

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

PRINTED: 03/29/2013  
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  03/15/2013
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOSPITAL DRIVE WINCHESTER, KY 40391
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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
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F 000	INITIAL COMMENTS  A Recertification Survey was conducted 03/11/13 through 03/15/13. Deficiencies were cited with the highest Scope and Severity of an "G".	F 000	Preparation and submission of this plan of correction does not constitute an admission of guilt by the facility. This plan of correction is being submitted as required by State and Federal law.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  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.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy it was determined the facility failed to promote care for the residents in a manner and in an environment that maintains or enhanced each resident's dignity and respect in full recognition of his/her individuality for three (3) of eight (8) sampled residents (Residents # 6 and #7, and Unsampled Resident A). Interviews with the three (3) residents revealed complaints of staff not answering call lights soon enough which resulted in each resident having an incontinent episode which made them feel bad.  The findings include:  Review of the facility's policy titled "Plan for the Provision of Patient Care and Services, dated 04/2012, revealed staff would care for residents in a way that promoted respect and dignity. The policy also stated care would be based on the resident's individual needs and preferences and interactions with residents would serve to build	F 241	F241  The Activity Director held a special resident council meeting on 03/21/2013 to review findings of the survey. The agenda items included water temperatures, answering call lights, resident preferences, steps to filing a grievance/concern. There were 6 residents in the group with resident's #6 and #7 in attendance. The Activity Director met one on one for those residents not in attendance. Residents #6 and #7 agreed bed bath until room 242 available.  The facility recognizes other residents of the facility have the potential to be affected by the alleged deficient practice. Facility staff were in-services by the Administrator on promoting 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/her individuality. Education will be completed by 04/12/2013. The facility developed a 10 question survey tool and residents were interviewed privately by the Activity Director to ensure residents have choices and their preferences are being honored. The Activity Director also reviewed the Grievance/Concern procedure and encouraged residents to voice their concerns. New admissions to the Transitional Care	04/16/2013

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Denise Kirk</i>	DATE 04-05-2013
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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.

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and maintain his/her self-esteem and self worth.

1. Review of Resident #7's medical record revealed the facility admitted the resident, on 03/29/12, with diagnoses which included Diabetes, Morbid Obesity, Intracranial Hemorrhage, Anxiety Disorder and Depression. Review of the Quarterly Minimum Data Set (MDS), dated 01/03/13, revealed the Brief Interview for Mental Status assessed the resident was cognitively intact.

Continued review of the MDS revealed the resident was totally dependent on staff for transfers, tilting assistance, and was frequently incontinent.

Review of the Comprehensive Plan of Care, dated 01/13, revealed Resident #7 required the use of a mechanical lift for transfers. Further review of the care plan revealed the resident needed help toileting, the resident used a bedpan, and staff was supposed to ask and/or toilet the resident every two (2) hours between 8:00 AM and 10:00 PM; and then at midnight and 4:00 AM. In addition, staff was supposed to write the time the resident was scheduled to be toileted.

Interview, on 03/11/13 at 3:00 PM, revealed Resident #7 reported staff was slower to answer call lights on the weekends. Resident #7 stated that yesterday (03/10/13) she/he had to wait approximately twenty-five (25) to thirty (30) minutes to go to the bathroom. Further interview revealed there had been times the resident wet himself/herself waiting for staff and it made him/her feel bad.

F 241 F241 Cont.

Unit will also be interviewed by the Activity Director regarding resident choices and preference. The RN Case Manager or facility Administrator will review the Grievance/Concern procedure at the time of admission.

Social Services or Activity Director will conduct resident interviews monthly for 3 months to ensure the facility is honoring resident choices and preferences. Resident interviews will then be conducted on admission, quarterly with the MDS assessment, significant change MDS and annually with the MDS. The Administrator or RN Charge Nurse will audit call light responses 1 time each week on each shift for 4 weeks. The RN House Coordinator will also audit call light responses on the week end on each shift weekly for 4 weeks then monthly for 3 months. At the monthly Resident Council Meeting residents will be asked if their preferences are being honored and if they have any concerns they wish to discuss.

The State Ombudsman is usually present for the monthly meeting and will facilitate the group discussion.

Results of the audits will be presented at the monthly Transitional Care Unit Quality Assessment and Assurance Meeting by the Administrator for further recommendations. The results will also be reported monthly through the hospital's Quality Department.

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Interview, on 03/14/13 at 6:00 PM, with SRNA #5 revealed Resident #7 was on a two (2) hour toileting program, but the resident did use the call bell before his/her scheduled bathroom time. She stated most of the time the resident was continent when they assist him/her to the toilet. Continued interview revealed she felt they tried to respond to the resident's call light in a timely manner. She further stated if they were caring for another resident it may take them longer or they would call the nurse. She stated she did recall one time it may have taken fifteen (15) minutes to respond. Continued interview with SRNA #5 revealed the resident had complained about how long it took for them to answer the call light, but the resident had not complained about soiling themselves.

Interview with weekend Licensed Practical Nurses (LPN) #2 and #3, on 03/15/13 at 10:15 AM, revealed Resident #7 was on a toilet program and was supposed to be toileted every two (2) hours. Continued interview with the LPNs revealed the aides wrote his/her next bathroom time on the board and they encouraged the resident to wait. The nurses stated the resident would use the call light prior to the two (2) hours to say he/she needed to go and couldn't wait until the next scheduled time so they would send an aide to toilet the resident; however, other times the resident would call and they encouraged the resident to try and wait and the resident would say "okay" and was able to wait most of the time. However, sometimes called back later to say he/she couldn't wait and when the aides went down the resident was wet.

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F 241 : Continued From page 3

2. Review of Resident #6's medical record revealed the facility admitted the resident, on 03/02/1,1 with diagnoses which included Parkinson's, Arthritis, Coronary Artery Disease, and Depression. Review of the Quarterly Minimum Data Set (MDS), dated 03/11/13 revealed the Brief Interview for Mental Status assessed the resident was cognitively intact.

Further review of the MDS revealed the resident required total assistance of two (2) staff for toilet use and was assessed as being frequently incontinent.

Interview with Resident #6, on 03/13/13, revealed the resident had to wait sometimes for staff to answer the call light, but was unable to state how long. Continued interview revealed the resident had soiled him/herself sometimes waiting for staff to assist with toileting and it made him/her feel bad.

3. Interview with Unsampled Resident A, on 03/13/13, who was identified as interviewable by the facility revealed he/she had used their call light because they needed to use the bathroom and had to wait for staff to answer. Continued interview with the resident revealed he/she thought it was not more than a half hour, but a time or two the staff didn't come at all. Further interview with Unsampled Resident A revealed the resident had soiled him/herself waiting and it made them feel "awful".

Interview with SRNA #4, on 03/15/13 at 2:30 PM, revealed occasionally a resident had voided before they were able to answer the call light, but was unable to recall the resident's name or when

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F 241 Continued From page 4  
It had happened. She further stated it happened when they were busy with another resident.  
  
