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

PRINTED: 11/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185428		11/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	1107 WEST LEXINGTON AVENUE WINCHESTER, KY 40392

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was conducted on 11/08/10 through 11/10/10 and a Life Safety Code Survey was conducted on 11/10/10. Deficiencies were cited. with the highest Scope and Severity being a "F".	F 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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185428		11/10/2010

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on November 10, 2010. The facility was found not to meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70. Deficiencies were cited with the highest Scope and Severity cite being an "F".	K 000		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 072	ALL OBJECTS IN HALLWAYS REMOVED AND STORED	11/29/10
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the corridors were maintained free from obstructions in the case of fire or other emergency. This deficiency could affect all (22) twenty-two residents and staff. The facility is licensed for (25) twenty-five beds and the census on the day of the survey was (22) twenty-two. The findings include: Observation on 11/10/2010 at 9:00 AM, revealed soiled linen carts, Hoyer lifts, clean linen carts, and a table with decorations stored in the corridor. These obstructions were blocking the handrail causing the handrail to be non-accessible for resident use. This observation was confirmed with the Unit Administrator and Maintenance Staff.		HALLWAYS CLEARED DECORATED TABLE REMOVED SOILED LINEN CARTS IN SOILED UTILITY ROOM HOYER LIFTS, MEDICATION CARTS, LINEN CARTS STORED IN ALCOVE	11/29/10 11/25/10 11/29/10 11/29/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
RL Buchman	TCU Administrator	11/29/10

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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	185428	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/10/2010

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K 072	Continued From page 1	K 072		
	Interview with the Unit Administrator and Maintenance Staff on 11/10/2010, indicated that the carts were placed there because the facility did not have any other area to store them.		STORAGE ALTERNATIVES SECURED TO COMPLY WITH 100% OF HALLWAYS CLEARED	11/29/10
	Reference: NFPA 101 (2000 Edition) 7.1.10.1 Means of egrees shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.		HALLWAYS CLEARED	11/29/10
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4	K 073		
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could affect all twenty-two (22) residents and staff. The facility is licensed for (25) twenty-five beds and the census on the day of the survey was (22) twenty-two.		DOOR DECORATIONS REMOVED, TABLE DECORATIONS REMOVED	11/25/10
	The findings include:			
	Observation on 11/10/2010 at 9:00 AM, revealed seven (7) resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 318, 319, 321, 322, 325, 326, and 329. This observation was confirmed with the Unit Administrator and Maintenance Staff.		REMOVED ALL DOOR WREATHS UNTIL INVENTORY, TRACKING AND TAGGING CAN BE COMPLETED TO MEET REQUIREMENTS WITH FIRE RETARDANT POLICY AND PROCEDURE	11/25/10
	Interview with the Unit Administrator and			

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K 073	Continued From page 2 Maintenance Staff on 11/10/2010 at 9:00 AM, indicated they were unaware of the requirement that the decorations had to be flame retardant. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	FLAME RETARDANT POLICY + PROCEDURE DEVELOPED WHICH INCLUDES	11/29/10
			NOTIFICATION TO INCOMING ADMISSIONS TO COMPLY WITH FLAME RETARDANT POLICY AND PROCEDURE	11/29/10
			BIANNUAL INFORMATION SENT TO RESIDENTS/FAMILIES TO ENSURE 100% COMPLIANCE OF FIRE RETARDANT ITEMS PURCHASED WITH DOCUMENTED FIRE RETARDANT PRIOR TO USE (NOV + MAY)	11/29/10
			DEVELOPED INVENTORY, TRACKING AND TAGGING TO SECURE 100% COMPLIANCE	11/29/10
			PROCESS WITH MANUFACTURERS INSTRUCTION OF FIRE RETARDANT APPLICATION. RETARDANT ORDERED - ANTICIPATED ARRIVAL IS	12/15/10
			REAPPLICATION PROCESS IF NEEDED	11/29/10
			IDENTIFICATION PROCESS TO IDENTIFY WHO APPLIED FIRE RETARDANT BY SIGNATURE	11/29/10
			DATE OF FIRE RETARDANT APPLICATION RECORDED AS ITEMS SPRAYED	12/15/10
			LIST OF MATERIALS TO WHICH RETARDANT APPLIED FOR EACH RESIDENT WILL BE DOCUMENTED AND REVIEWED WKLY BY ADMINISTRATOR	12/15/10