

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

PRINTED: 07/09/2010  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/25/2010
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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031
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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	F 000		
F 226 SS=D	<p>An annual survey was conducted 06/22-25/10 to determine the facility's compliance with Federal Regulatory Requirements. Deficiencies were identified with the highest S/S being an "E".</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. A review of two (2) of five (5) personnel records revealed a Nurse Aide Abuse Registry (NAAR) check was not completed prior to hire for Licensed Practical Nurse (LPN) #2 and a Food Service Aide (#1). Findings include:</p> <p>1. A review of LPN #2's personnel record revealed a hire date of 03/08/10 and the NAAR was not completed until 04/14/10.</p> <p>An interview with the Director of Nursing (DON), on 06/24/10 at 10:15 AM, revealed each department was responsible for the completion of its' own personnel checks. The DON stated LPN #2 was hired on 03/08/10 and had previously worked in another state. The information obtained on hire was from the state where LPN #2 last worked and was received on 03/04/10.</p>	F 226	<p>LPN# 2 NAAR was completed on 4-14-2010 with no abuse record found. Food Service Aide #1 NAAR was completed on 4-26-2010 with no abuse record found.</p> <p>All other employment files were reviewed for NAAR information on 6-25-2010.</p> <p>Abuse policy revised to include employee full name when contacting abuse agency and NAAR to be completed prior to scheduled time of work. All Department heads were in-serviced on policy change by administrator on 7-14-2010.</p> <p>A QA monitor has been implemented to audit employee's NAAR abuse check. First QA completed on 7-14-2010 by administrator and found no deficient practices. QA monitor will be completed monthly for three months and quarterly for one year by administrator or designee.</p>	7/15/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Camandra Godmon* TITLE: *Director of Nursing* (X6) DATE: *7-29-10*

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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F 226	Continued From page 1 However, in April 2010, an audit revealed the error and the staff completed the required current NAAR report on 04/14/10. LPN #2 had provided care for residents during the timeframe, of 03/08/10 through 04/14/10.  2. A review of Food Service Aide #1's personnel record revealed a hire date of 04/22/10 and the NAAR was not completed until 04/26/10.  An interview with the Dietary Manager, on 06/24/10 at 10:15 AM, revealed Food Service Aide #1 was hired on 04/22/10 and a NAAR was completed on 04/21/10. The Dietary Manager stated she failed to include the Food Service Aide's full name and received numerous (same name) responses. A second NAAR check was completed on 04/26/10.  A review of the facility's policy/procedure entitled, "Abuse Policy Procedures," dated 10/07/99, revealed "contact (Kentucky) Abuse Registry for past record, if any. Contact Nurse Aide Registry as well as other professional licensing agencies for proper licensing and status."	F 226			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314			

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F 314	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to ensure one resident (#4) in the selected sample of ten, received the appropriate assessment, care, and services to promote healing of a pressure ulcer and to prevent any additional pressure ulcers from developing.</p> <p>Resident #4 had a history of a pressure sore on his/her left upper thigh caused by contact with the arm rest of his/her wheelchair. A bolster was implemented to prevent the pressure and recurrence of a pressure sore; however, the intervention proved ineffective, as evidenced by the development of a new pressure sore. The facility failed to ensure evaluation of the effectiveness of the bolster and failed to develop and implement alternatives, based on a reassessment of the resident's needs.</p> <p>Findings include:</p> <p>Resident #4 was admitted to facility on 03/08/04, with a diagnosis of Cerebral Vascular Accident (CVA) with left side hemiplegia.</p> <p>An observation, on 06/24/10 at 10:36 AM, during a dressing change revealed Resident #4 had a pressure sore on the left upper/outer thigh, which measured one centimeter in diameter with redness noted around the sore. The pressure sore had no drainage and the center of the sore was yellow in appearance. The nurse cleansed the pressure sore with sterile saline and applied antibiotic ointment. A self-adhesive pad was placed over the pressure sore after the treatment.</p>	F 314	<p>Resident #4 evaluated by Physical Therapist on 6-25-2010 and new interventions ordered. A new pressure reducing bolster was implemented on 7-7-2010. Resident # 4 care plan has been updated to reflect current interventions.</p> <p>All residents with adaptive equipment were assessed for effectiveness of current interventions on 7-14-2010 by Therapy Department.</p> <p>Skin assessment and pressure ulcer policy was reviewed and revised to include notification of pressure ulcers to the Therapy Department on 7-14-2010.</p> <p>Nursing staff in-serviced on policy changes on 7-14-2010 by Director of Nursing.</p> <p>QA completed on 7-14-2010 by Rehab Manager with no deficiency noted. QA will be completed monthly for 3 months and quarterly for 1 year by Rehab manager or designee.</p>	7/15/10	

