any damage, or to notify DON/Administrator. It will also be on the agenda for the next unit Meeting on 12/16/11. Administrator began a weekly rounding and check sheet of the unit on 12/8 11 to specifically look at environment for damage and follow up on needed repairs. The check sheet outcomes will be added to the data that is submitted to the TCU QA committee that meets Quarterly. The QA committee consists of the Administrator, DON, Medical Director,	12/17/11	

MDS Coordinator, Risk and Compliance Manager,

pharmacist and Admissions Coordinator.

All audit results are documented, analyzed and trended by the TCU QA Committee to identify opportunities for improvement and take appropriate and immediate action. The TCU QA Committee will develop and implement appropriate plans of action to correct identified quality deficiencies.

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F 323 SS=E	<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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the residents' environment remained free of accident hazards. During tour of the facility, the medication cart was found to be unlocked as well as the pharmacy office door.</p> <p>The findings include: During the initial tour of the facility, on 11/14/11 at 8:00 PM, the entry door to the pharmacy office was found to be unlocked. Upon entering the office, a can of uncapped Lysol Aerosol spray was found sitting on the floor and a spray bottle of rubbing Alcohol was hanging from the tray above the first desk facing the wall. Also during the tour, the medication cart was found to be unlocked for a period of ten (10) minutes. The cart was unlocked from 9:00 PM until 9:10 PM, when the surveyor asked Registered Nurse (RN) #6 to check the cart to ensure the cart had automatically locked. Upon her verification, the cart was not locked.</p>	F 323	<p>Corrective Action:</p> <p>Pharmacy office door now has a lock.</p> <p>Pharmacy staff have been instructed to close and lock door when there is no one in the room.</p> <p>Med cart – BioMed was called to look at the cart in question and verified it was working correctly and should have auto-locked after 3 mins. We are not clear as to why it did not lock and are currently in conversation with the manufacturer.</p> <p>The medication carts have been moved to the inside of the nurse's station as of 11/17/11 which now adds another level of security.</p> <p>Nurses have also been instructed to make sure the med cart drawers are locked before they move away from the cart.</p> <p>Bio Med changed the auto-lock on the cart to Lock after 30 seconds of non-use.</p>	

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F 323	<p>Continued From page 4</p> <p>Interview, on 11/14/11 at 8:15 PM, with RN #7/House Supervisor, validated the pharmacy door was open and should have been locked when no personnel was present in the office. Further interview identified, the Lysol and Alcohol were chemicals that posed an accident risk for residents. Continued interview revealed, if a resident came in contact with a chemical staff would be required to obtain the MSDS from Environmental Services in order to determine the type of first aid to administer.</p> <p>Review of the Material Safety Data Sheet (MSDS) for the Lysol Disinfectant Spray, dated 09/08/05, MSDS number not available, revealed emergency overview to indicate, "Warning: Flammable. Contents under pressure. Causes eye irritation. Do not spray in eyes, on skin or on clothing. Keep away from heat, sparks and open flame. Exposure to temperatures above 130 degrees Fahrenheit may cause bursting. Do not puncture or incinerate. Keep out of reach of children."</p> <p>Review of the MSDS for the Isopropyl Alcohol, dated 02/21/01, MSDS reference number: 213145, revealed potential health effects to include: "severe irritation and discomfort to the eyes as well as reversible and/or irreversible corneal damage may occur. If ingested, gastrointestinal tract irritation and/or discomfort is possible. Inhalation effects include; respiratory tract irritation and/or headaches possible and significant systemic toxic effects are likely following repeated exposure to high concentrations. Guidelines for personal protection was also indicated on the MSDS to include; eyes and face-wear safety glasses with side shields or goggles when handling this material; skin-to</p>	F 323	<p>DON, Administrator and Activity Therapist complete daily rounds. The med carts will be checked during those rounds to ensure it is locked. Any issues/occurrences of carts not being locked will be reported to the DON investigate immediately and also reported to the TCU QA committee that meets Quarterly. The QA committee consists of the Administrator, DON, Medical Director, RN, Activity Therapist, PT, Dietician, Social Worker, MDS Coordinator, Risk and Compliance Manager, pharmacist and Admissions Coordinator.</p> <p>All audit results are documented, analyzed and trended by the TCU QA Committee to identify opportunities for improvement and take appropriate and immediate action. The TCU QA Committee will develop and implement appropriate plans of action to correct identified quality deficiencies.</p>	12/15/11