Continued interview with LPNs #2 and #3, on 03/15/13 at 10:15 AM, revealed they monitored response to call lights and if an aide was unable to respond, because they were with a patient, the nurse would respond. The nurses stated call lights were answered timely and they didn't think it took any longer then five (5) minutes.  
  
interview, on 03/15/13 at 6:36 PM, with the Administrator revealed her expectation was call lights would be answered in a timely manner and they wanted to maintain the independence and dignity of the residents. She further stated she felt they answered call lights in a timely manner. Further interview revealed she was unaware of any call light issue which resulted in an incontinent episode, but if staff was busy it could happen maybe on weekends. The Administrator reported they had a no pass zone where all staff was responsible for answering the call light.

F 241

F 246 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  
SS=E  
  
A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

F 246 F246  
The facility has installed a new hot water heater for the Transitional Care Unit. Installation was completed 03/26/2013. The facility identified room #242 which is a roll in shower to be utilized as the community shower room. This room shall remain unoccupied until construction of a new shower room is completed. The facility recognizes other residents have the potential to be affected by the alleged deficient practice. Facility staff has been educated by the Administrator regarding reasonable accomodation of needs and preferences. Education to be completed by 04/12/2013. 04/16/2013

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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 reasonable accommodation of the residents individual needs and preferences in regards to the individual's environment for two (2) of eight (8) sampled residents (Resident #6 and #8) who required the use of a roll in shower, which was currently unavailable, therefore the residents were unable to shower and had to take bed baths. In addition, the water temperatures in the resident's room tested below the expected level of comfort.

The findings include:

Review of the facility's policy titled "Accommodation of Resident Needs, dated 04/2012, revealed the purpose was to insure residents received services in the facility with reasonable accommodations of individual needs and preferences. The facility defined reasonable accommodations of individual needs and preferences to mean the facility's efforts to individualize the resident's physical environment. Further review of the policy revealed the facility was responsible for evaluating each resident's unique needs and preferences and would make adaptations to meet these needs. Staff were to observe the resident in bathroom facilities to ensure resident had access to assistive devices if needed.

1. Interview, on 03/15/13 at 5:50 PM, with the facility's Administrator revealed they did not have a policy regarding specific water temperatures for

F 246 F246 cont.

Using the 10 question survey tool developed by the Activity Director, residents were interviewed by the Activity Director to ensure resident choices and preferences are being met. The Administrator attended the Resident Council Meeting on 04/03/2013 to inform them of the new hot water heater and room #242 will be available for showers. The Administrator will check and record water temperatures 3 times a week for 4 weeks in various resident rooms and sinks and then weekly to ensure water temperatures are between 100 and 110 degrees Fahrenheit. The SRNA's will record water temperatures prior to bathing residents. If temperatures are out of range the Administrator will be notified as well as Facilities Management. Results of audits and residents concerns will be addressed at the TCU monthly QA&A Meeting for further recommendations and follow up. Audit results will also be presented at the hospital's monthly Quality Department Meeting.

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comfort, but the goal was to have the water temperature close to one-hundred and ten (110) degrees for the comfort of the residents.

Observations of hot water temperatures, on 03/11/13, revealed the following bathroom sink water temperatures were recorded. Room 232, unoccupied, had a hot water temperature of eighty-six (86) degrees Fahrenheit (F) when tested at 3:30 PM. Room 225 had a hot water temperature of eighty-two (82) degrees F when tested at 3:35 PM. Room 244 (unoccupied) had a water temperature of eighty (80) degrees F when tested at 4:00 PM. Room 242 had a water temperature of sixty-four (64) degrees F when tested at 4:10 PM

Observations of hot water temperatures, on 03/12/13, performed by the Facility Director of Maintenance (FDOM) revealed the following temperatures: room 244 had a bathroom sink hot water temperature of ninety-five (95) degrees F when tested at 10:50 AM; room 242 had a bathroom sink hot water temperature of sixty (60) degrees F and hot water shower temperature of seventy-one (71) degrees F when tested at 11:00 AM; room 245 had a bathroom sink hot water temperature of 92 degrees F when tested at 11:05 AM; room 225 had a hot water shower temperature of seventy-nine (79) degrees when tested at 11:10 AM; room 231, unoccupied, had a hot water shower temperature of eighty-two (82) degrees F when tested at 11:20 AM; room 202 had a hot water shower temperature of eighty-eight (88) degrees F when tested at 11:30 AM.

Interview with the FDOM, 03/12/13 at 10:30 AM,

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revealed the water temperature had been identified as a problem. The FDOM stated they contacted CMTA Engineering Consultants regarding the low temperatures and they had been working on the problem. He stated it was a problem the residents were not getting hot water and it had been going on for about a year with varying degrees. He further stated they check the hot water temperature at the source, which was far from the skilled nursing unit, but did not routinely check water temperatures in the resident rooms only when there was a complaint about the temperature. The FDOM stated he thought it was in part the mixing valves and getting the hot water to the back of the building.

Interview with a Facility Mechanic, on 03/12/13 at 11:30 AM, revealed the water mixing valve across from the nursing station could only be set to 110 degrees F and they were having circulation problems. The Mechanic stated they were not aware of the low water temperature in room 242 and the nurses were supposed to contact them if there was a problem. The Mechanic further stated they should check water temperatures in the skilled unit more frequently until they got the temperature problem straightened out.

Review of Resident #1's medical record revealed they were re-admitted by the facility on, 03/01/13, with diagnosis which included Left Hip Fracture, Anemia, Coronary Artery Disease, and Lung Cancer. Review of the Admission Minimum Data Set, dated 01/27/13, revealed the Brief Interview for Mental Status assessed the resident was cognitively intact.

Resident #1 was in room 242 and interview, on

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F 246 Continued From page 8

03/11/13 at 3:50 PM, revealed there was no hot water in his/her bathroom sink or shower since he was admitted. Review of the Admission Minimum Data Set, dated 01/27/13, revealed the resident was cognitively intact.

Interview with State Registered Nursing Assistant (SRNA) #5, on 03/14/13 at 5:15 PM, revealed some room sinks and shower water temperatures got hot right away and some took up to thirty (30) minutes to get warm.

Interview with SRNA #6, on 03/14/13 at 8:30 PM, revealed the showers do get warm, but it took awhile and they did not get real hot.

Interview, on 03/14/13 at 8:35 AM, with the CMTA Engineering Consultant revealed they had identified a problem with hot water temperatures due to the mixing valves getting clogged by the hard water. He stated cold water was being dispensed at higher pressure and this caused the cold water to go into the hot water loop cooling the hot water. He further stated this was a problem in the hospital part of the facility and now the whole building has soft water. The Engineering Consultant stated because of the cross over of cold water, the mixing valve for the unit couldn't keep the water hot enough and the hot water coming off the mixing valve was below one-hundred (100) degrees F. He further stated the mixing valve temperature could have been adjusted but they would have needed to check the temperature on a regular basis.