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F 314	<p>Continued From page 3</p> <p>An interview with Registered Nurse (RN) #1, on 06/22/10 at 3:54 PM and RN #2 on 06/24/10 at 9:28 AM, revealed the pressure sore was identified on 06/22/10, during the survey initial tour of the facility. Resident #4 utilized a bolster in his/her wheelchair to prevent pressure from the arm rest of the wheelchair to the resident's left upper/outer thigh. The resident had a history of skin breakdown in the area caused by rubbing the left thigh against the arm rest. The nurses stated skin assessments were provided twice monthly, by a licensed nurse, for all residents.</p> <p>An observation and interview with Resident #4, on 06/22/10 at 3:30 PM and at 4:30 PM, revealed he/she propelled his/her wheelchair down the hallway, using his/her right hand and right leg for movement. A bolster was observed positioned on the left side of the wheelchair. Resident #4's left leg was observed positioned outward and in direct contact with the bolster pad, as the resident propelled the wheelchair. Resident #4 stated he/she did not like the bolster used in the wheelchair.</p> <p>Further observation, on 06/24/10 at 3:15 PM, revealed Resident #4 was in his/her room exercising with a pedal operated exerciser, a restorative therapy intervention. The resident's left leg was observed leaning against the bolster pad, positioned to the left side of the wheelchair. The bolster pad was bent out away from the wheelchair at a forty-five degree angle and the resident's left leg was observed rubbing against the side of the bolster.</p> <p>A review of the Resident Assessment Protocol Summary (RAP), dated 06/07/10, revealed Resident #4 had a history of pressure sores to the</p>	F 314			

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F 314	<p>Continued From page 4</p> <p>left outer thigh (leg) related to wheelchair positioning and the result of rubbing his/her leg against the arm of the wheelchair. A bolster cushion was ordered and implemented on 04/13/09, after an Occupational Therapy consultation, to prevent pressure to the resident's left upper thigh.</p> <p>A review of the skin assessment, dated 04/14/10, revealed the facility identified Resident #4 was at high risk for the development of pressure ulcers. A review of the Physician's progress notes and Restorative treatment record, dated 05/26/10, revealed Resident #4 received Restorative Therapy, six times a week for fifteen minutes each day and used a Restorator (a device with pedals attached to a wheelchair) to exercise and provide range of motion to the resident's lower legs. A review of the current care plan, dated 06/09/10, revealed the bolster was to be used while the resident was up in the wheelchair.</p> <p>An interview with Physical Therapy Assistant (PTA) #1, on 06/24/10 at 10:14 AM, revealed the bolster was implemented "about a year ago". The bolster was implemented related to the development of a pressure sore on the resident's left upper leg. There had been no further reports or referrals received from the facility in regard to the development of new pressure areas or problems with positioning. PTA #1 stated an order was required from the physician or a referral from nursing staff with any documentation showing a decline or a change in the function of the resident, for a reassessment to be completed.</p> <p>Interviews with the Director of Nursing (DON), on 06/22/10 at 4:06 PM, on 06/23/10 at 9:46 AM and on 06/25/10 at 9:20 AM revealed Resident #4</p>	F 314			

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F 314	Continued From page 5 had two different wheelchairs and OT had implemented the bolster last year. The DON stated she was aware Resident #4 did not like the bolster placed in the wheelchair, but she was unsure whether Resident #4 had been reevaluated for wheelchair positioning. A referral could be initiated by any staff member and documented in the nurse's note. The DON stated no alternatives to the bolster had been attempted.  A review of the facility's Skin Assessment Policy, dated 05/2009, revealed skilled and intermediate care residents were provided a skin assessment twice monthly by a Licensed Nurse. Any skin conditions found by a Certified Nursing Assistant or Certified Medication Aide, was reported to the nurse in charge, for further investigation. The policy stated a skin assessment should be completed on admission to the facility and then again quarterly. All staff should review and follow the care plan accordingly for any additional interventions to be followed.	F 314			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility failed to provide adequate supervision to prevent	F 323			