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F 323	Continued From page 5 prevent any contact, wear impervious protective clothing such as neoprene or butyl rubber gloves, apron, boots or whole bodysuit, as appropriate; respiratory-use NIOSH/MSHA approved respirator when vapors or mist concentrations exceed permissible exposure limits; protective clothing-chemical resistant boots, apron, etc. as necessary to prevent contamination of clothing and skin contact. Keep out of reach of children." Interview with the Administrator and Director of Nursing (DON), on 11/15/11 at 10:10 AM, confirmed the door to the pharmacy door should have been locked at all times when pharmacy staff was not present in the office. Further interview, identified the pharmacy door being open was a hazard for residents and visitors.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	Corrective action – Resident #1 was affected directly by RN#5. Resident # 1 was monitored closely for signs of possible infection. None were noted up to the discharge of resident on 11/30/11. RN #5 was counseled and re-educated verbally by DON immediately after incident. A mandatory in-service by the Hospital's Infection Control Nurse was completed on 11/22/11 regarding preventing spread of infection.	

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F 441	<p>Continued From page 6</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to 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>The findings include:</p> <p>Observation of Registered Nurse (RN) #5, on 11/15/11 at 4:00 PM, revealed RN #5 started a skin assessment at Resident #1's feet, then went to the perineal area, then touched her face and then the resident's head without changing gloves or washing hands. Additionally, RN #5, touched the wound on Resident #1 with the same</p>	F 441	<p>A mandatory in-service by the Hospital's Certified Wound Nurse on Skin and Wound Assessment was completed on 11/22/11 for all unit nursing staff.</p> <p>Any nursing staff that were not in attendance are required to read and sign a written summary of the in-service by 12/16/11. The DON will ensure this is done. Any staff not complying will not be allowed to work until this has been completed.</p> <p>Weekly audits to be completed by an RN, were put in place 12/22/2011. The audit outcomes will be reviewed weekly by the Administrator and DON and issues rectified immediately. It will be reported to the TCU QA committee that meets Quarterly. The QA committee consists of the Administrator, DON, Medical Director, RN, Activity Therapist, PT, Dietician, Social Worker, MDS Coordinator, Risk and Compliance Manager, pharmacist and Admissions Coordinator.</p> <p>All audit results are documented, analyzed and trended by the TCU QA Committee to identify opportunities for improvement and take appropriate and immediate</p>		

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F 441	Continued From page 7 contaminated gloves and continued the skin assessment without changing gloves or washing her hands. Interview, on 11/15/11 at 5:00 PM, with RN #5, revealed she should have started the skin assessment at the head and completed the assessment with the feet. Further interview revealed infection control procedures were not followed during the skin assessment and she should have changed the gloves at least three (3) to four (4) times during the assessment. Interview, on 11/16/11 at 2:30 PM, with RN #1 (Director of Nursing), confirmed the infection control policy for skin assessments was not followed by RN #5. Further interview revealed, staff were educated to change gloves during the process of doing a skin assessment when going from area to area, especially when contaminating the gloves after touching the perineal area.	F 441	action. The TCU QA Committee will develop and implement appropriate plans of action to correct identified quality deficiencies. 12/23/11
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	