Further interview with the Engineering Consultant, on 03/14/13 at 11:15 AM, revealed the water temperatures were colder for the residents

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because they could not get the proper water mix to keep the temperatures up. He stated he was not sure how long they had been an issue, but they had been working on it for four (4) months.

Interview, on 03/14/13 at 5:45 PM, with the FDOM revealed they were aware of the low water temperatures in the unit and water temperatures in the eighty's would not be comfortable for the residents.

Interview, on 03/15/13 at 5:50 PM, with the Administrator revealed the concerns about the water temperatures was well known and water temperatures in the eighties would not be comfortable. She stated sometimes she was told the water temperature was tepid, but was unaware Resident #1 had no hot water. She further stated they did not routinely take the temperatures in resident rooms, only at the source, so they did not know the temperatures. Continued interview with the Administrator revealed they did test the temperature a couple of weeks ago, but she was not here and failed to follow-up to see what the result was. The Administrator stated based on the water temperature findings, they were not providing a comfortable water temperature for the residents and were not accommodating their needs.

2. Review of Resident #7's medical record revealed the resident was admitted by the facility, on 03/29/12, with diagnoses which included Morbid Obesity, Intracranial Hemorrhage, Anxiety Disorder and Depression. Review of the Quarterly Minimum Data Set (MDS), dated 01/03/13, revealed the Brief Interview for Mental Status assessed the resident was cognitively

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F 246	<p>Continued From page 10 intact.</p> <p>Continued review of the MDS revealed the resident was totally dependent on staff transfers and was unable to ambulate. Review of the resident's care plan revealed the resident required the use of a mechanical lift for transfers.</p> <p>Continued record review revealed, on 04/02/12, the resident was assessed for daily preferences and being able to choose between a tub bath, shower, bed bath or sponge bath was somewhat important to the resident.</p> <p>Review of the Bath Schedule revealed resident #7 was to get a shower three times a week on Monday, Wednesday, and Friday.</p> <p>Observation Resident #7's room (#249), on 03/13/13 at 5:00 PM, revealed the shower appeared narrow and the bottom of the shower had a lip to prevent roll-in.</p> <p>Interview, on 03/13/13 at 5:10 PM, with Resident #7 revealed he/she got showered weekly and had to go to another room to shower.</p> <p>Continued interview, on 03/14/13 at 8:30 PM, with SRNA #6 who routinely took care of Resident #7, revealed the resident liked to take showers. The SRNA stated they were not able to shower the resident in his/her room because the resident had to be rolled into the shower. She stated the facility had four (4) resident rooms which had a roll-in shower, but had just placed a resident in the last available room with a roll in shower. Continued interview with the SRNA revealed they should have a roll-in shower available to</p>	F 246		

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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOSPITAL DRIVE WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(1) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 246 Continued From page 11 residents.

Interview with Licensed Practical Nurses (LPN) #2 and #3, on 03/15/13 at 10:15 AM, who reviewed the shower schedule revealed the resident was supposed to get a shower three (3) times a week with a hair wash. Continued interview with LPNs revealed Resident #7 required a roll in shower and could no longer get a shower because the resident used to be taken to an unoccupied resident room that had a roll-in type shower because his/her room did not have one. LPN #3 stated they were not able to accommodate Resident #7's shower needs and a bed bath was not the same as a shower.

Interview with Registered Nurse (RN) #1, on 03/14/13 at 6:30 PM, revealed if they were lucky and one of the rolling shower rooms was open they would take Resident #7. The RN stated currently all the rolling shower rooms were occupied so the resident got just a bed bath.

Review of Resident #6's medical record revealed the resident was admitted by the facility, on 03/02/13, with diagnoses which included Parkinson's, Arthritis, Coronary Artery Disease, and Depression. Review of the Quarterly Minimum Data Set (MDS), dated 03/11/13, revealed the Brief Interview for Mental Status assessed the resident was cognitively intact.

Review of the MDS Functional Status Assessment revealed the resident required extensive assistance of two staff for transfers and did not ambulate. Continued record review of the most recent Comprehensive MDS, dated 09/11/12, revealed it was very important for the

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F 246 Continued From page 12  
resident to choose between a tub-bath, shower, bed bath, or sponge bath.

Review of Resident #6's plan of care, dated 09/11/12, revealed the resident could not ambulate and required the use of a mechanical lift and two (2) staff to transfer.

Review of Resident #6's shower schedule revealed the resident was supposed to get a shower once a week on Wednesday.

Observation, on 03/13/13 at 4:15 PM, of Resident #6's bathroom revealed the shower was not roll-in accessible.

Interview, on 03/13/13 at 4:45 PM, with Resident #6 revealed the resident expressed a desire to be able to take a shower and use the toilet instead of the bedpan or bedside commode.

Interview, on 03/14/13 at 8:40 AM, with SRNA #2 revealed she worked with resident #6 and the resident had expressed a desire to be able to use the commode instead of a bed pan. The SRNA further stated the resident used to use the commode several months ago but it got too hard on her shoulders and wore the resident out.

Interview, on 03/13/13 at 4:45 PM and on 03/14/13 at 9:15 AM, with Registered Nurse (RN) #3 revealed the Resident #6 had no upper body strength to move from a chair to the toilet without the assistance of 3-4 aides. She stated the resident had commented he/she wished he/she could take a shower and use the commode, but had never asked to do either. RN #3 further stated at one time she heard the resident remark

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F 246 Continued From page 13  
He/she wished they could knock out the bathroom wall.

Interview, on 03/14/13 at 12:15 PM, with the Physical Therapist (PT) revealed the last PT evaluation was performed on 04/30/12. The PT stated the Resident #6 has medical conditions which limit his/her ability to safely transfer and the resident without the use of a Hoyer lift. Further interview with the PT revealed he was not aware of any type of lift that might be used to help the resident to sit on the toilet.

Further interview, on 03/14/13 at 11:10 AM, with RN #1 revealed there were only four (4) rooms that had roll-in shower accommodations and those rooms were now occupied by other residents. She further stated in order to accommodate residents who required a roll-in shower one of those residents had to agree to move to another room.

Further interview with LPN #3, on 03/15/13 at 10:15 AM, revealed there were four (4) rooms available with a roll-in shower, but they currently all had a resident in the rooms. She stated the last room was occupied, on 03/12/13, so there were none available to the residents who did not have one in their rooms.

Continued interview with the Administrator, on 03/15/13 at 5:50 PM, revealed they had four (4) resident rooms that had roll-in showers which would enable staff to use a bath shower chair and roll the residents in the shower and no roll-in shower rooms were available to accommodate the residents. The Administrator stated she was unaware the residents did not have a roll-in

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F 246	Continued From page 14 shower room available for use and was not notified residents were no longer able to use. Continued interview with the Administrator revealed she would have expected staff to make her aware.	F 246		
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  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 the Comprehensive Care Plan was revised for one	F 280	F280 Resident #3's care plan has been revised by the interdisciplinary team to include current fall interventions for this resident. Potential problems identified were also reviewed to ensure appropriate and current interventions are in place for this resident. The facility recognizes other residents have the potential to be affected by the alleged deficient practice. Facility staff has been educated by the Director of Staff Development regarding care planning and appropriate interventions. Education to be completed by 04/12/2013. The interdisciplinary team is reviewing all resident care plans to ensure current interventions are in place for problems identified. Review of all care plans will be completed by 04/12/2013. Resident care plans are developed on admission to the TCU. Comprehensive care plans are written within the MDS guidelines and timeframes. Care plans will be reviewed during the resident care conference and updated at that time by the MDS Coordinator. The MDS Coordinator and staff nurses will be responsible for updating the care plan when there is a change in the resident's health status. The RN Administrator will attend no less than 2 resident care conferences each month to ensure care plans are current and interventions are	04/16/2013

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F 280 : Continued From page 15  
(1) of eight (8) sampled residents (Resident #3).

Resident #3 experienced falls while attempting to toilet self and obtain snacks; however the facility failed to investigate the falls to determine the root cause and failed to revise the plan of care to include effective interventions to prevent further falls. Resident #3 experienced five (5) falls from 08/02/12 through 01/20/13. Interview and record review revealed the falls were sustained while the resident was attempting to self toilet (08/02/12, 09/07/12 and 01/20/13) and attempting to obtain his/her snacks (10/02/12, and 12/16/12). Resident #3 was diagnosed with a right hip fracture after the fall on 08/02/12; a left hip fracture after the fall on 12/06/12; and a left femoral fracture and proximal humeral fracture after the fall on 01/20/13. (refer to F-323)

The findings include:

Review of the facility's policy entitled "Comprehensive Care Plans", dated 07/09, revealed the purpose was to develop care plans for each resident that included resident preferences of past and present lifestyle with measurable objectives and timetables to meet residents' medical, nursing, mental and psychosocial needs that are identified in the assessment. Further review of the policy revealed objectives and outcomes must be reviewed quarterly or updated/changed based upon residents' needs or changes.

Review of Resident #3's record revealed the facility admitted the resident on 04/26/12, with diagnoses which included a history of Falls, history of Mitral Valve Replacement, Pacemaker

F 280 : F280 cont.  
appropriate.  
The MDS Coordinator will report care plan review at the monthly QA&A Meeting and the monthly hospital Quality Meeting for further recommendations and follow up.

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F 280: Continued From page 16

Placement, Anemia, and history of Acute Renal Failure. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/10/12, revealed the facility assessed Resident #3 to have a Brief Interview of Mental Status (BIMS) of fourteen (14) which indicated the resident was cognitively intact. The facility assessed the resident to be continent of bowel and bladder; required supervision to limited assist with Activities of Daily Living (ADLs), and to be independent with ambulation. Review of Resident #3's Comprehensive Care Plan, dated 05/10/12, revealed the facility had determined Resident #3 was at high risk for falls related to falls prior to admission to the facility. Interventions on this Care Plan included staff was to remind the resident to use his/her call light, use shoes or nonskid socks, keep walker within reach, keep pathway clear to bathroom and chair, and the bed needed to be in low locked position.

Review of a Significant Change Assessment, dated 02/01/13, revealed the facility assessed Resident #3 to have a score of four (4) which indicated the resident was severely impaired in cognition. The facility assessed Resident #3 to be always incontinent of bladder and frequently incontinent of bowel; and to require limited assist of one with toilet use. The facility assessed the resident to no longer walk in the room or corridor.

Review of the Fall Incident Report documentation, 08/02/12 revealed Resident #3 fell on 08/02/12 at 4:45 AM, while ambulating to the bathroom with the use of his/her walker. The Incident Report indicated staff found Resident #3 sitting on the bathroom floor, "moaning in pain". Review of the record revealed the Physician was

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F 280: Continued From page 17

notified after the fall and an x-ray was ordered which indicated Resident #3 had a right femoral neck fracture. Review of the Incident Report revealed an alarm was to be placed on the resident's bed and staff was to ask or toilet the resident every two (2) hours while awake and to toilet at 11:00 PM and 3:00 AM, and, as necessary during the night. Review of the Care Plan revealed no documented evidence the care plan was revised with the intervention to put a bed alarm in place until 08/08/12, six (6) days after the incident report.

Review of the Incident Report, dated 09/07/12 revealed at 7:00 PM, the resident experienced a fall in the bathroom, the resident's bed alarm was on and sounding. Review revealed Resident #3 did not experience an injury related to the fall. An intervention was added to have nurses round on the even hours and State Registered Nursing Assistants (SRNAs) to round on odd hours. Review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include this intervention until 09/09/12, two (2) days after the incident report. The Incident Report indicated an intervention to place "blue tape" on the resident's toilet to assist him/her with identifying the toilet. Additionally, Resident #3 was to go to "exercise class" on Monday, Wednesday, and Fridays. Review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include this information until 09/17/12, ten (10) days after the incident report.

Interview, on 03/15/13 at 3:30 PM, with the Administrator revealed the intervention to have nurses round on the even hours was not feasible

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F 280 i Continued From page 18

and the Comprehensive Care Plan should have been revised to say SRNAs would do every one (1) hour checks on Resident #3.

Review of a "Mandatory Fall Prevention Inservice" dated 09/06/12 through 09/16/12, revealed alarm reductions were to occur for some residents. The Inservice indicated Resident #3's alarms were to be removed from 7:00 AM to 7:00 PM only. Further review of an inservice, dated 10/01/12 through 10/07/12, revealed Resident #3's alarms were to be removed on all shifts. Review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to reflect this information.

Review of the Incident Report, dated 10/02/12 revealed at 2:25 PM, a Registered Nurse (RN) heard Resident #3 yelling, "help me". Continued review of the Incident Report revealed the RN found the resident on the "opposite" side of the bed sitting next to the wardrobe with his/her feet "stretched" out. Resident #3 was noted to have told the RN he/she had been "chasing" after a cracker that rolled away and lost his/her balance. Further review of the Incident Report revealed Resident #3 was assessed to have a skin tear to the right elbow and a "small lump" on the back of his/her head. It was noted the resident had on nonskid footwear and had not used his/her call light.

Review of the record revealed an alarm reduction was performed on 12/12/12, per the resident's request and removed completely. However, review of the Comprehensive Care Plan revealed no documented evidence it was revised to include the reduction and removal of the alarms.

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F 280 Continued From page 19

F 280

Interview, on 03/15/13 at 3:30 PM, with the Administrator revealed the Comprehensive Care Plan should have been revised to include the alarm reduction.