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F 514	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of the facility's policy it was determined the facility failed to maintain clinical records that were complete and accurately documented for one (1) of five (5) sampled residents, (Resident #1). The facility failed to provide documented skin assessments for Resident #1 as directed by facility's policy, number 14-0107-10 dated 4/11/08, titled Assessment, Prevention and Treatment of Pressure Ulcers and Braden Scale for Predicting Pressure Ulcer Risk. The findings include: Review of the facility's policy titled "Assessment, Prevention and Treatment of Pressure Ulcers and Braden Scale for Predicting Pressure Ulcer Risk", number 14-0107-10 dated 4/11/08, revealed a resident with a Braden score of 18 or higher, the Registered Nurse will perform a head to toe skin assessment initially and every shift (12 hours). Interview Registered Nurse (RN) #3/Wound Nurse, on 11/16/11 at 10:42 AM, validated facility's policy, skin assessments were to be performed by a Registered Nurse on admission and every shift (12 hours) and documented in the residents' medical record. Record review revealed the facility admitted Resident #1 on 11/14/11, with diagnoses which included right leg Cellulitis, right wrist Fracture, Debility and Failure to Thrive. Further review revealed the facility completed an initial Braden	F 514	Resident #1 – has since been discharged. All current resident's charts were checked for accurate and timely skin documentation on 11/18/11 and updated as necessary. A mandatory in-service on skin and wound assessment and documentation was given by the Certified Wound Nurse on 11/22/11. Any nursing staff that were not in attendance are required to read and sign a written summary of the in-service by 12/16/11. The DON will ensure this is done. Any staff not complying will not be allowed to work until this has been completed. The Wound Care Nurse has developed a new skin assessment form to be filled out by nursing per shift. This will automatically print out daily with the Nursing progress notes. Start date 12/19/11. Skin documentation has also been added to the Monthly QA audits by an RN. The results will be reported to the DON and Administrator weekly and reported to the quarterly TCU QA committee. The QA committee consists of the Administrator,	

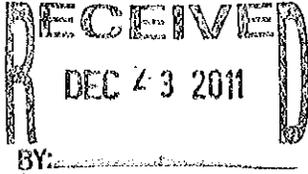
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F 514	<p>Continued From page 9 Scale Assessment and scored the resident as 18.</p> <p>Review of the Resident #1's record revealed no evidence of a documented skin assessment upon admission. Further review revealed no evidence of a documented skin assessment every shift there after, as per the facility's policy.</p> <p>Observation, on 11/15/11 at 4:00 PM, revealed RN #5 performed a skin assessment on Resident #1.</p> <p>Record review, following the assessment, revealed RN #5 failed to document newly identified wounds and measurements of the existing wounds observed during the skin assessment for Resident #1.</p> <p>Interview with RN #5, on 11/15/11 at 4:00 PM, revealed the Wound Nurse documented the skin assessments and measurements of any wounds.</p> <p>Further Interview with RN #3/Wound Nurse, while reviewing the record for Resident #1, revealed no documented evidence of a skin assessment performed for Resident #1, on admission or every shift as per the facility's policy.</p> <p>Interview with the Director of Nursing, on 11/16/11 at 11:04 AM, while reviewing the record for Resident #1, revealed no documented evidence of a skin assessment performed for Resident #1, on admission or every shift as per the facility's policy.</p>	F 514	<p>All audit results are documented, analyzed and trended by the TCU QA Committee to identify opportunities for improvement and take appropriate and immediate action. The TCU QA Committee will develop and implement appropriate plans of action to correct identified quality deficiencies.</p>	12/20/11	#

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

PRINTED: 12/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188430	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING: _____	(X3) DATE SURVEY COMPLETED 11/16/2011
NAME OF PROVIDER OR SUPPLIER ST CLAIR MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40361	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan approval date: 1978 Survey under: NFPA 101 (2000 Edition) Facility type: SNF Type of structure: Seven story Type I (332) Smoke Compartment: Two Fire Alarm: Complete fire alarm Sprinkler System: Complete sprinkler system A standard Life Safety Code survey was conducted on 11/16/11. Saint Claire Medical Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was four (4). The facility is licensed for ten (10) beds.	K 000		
K 082 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA	K 082		

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

[Signature]