Review of the Nurse's Notes revealed on 12/16/12 at 8:15 PM, Resident #3 was found sitting on the floor with his/her left leg and foot turned out to the "side". The resident was noted to complain of pain in the left knee and pain with movement of the leg. Continued review of the Note revealed the Physician was notified and Resident #3 was to be transferred to the Emergency Room (ER). Record review revealed Resident #3 was transferred to the ER where he/she was diagnosed with a Left Hip Fracture.

Review of the facility's Incident Reports revealed on 12/16/12 at 9:20 PM, Resident #3 was found sitting on the floor in her/his room after calling out for help; the resident was noted to tell staff he/she had been attempting to get some crackers, became dizzy and fell. Further review of the Nurse's Notes revealed Resident #3 was admitted back to the facility on 12/22/12. Further review of the Incident Report revealed a bed alarm was to be placed and rounds were to be conducted hourly. However, review of the Comprehensive Care Plan revealed no documented evidence it was revised to include the interventions indicated on the Incident Report until 12/24/12. Additional review of the Comprehensive Care Plan revealed the intervention to toilet the resident every two (2) hours while awake and to toilet at 11:00 PM and 3:00 AM and, as necessary during the night was discontinued on 12/24/12. However, there was no

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F 280 Continued From page 20  
documented evidence of why this Care Plan intervention was discontinued.

Review of the Nurse's Notes dated 01/20/13 and timed 6:09 PM, revealed at 4:20 PM staff heard Resident #3 "yelling out" and found the resident on the floor on his/her right side at the foot of the bed. The left lower extremity "with foot up near neck and hip in a twist". Review of the Note revealed the resident's bed alarm did not sound. The Nurse documented the Physician was present and orders were received to send Resident #3 to the ER. Review of the Incident Report dated 01/20/13 revealed Resident #'s bed alarm did not sound. Review of the Post-Fall Huddle form revealed the resident's bed alarm did not sound until twenty minutes after staff were in the room. Continued review of the Post-Fall Huddle form revealed the only recommendation made was for resident and family education. Further review of the Post-Fall Huddle form revealed the Comprehensive Plan of Care was to be revised to include prevention strategies based on the Huddle findings. However, review of the Comprehensive Care Plan revealed no documented evidence of added interventions to address the resident's risk for falls when attempting to ambulate to the bathroom; and, no increased supervision or, assistance related to routine toileting.

Interview, on 03/15/13 at 3:30 PM, with the Administrator revealed the facility started a collaborative with a university towards the end of September, 2012 related to fall prevention. She stated in January the facility started the Post-Fall Huddle as part of the fall prevention collaborative.

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F 280 Continued From page 21  
The Administrator indicated the Post-Fall Huddle was a meeting of staff immediately after a fall where the fall was discussed and root cause analysis was performed to identify possible causes and implement interventions. She stated placement and functionality of alarms was checked every shift every day by nurses. The Administrator stated the facility's alarms were upgraded in January, however she was unable to recall if it was before or after Resident #3's fall in January. She stated a root cause analysis was performed after the January fall. According to the Administrator, the facility identified that the placement of the alarm sensor mat was being placed under the resident's bottom. She indicated this was identified as a problem, and now the alarm sensor mat was being placed under the residents' thoracic region which allowed for earlier response to the residents who were attempting to get out of bed without assistance. Further interview with the Administrator revealed the Comprehensive Care Plan should have been revised.

F 280

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  
SS=G  
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.

F 323 F323  
Resident #3's care plan has been revised by the interdisciplinary team and includes current interventions to prevent the resident from falling and preventing injury. Resident #3 has a physician's order for bed/chair sensor alarm, perimeter mattress, hip protectors. Bed is to be kept in the lowest position with wheels locked. Resident has received physical and occupational therapy and is walking with use of walker and assist of 1 staff member. To date, resident has had no further falls. The facility recognizes other residents have the potential to be affected by the alleged deficient practice. Facility staff

04/16/2013

This REQUIREMENT is not met as evidenced by:

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F 323 Continued From page 22

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent falls for one (1) of eight (8) sampled residents (Resident #3). Resident #3 sustained falls with injury while attempting to self toilet and obtain snacks; however, there was no documented evidence the facility conducted a thorough investigation to determine the root cause of the falls and/or revised fall interventions to prevent further falls. Resident #3 sustained five (5) falls from 08/02/12 through 01/20/13. Interview and record review revealed the falls were sustained while the resident was attempting to self toilet (08/02/12, 09/07/12 and 01/20/13) and attempting to obtain his/her snacks (10/02/12, and 12/16/12). Resident #3 was diagnosed with a right hip fracture after the fall on 08/02/12; a left hip fracture after the fall on 12/06/12; and a left femoral fracture and proximal humeral fracture after the fall on 01/20/13. The facility failed to ensure effective interventions were in place prior to Resident #3's falls and to prevent further falls. (refer to F-280)

The findings include:

Review of the facility's policy, "Falls Prevention", dated 01/09, revealed the purpose was to provide a mechanism to identify patients who were at high risk for falls and to reduce the potential for patient injury related to a fall and implement guidelines to identify a resident's risk for falls. The policy stated the Registered Nurse (RN) would discontinue fall precautions when it was determined through re-assessment the resident

F 323 F323 Cont.

have been in-serviced by the Administrator, regarding maintaining a safe environment that is free of accident hazards and that each resident receives adequate supervision and assistance devices to prevent accidents. Content of the in-service also included resident elopement, securing medications, no chemicals unattended, and environmental hazards such as loose/chipped floor tile, loose handrails. Doors to the nourishment kitchen, which has a coffee pot in use, the dirty utility room, and the occupational therapy kitchen remain locked. Education to be completed by 04/12/2013. The nursing staff are currently assessing resident's fall risk each shift. All residents will have purposeful rounding completed each hour. Purposeful rounding includes asking the resident if they need to be toileted, repositioning residents, managing pain and assuring articles such as water, snacks, call light and telephone are within the resident's reach. The facility has also included a "STOP SIGN" in each resident's room which states, "CALL DON'T FALL." Families and visitors are also educated about fall precautions when they are visiting. Should a resident fall the Post Fall Huddle Form will be completed at the time of the fall. Those attending the Post Fall Huddle at a minimum, will include, a witness to the fall if appropriate, the primary nurse and primary SRNA. The pharmacist will evaluate medications the resident is taking to determine if that was a causative factor relating to the fall. The Director of Staff Education will review

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F 323 Continued From page 23  
no longer was a high risk for falls.

Review of Resident #3's record revealed the facility admitted the resident on 04/26/12, with diagnoses which included a history of Falls, history of Mitral Valve Replacement, Pacemaker Placement, Anemia, and history of Acute Renal Failure. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/10/12, revealed the facility assessed Resident #3 to have a Brief Interview of Mental Status (BIMS) of fourteen (14) which indicated the resident was cognitively intact. The facility assessed the resident to be continent of bowel and bladder; required supervision to limited assist with Activities of Daily Living (ADLs), and to be independent with ambulation. Review of Resident #3's Comprehensive Care Plan, dated 05/10/12, revealed the facility had determined Resident #3 was at high risk for falls related to falls prior to admission to the facility. Interventions on this Care Plan included staff was to remind the resident to use his/her call light, use shoes or nonskid socks, keep water within reach, keep pathway clear to bathroom and chair, and the bed needed to be in low locked position.

Review of a Significant Change Assessment, dated 02/01/13, revealed the facility assessed Resident #3 to have a score of four (4) which indicated the resident was severely impaired in cognition. The facility assessed Resident #3 to be always incontinent of bladder and frequently incontinent of bowel; and to require limited assist of one with toilet use. The facility assessed the resident to no longer walk in the room or corridor.

Review of the Fall Incident Report

F 323 F323 Cont.  
each Post Fall Huddle Form to ensure the facility identified the root cause of the fall and all incidents are thoroughly investigated. The facility will check placement and functionality of sensor alarms in use and document in the medical record each shift. Alarms identified as non-functioning will be replaced. Those residents needing bed/chair sensor alarms will have a physician order. All care plans have been reviewed and updated by the interdisciplinary team and have current interventions.

Care plans will be reviewed by the interdisciplinary team during their initial, quarterly and annual MDS assessment, Significant Change MDS and after each fall or event to ensure appropriate interventions and root cause analysts is identified, and the event is thoroughly investigated. This process will be audited by the RN Administrator. The RN Administrator will also attend no less than 2 resident's care conferences each month to review problems identified and interventions are appropriate. Results of the audit will be presented by the RN Administrator at the monthly QA&A Meetings for additional recommendations and follow up. Results of the Post Fall Huddle will also be presented in the monthly Falls Committee Meeting to evaluate the fall prevention plan. Results of audits will also be presented at the hospital's monthly Quality Department Meeting.

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F 323 Continued From page 24

documentation, 08/02/12, revealed Resident #3 fell on 08/02/12 at 4:45 AM, while ambulating to the bathroom with the use of his/her walker. The documentation indicated Resident #3 left his/her walker outside the bathroom door, went to the bathroom; attempted to ambulate back to his/her walker; lost his/her balance and fell to the floor. According to the documentation the resident was found sitting on the floor "moaning in pain". Review of the record revealed the Physician was notified after the fall and an x-ray was ordered which indicated Resident #3 had a right femoral neck fracture.

Review of the Incident Report, dated 09/07/12 revealed at 7:00 PM, the resident experienced a fall in the bathroom, the resident's bed alarm was on and sounding. Review revealed Resident #3 did not experience an injury related to the fall. An intervention was added to have nurses round on the even hours and State Registered Nursing Assistants (SRNAs) to round on odd hours. Review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include this intervention until 09/09/12, two (2) days after the incident report. The Incident Report indicated an intervention to place "blue tape" on the resident's toilet to assist him/her with identifying the toilet. Additionally, Resident #3 was to go to "exercise class" on Monday, Wednesday, and Fridays. Review of the Comprehensive Care Plan revealed no documented evidence the care plan was revised to include this information until 09/17/12, ten (10) days after the incident report.

Review of the Incident Report, dated 10/02/12, revealed at 2:25 PM the Registered Nurse (RN)

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had just left the room after checking Resident #3's pacemaker. According to the Incident Report, approximately thirty (30) seconds after exiting the resident's room, the RN heard Resident #3 yelling, "help me". Continued review of the Incident Report revealed the resident was found on the "opposite" side of the bed sitting next to the wardrobe with his/her feet "stretched" out. Resident #3 was noted to have told the RN he/she had been "chasing" after a cracker that rolled away and lost his/her balance. Further review of the Incident Report revealed Resident #3 was assessed to have a skin tear to the right elbow and a "small lump" on the back of his/her head. It was noted the resident had on nonskid footwear and had not used his/her call light.

Review of the record revealed an alarm reduction was performed on 12/12/12, per resident request and removed completely; frequent rounding by staff was to be performed to ensure the resident's safety and compliance with use of the walker. However, review of the record revealed no documented evidence of "frequent" rounding by staff until 01/07/13.

Review of the Nurse's Notes revealed, on 12/16/12 at 8:15 PM, Resident #3 was found sitting on the floor with his/her left leg and foot turned out to the "side". The resident was noted to complain of pain in the left knee and pain with movement of the leg. Continued review of the Note revealed the Physician was notified and Resident #3 was transferred to the Emergency Room (ER). Review of the facility's Incident Reports revealed on 12/16/12 at 9:20 PM, Resident #3 was found sitting on the floor in her/his room after calling out for help, the resident

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F 323 Continued From page 26

was noted to tell staff he/she had been attempting to get some crackers, became dizzy and fell. However, there was no documented evidence the facility conducted a fall's investigation follow-up to determine any contributing factors to the fall. Further review of the Incident Report revealed a bed alarm was to be placed and rounds were to be conducted hourly.

Review of the Nurse's Notes, 12/22/12 revealed Resident #3 was readmitted to the facility on that date. Review of the Physician's Orders revealed no documented evidence of an order for a bed alarm after re-admission to the facility on 12/22/12. Further review of the Nurse's Notes revealed a bed alarm was in place and being checked to see that it was in working order 12/01/12 through 12/31/12; however there was no documented evidence of a bed alarm being in place or of it being checked 01/01/13 through 01/20/13. Review of the Physician's Orders revealed an order, dated 01/31/13, for Resident #3 to have a bed and chair alarm. Review of the record revealed no documented evidence of one (1) hour rounding until 01/07/13.

Interview, on 03/15/13 at 3:30 PM, with the Administrator revealed the resident told staff he/she had been attempting to get crackers from his/her closet where the crackers were stored when he/she fell on 12/16/12. She stated the reduction in the bed alarm was that there would be no alarm used while Resident #3 was up during the day. According to the Administrator, the bed alarm was to go back on the resident's bed when he/she was in bed. She stated SRNAs should have been doing one (1) hour rounds on Resident #3 after the resident's fall on 12/16/12

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F 323 Continued From page 27  
and it should be documented.

Review of a Nurse's Note dated 01/10/13, timed 10:30 PM revealed Resident #3 was found in the bathroom without ringing for assistance. The Nurse noted she informed the resident he/she could fall and requested Resident #3 use his/her call light.

Review of the Nurse's Note, dated 01/13/13 and timed 6:43 AM, revealed Resident #3 had been up to the bathroom "many times" during the night. The resident was noted to be "very impatient" with staff. The Nurse noted Resident #3 had stated several times, "I had to wait an hour. When using the call bell Resident #3 stated, "if you don't come down here now, I will get up by myself". Several times during the night resident's bed alarm sounded, and resident was getting out of bed without calling for assistance...". The Nurse documented she encouraged Resident #3 to use the "call bell" for assistance before getting out of bed.