TITLE

Administrator

(X6) DATE

12/14/11

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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NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40361		
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K 082	<p>Continued From page 1 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler system standpipes were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, Ten (10) residents, staff and visitors. The findings include: Record review of the sprinkler inspection report on 11/16/2011 at 1:00 PM, revealed the sprinkler inspection report dated on 08/13/2011 and 06/13/2011 stated the sprinkler standpipe needed performed. Sprinkler standpipe systems must be inspected to ensure their reliability during a fire. The observation was confirmed with the Maintenance Director. Interview on 11/16/2011 at 1:00 PM, with the Maintenance Director, revealed the facility had received a bid proposal for the sprinkler standpipe inspection from the outside contractor but the facility had not followed up on the bid proposal.</p> <p>Reference: NFPA 25 (1998 edition) 3-3.1.1* A flow test shall be conducted at the hydraulically most remote hose connection of each zone of a standpipe system to verify the water supply still adequately provides the design pressure at the required flow. Where a flow test of the hydraulically most remote outlet(s) is not practical, the authority having jurisdiction shall be consulted for the appropriate location for the test. A flow test shall be conducted every 5 years.</p>	K 062	<p>Corrective Action: Sprinkler standpipe inspection has been scheduled to be completed on 12/16/11 by Simplex. (All Residents are affected)</p> <p>A contract has been signed with Simplex, as of 11/16/11.</p> <p>The standpipe inspection will be included in the preventative maintenance contract with Simplex to be performed every 5 years. It has also been added to the Unit's preventive maintenance program Through the maintenance department, to issue a "reminder" every 4.5 years.</p>	12/17/11	

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NAME OF PROVIDER OR SUPPLIER ST CLARE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40361	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure exit corridors were maintained free and clear of obstructions, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, ten (10) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 11/16/2011 at 12:46 PM, revealed various equipment (medicine carts, equipment for monitoring resident vitals, mobile computer) was unattended and not in use in corridors. Exits must be maintained clear of obstructions to allow for use during an emergency. Items not in use can not be stored in corridors. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 11/16/2011 at 12:46 PM, with Nursing Staff and the Maintenance Director, revealed the items are routinely left in corridors due to lack of storage space.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 072	<p>Corrective Action: All Residents are affected. All objects were moved from the hallways and relocated immediately after the surveyor informed the unit of the deficiency.</p> <p>Staff have been verbally educated one on one and in the unit meeting 11/22/11, by the DON as to the new locations of the equipment and that the hallways are to be maintained free and clear of <u>ANY</u> items/furniture/med carts.</p> <p>This will be reinforced daily in DON rounds and in unit postings. It has also been added to the ongoing monthly staff meeting reminders.</p> <p>The Activities Therapist has added hallway checks to her daily rounds. Rounds will be done by Unit Secretary in her absence. Signs have been placed in appropriate areas to remind staff not to leave equipment in hallways.</p>	

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NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
(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 072	Continued From page 3 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		11/23/11
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen supplies were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect (1) of two (2) smoke compartments, ten (10) residents, staff and visitors. The findings include: Observation on 11/18/2011 at 1:01 PM, revealed in the oxygen supply room, combustible materials (cardboard, plastics) were stored within five (5) feet of the supply of oxygen cylinders.	K 076	Corrective Action: All Residents are affected. Flammable objects were immediately removed from within 5 feet of the oxygen tank storage. Signs have been placed around the oxygen storage area. A 5ft area has been taped on the floor in red tape to serve as a reminder. The Activities Therapist has added oxygen storage checks to her daily rounds. Rounds will be done by Unit Secretary in her absence. This was also reinforced in the mandatory staff meeting on 11/22/11 and in the unit meeting scheduled for 12/16/11.	

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K 076	<p>Continued From page 4</p> <p>Combustible cannot be stored within five (5) feet of oxygen supplies due to spread of fire. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 11/16/2011 at 1:01 PM, with the maintenance Director, revealed he was not aware combustibles should not be stored within five (5) feet of oxygen eupples.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p>	K 076		12/17/11	