Review of a Nurse's Note dated 01/18/13, timed 6:26 PM revealed Resident #3 had "gotten up alone". The Nurse documented she "cautioned" Resident #3 on the risk of falls and the resident verbalized understanding. The Nurse further documented Resident #3 was non-compliant.

Review of the Nurse's Notes dated 01/20/13 and timed 8:09 PM, revealed at 4:20 PM staff heard Resident #3 "yelling out" and found the resident on the floor on his/her right side at the foot of the bed. The left lower extremity "with foot up near neck and hip in a twist". Review of the Note revealed the resident's bed alarm did not sound.

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The Nurse documented the Physician was present and orders were received to send Resident #3 to the ER. Review of the Incident Report, dated 01/20/13, revealed Resident #3's bed alarm did not sound. Review of the Post-Fall Huddle form revealed the resident's bed alarm did not sound until twenty (20) minutes after staff was in the room. Continued review of the Post-Fall Huddle form revealed the only recommendation made was for resident and family education. Further review of the Post-Fall Huddle form revealed the Comprehensive Plan of Care was to be revised to include prevention strategies based on the Huddle findings. Review of the Comprehensive Care Plan revealed no documented evidence of added interventions to address the resident's risk for falls when attempting to ambulate to the bathroom and no increased supervision or assistance related to routine toileting.

Interview, on 03/15/13 at 11:00 AM, with SRNA #7 revealed Resident #3 had a bed alarm, chair alarm, every one (1) hour rounding and was offered to toilet every one (1) hour. She stated the resident could use the call light, however he/she forgets that staff had attended to his/her needs. She stated that sometimes staff was busy and couldn't get there right away and Resident #3 was incontinent on his/herself.

Interview, on 03/15/13 at 2:20 PM, with SRNA #4 revealed she thought that prior to December, Resident #3 was a one (1) person assist with a gait belt. According to SRNA #4, after the December fall Resident #3 was a two (2) person assist. She stated Resident #3 had a "sitter" for approximately one (1) week about one (1) and a

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half months ago. SRNA #4 stated that staff try to answer call lights as soon as they can, however there have been times when a resident wanted to use the bathroom and "soiled" themselves before staff got to them.

Interview, on 03/15/13 at 10:03 AM, with Licensed Practical Nurse (LPN) #2 revealed that prior to the falls Resident #3 was an assst of one (1) with everything and required supervision with ambulation in the room and hallway. LPN #2 stated Resident #3 was "notorious" for trying to get up on his/her own. She indicated the resident had a bed alarm and staff were doing every one (1) hour checks of Resident #3. The LPN stated that since the falls Resident #3 required more assistance with with his/her ADLs and now "yells out" for staff's assistance instead of using the call light. She stated the bed alarm and one (1) hour checks were in place in December except for one (1) time "when we were doing an alarm reduction". According to LPN #2, the majority of Resident 3's fall occurred when he/she was trying to get a snack for his/her closet.

Interview, on 03/15/13 at 10:42 AM, with LPN #3 revealed Resident #3 had interventions in place of a bed alarm, and hourly rounding. LPN #3 stated staff went to Resident #3's room as soon as the alarm went off. She stated the resident "calls out" for assistance now instead of using the call light. According to the LPN, Resident #3 knew when he/she needed to go to the bathroom and sometimes he/she would ring for assistance and sometimes not. The LPN stated SRNAs were doing odd hour checks and nurses were doing even hour checks. She stated after Resident #3's December fall the bed alarm was

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switched out and the every one (1) hour rounding was started then. The LPN indicated Resident #3's incontinence didn't "really start until this last fall in January".

Interview, on 03/15/13 at 12:12 PM, with LPN #4 revealed prior to the falls Resident #3 was supervision with everything; was unsteady on his/her feet; and was encouraged to use his/her call light. LPN #4 stated the resident would "get up and take off"; wouldn't call for assistance. According to the LPN, after the first fall the resident "ended up" with a bed alarm, chair alarm and every one (1) hour rounding. When asked if Resident #3 had been on a toileting program, LPN #4 stated "basically everyone" was on a toileting program as staff offered every time they went into resident rooms. She stated after the December fall the alarms were replaced with a voice activated alarm that had a recording of the resident's daughter telling Resident #3 to sit back down and wait for the nurses to help him/her. LPN #4 indicated that prior to the falls Resident #3 was continent, wore pull-ups related to stress incontinence at times. The LPN stated after the falls the resident's ADL status changed; now he/she was a two (2) person assist with most ADLs.

Interview, on 03/15/13 at 4:15 PM, with Registered Nurse (RN) #1 revealed there was no Physician's Order for a bed alarm when Resident #3 was readmitted to the facility on 12/22/12. She indicated there was an order for the alarm, dated 01/31/13; however there was no documentation alarms were checked and it did not appear Resident #3 had an alarm in January until 01/30/13.

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Interview, on 03/15/13 at 3:30 PM, with the Administrator revealed the facility started a collaborative with a university towards the end of September, 2012 related to fall prevention. She stated in January the facility started the Post-Fall Huddle as part of the fall prevention collaborative. The Administrator indicated the Post-Fall Huddle was a meeting of staff immediately after a fall where the fall was discussed and root cause analysis was performed to identify possible causes and implement interventions. She stated placement and functionality of alarms was checked every shift every day by nurses. The Administrator stated the facility's alarms were upgraded in January, however she was unable to recall if it was before or after Resident #3's fall in January. She stated a root cause analysis was performed after the January fall. According to the Administrator, the facility identified that the placement of the alarm sensor mat was being placed under the resident's bottom. She indicated this was identified as a problem, and now the alarm sensor mat was being placed under the residents' thoracic region which allowed for earlier response to the residents who were attempting to get out of bed without assistance. The Administrator indicated the care plan should have been revised when the alarm reduction was performed in September and October, 2012. She stated there should have been an order for the resident's alarm. The Administrator stated she was unaware of how alarms were being checked prior to the end of January when this was "built" into the facility's computerized charting system. She indicated Resident #3 could not be moved closer to the Nurse's station because there was not a Medicaid bed close to the Nurse's station,

F 323

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

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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  03/15/2013
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOSPITAL DRIVE WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IF PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 323 Continued From page 32  
and the facility might have to look into dually certifying the beds.

F 371 483.35(i) FOOD PROCURE, SS=E STORE/PREPARE/SERVE - SANITARY

The facility must -  
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and  
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and review of facility policy it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations, on 03/11/13, revealed there was a scoop in a storage container of self rising cornmeal. Two (2) tray line holding refrigerators did not have thermometers on the inside of the refrigerator to ensure proper holding temps. A clean mixer had brownish particle areas on the mixer which the Dietary Manager (DM) identified as old batter. On 03/12/13 at 4:10 PM, the DM tested the three (3) compartment sink "Quat Sanitizer" solution and the level was below the proper sanitizing level required. Also on 03/12/13 at 4:40 PM, a food worker was taking temperatures and touched a pork chop, to remove from the thermometer with her potentially contaminated gloved hand and then changed her gloves without washing her hands.

F 323

F 371 F371  
Nutritional Services staff was in-serviced by the Director regarding Food Storage, Preparation, and Serving on 03/11/2013 and 03/12/2013. All staff will have completed training by 04/12/2013.  
The scoop in the storage container of self rising cornmeal was immediately removed. All food product was discarded and container as well as scoop were washed and sanitized. The Director completed immediate education with staff regarding prevention of cross contamination and infection control issues. The Director/Chef placed thermometers in Supervisor's reach-in refrigerator. Immediate education was completed with Nutritional Services staff on why every cooler/freezer must contain an internal thermometer to ensure proper cold food storage.  
The mizer was immediately cleaned and sanitized in front of surveyor. Education was completed the same day with staff on why the mizer and other equipment must be completely cleaned and sanitized. Director suggested to staff to use a small flashlight to better see the detail work.  
The Director immediately emptied the sanitizer on the 3 compartment sink and staff re-washed and sanitized all pots and pans that were currently draining. Staff education was completed the same day on why sanitizer must test between 150-200 parts per million and take action if it does not test accordingly. The staff

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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOSPITAL DRIVE WINCHESTER, KY 40391
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(X4) IO 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
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F 371 Continued From page 33

The findings include:

- Review of the facility's policy titled "Food Handling Guidelines", revised 08/2012, revealed under cross contamination procedures gloves were to be placed over clean hands and changed in between tasks. Hands were supposed to be washed after gloves were removed and before pulling on gloves. Further review of the policy revealed food should be prepared using clean sanitized equipment.
- Review of the facility's policy titled "Hand Hygiene", revised 08/2012, revealed all employees associated with the handling of food should wash hands. Hands were washed with soap and water at the following times: after any activity that may contaminate the hands, after removing gloves and putting on gloves.
- Review of the facility's policy titled "Food And Supply Storage Procedures", revised date 08/2012, revealed scoops may be stored in food bins on a scoop holder. The food level must be no closer than one-inch below the handle of the scoop. Refrigerated storage temperature must be maintained at forty-one (41) degrees Fahrenheit (F).
- Review of the facility's Potsink Sanitizer Concentration Log, undated, revealed the sterilization standard was between 150 - 400 Parts Per Million (PPM) for quaternary ammonium solution.
- Observation, on 03/11/13 at 10:45 AM, revealed a scoop was down in the food container labeled

F 371 F371 Cont.

member taking food temperatures was in-services immediately on proper hand hygiene. The Director explained why you must never touch food items that are ready to eat, even with a gloved hand, in order to prevent cross contamination. The facility recognizes other residents have the potential to be affected by the alleged deficient practice. The following systemic changes have been made to prevent the deficiency from reoccurring. Manager/Supervisor to conduct daily walk through to ensure scoops are hanging on holder appropriately. The Director will conduct monthly self food safety and sanitation audits to ensure additional compliance. The Supervisor/ Manager will conduct daily checks for all internal thermometers. The Director will also complete monthly self food safety and sanitation audits to ensure compliance. The Supervisor/Manager will conduct daily check for cleanliness of equipment. The Director to complete monthly self food safety and sanitation audits to ensure compliance. The Supervisor/Manager will ensure sanitizer sink is tested at each meal period and conduct checks for individual sanitizer buckets. The Director will complete monthly self food safety and sanitation audits to ensure compliance. The Managers will check each Supervisor monthly to ensure guidelines are being met. Additional and on-going education will be conducted each month at the Nutritional Services Monthly Staff Meeting.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOSPITAL DRIVE WINCHESTER, KY 40391
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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
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F 371 Continued From page 34

Self Rising Cornmeal and stored in direct contact with the cornmeal. The mixer that was stored in a plastic bag had brownish particle on the mixer holder.

Interview, on 03/11/13 at 10:45 AM, with the DM revealed the scoop was not stored correctly as it was supposed to be hung on the holder. She stated the scoop stored as observed was an issue of possible cross contamination. The DM stated when equipment was cleaned it should be covered with a plastic bag. Further interview revealed the DM thought the particle observed was old batter which possibly could contaminate new batter being mixed.

Continued observation and interview with the DM, on 03/11/13 at 10:55 AM, revealed two (2) tray line holding refrigerators did not have inside thermometers. The DM stated they were supposed to have thermometers on the inside to check and ensure the food was being held at a safe temperature.

Observation and interview with the DM, on 03/12/13 at 4:10 PM, revealed the sanitation compartment of the three (3) compartment sink had utensils in the sink and pots and pans drying after being sanitized. The DM performed a sanitation test using pHydrion Paper PT-40. The DM stated the test strip read between 0 and 150 PPM which was below the proper sanitation level for the Quat sanitizer product. Continued interview with the DM revealed they recorded the sanitizer test once a day, but she expected staff to test the sanitizer solution prior to sanitation of kitchen items. She stated the pots and pans had not been sanitized properly and they would have

F 371 F371 Cont.

Findings of the audits will be presented at the TCU monthly QA&A Meeting and also at the hospital's monthly Quality Department Meeting for further recommendations and follow up.

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

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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  03/15/2013
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NAME OF PROVIDER OR SUPPLIER  CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE HOSPITAL DRIVE WINCHESTER, KY 40391
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F 371 Continued From page 35  
to be re-sanitized.

F 371

Continued observation, on 03/12/13 at 4:25 PM, of the tray line food temperatures revealed the Supervisor/Catering Associate touched a pork loin slice to remove it from the thermometer with her potentially contaminated gloved hand and then changed her gloves without washing her hands.

Interview, on 03/12/13 at 6:00 PM, with the Supervisor/Catering Associate and the DM revealed she had touched the pork loin with her gloved hand to remove it from the thermometer. The Supervisor/Catering Associate stated her gloved hand had touched potentially contaminated surfaces and could have contaminated the meat. Continued interview revealed she was nervous and forgot to wash her hands when she changed her gloves. The Supervisor/Catering Associate stated she should have washed her hands and knew to do it.

Interview with the DM revealed the Supervisor/Catering Associate should not have touched the meat with there hand to remove the thermometer. The DM stated our policy was to wash hands before putting on clean gloves.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185428</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - CLARK REGIONAL MED CENTER NF</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLARK REGIONAL MEDICAL CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>ONE HOSPITAL DRIVE WINCHESTER, KY 40391</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition) New Health Care</p> <p>Plan approval: 01/17/2011</p> <p>Facility type: Hospital</p> <p>Smoke Compartments: Eight (8)</p> <p>Type of structure: One (1) story Type II (222)</p> <p>Fire Alarm: Complete Fire Alarm installed new.</p> <p>Sprinkler System: Complete sprinkler system (wet) installed new.</p> <p>Generator: Two (Type 1) Diesel</p> <p>A Life Safety Code survey was conducted on 03/12/2013. The facility was found to meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70.</p>	K 000			
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.