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F 323	<p>Continued From page 6</p> <p>accidents and failed to ensure the resident environment was as free of accident hazards as is possible for three residents (#4, #8, #10), in the selected sample of ten and one resident (#12), not in the selected sample.</p> <p>Resident #4 sustained a fall from a wheelchair, while propelling down the ramp located off the South Porch, resulting in a fracture to the left Tibia (lower leg).</p> <p>Resident #8 was identified at high risk for falls after assessment and able to make reasonable decisions. Resident #8 went to the South Porch, (designated area) to smoke.</p> <p>Residents #10 and #12 were identified as elopement risks and had histories of exit seeking behaviors at the South Porch door. Although Residents #10 and #12 wore wanderguards, the door remained unlocked and alarmed only after residents passed through the door. On several occasions, Residents #10 and #12 were found on the concrete porch area or had gone down the concrete stairs outside the door, prior to staff intervention. The facility failed to identify potential accident hazards related to the environment for these residents.</p> <p>Findings include:</p> <p>1. A record review revealed Resident #4 was admitted to the facility, on 03/08/04, with a diagnosis of Cerebral Vascular Accident (CVA) with left side hemiplegia.</p> <p>A review of the Resident Assessment Protocol (RAP) Summary, dated 06/09/10, revealed the facility assessed Resident #4 as alert and oriented and able to make his/her own decisions.</p>	F 323	<p>Resident #4 &amp; #8 was re-assessed for smoking which included their ability to use the South Porch. Their care plans were updated to reflect current assessment findings on 6-25-2010 which included a different designated smoking area and South porch was safely barricaded from resident and public use. Resident #10 is no longer a resident in this facility. Resident #12 -South exit was monitored continuously until upgraded door alarm and locking system was installed on 7-4-2010.</p> <p>All residents have the potential to be effected by the risk factors of the South Porch. The deck was safely barricaded from resident and public use on 6-25-2010. Policy for South Porch was implemented on 6-25-2010 and all staff was in-serviced of policy changes by Director of Nursing. Upgraded door alarm and locking system was installed on South exit on 7-4-2010. All residents have been assessed for their individual elopement risk factors on 7-16-2010. Elopement policy was reviewed and revised on 7-13-2010. Elopement policy changes were in-serviced with nursing staff by Director of Nursing on 7-13-2010. South Porch policy and Elopement in-services were placed on nursing report clipboard for review prior to work duties for nursing staff. Other departments were notified of policy changes and location of in-services for their respective departments to ensure they were educated prior to their work duties.</p> <p>QA completed on 7-16-2010 by Director of Nursing and no deficiency noted. QA will be completed monthly for 3 months and quarterly for 1 year by Director of Nursing or designee.</p>	7/17/10	

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F 323	<p>Continued From page 7</p> <p>Additionally, the facility identified Resident #4 as having left side hemiplegia, requiring extensive to total assistance with transfers, bed mobility, bathing, grooming, dressing, and incontinent care. The facility identified Resident #4 as able to propel his/herself in a wheelchair with supervision and occasional assistance with maneuvering the wheelchair.</p> <p>A review of the Comprehensive Care Plan, dated 03/09/04, revealed the facility identified Resident #4 at risk for falls, related to impaired balance, daily antidepressant use and left side hemiplegia. Care plan interventions included the assisted transfer from the bed to a wheelchair daily, by one to two staff members.</p> <p>An observation, on 06/22/10 at 11:40 AM, revealed an unlocked door, referred to by the facility as the "South Porch" door, which led to a concrete porch and wooden deck. A set of steps and a steep ramp was observed directly outside the door, leading down to a parking area. In order to enter the deck area, it was necessary for residents maneuvering wheelchairs or ambulating to pass the steps and ramp. Additionally, an uneven surface was observed at the point of transition from the concrete porch to the wooden deck.</p> <p>An observation, on 06/22/10 at 4:30 PM, revealed Resident #4 propelled his/herself in the wheelchair, using his/her right hand and right leg, without difficulty. Resident #4 was unable to use his/her left arm or left leg to propel in the wheelchair. Further observation and interview with Resident #4, on 06/23/2010 at 3:15 PM, revealed, on 03/14/10, at the time of the fall, he/she had been outside approximately 10</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>minutes and had propelled him/herself back up the ramp to re-enter the facility. While backing up the wheelchair, the wheel dropped off the wood deck and the resident and his/her wheelchair went down the ramp and the resident's chair overturned and the resident fell onto the concrete ramp.</p> <p>An interview with Registered Nurse (RN) #1, on 06/22/10 at 3:54 PM, revealed she was the nurse on duty when Resident #4 sustained the fall, on 03/14/10. RN #1 stated Housekeeper #1 yelled from the back door for help and she responded and found Resident #4 face down with the wheelchair up in the air on top of resident. RN #1 stated she assessed Resident #4 and identified the resident had sustained a cut and bruises to the right side of the head and both of the resident's knees were "scraped". The resident's family and the Medical Doctor were notified and orders to transfer the resident to the Emergency Department were obtained. Subsequently, Resident #4 was sent out to the Emergency Department for evaluation and treatment. The resident returned to the facility on 03/14/10 at 12:10 PM, with a diagnosis of a Fracture to the left Tibia (lower leg bone).</p> <p>An interview with the Director of Nursing (DON), on 06/22/10 at 4:06 PM and 4:25 PM and on 06/23/10 at 9:46 AM and review of the facility's fall investigation, dated 03/14-15/10, revealed Resident #4 was assessed for the risk for falls on a quarterly basis. The care plan was updated after a fall; however, the facility did not conduct a fall assessment after the fall, on 03/14/10. The fall investigation conducted by the DON, dated 03/14/10 at 9:00 AM, revealed Resident #4 had "turned over" in his/her wheelchair. The resident</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>was in the process of entering the building in his/her wheelchair and the wheels went off the wood part of the deck and the resident went down the ramp backwards. The DON stated the back door to the South Porch was left unlocked from 5:30 AM until 8:00 PM each day. The door was accessible for anyone exiting the facility, but could not be used to re-enter the facility, since the door was locked from the outside.</p> <p>An interview with Housekeeper #1, 06/22/10 at 4:18 PM, revealed she returned from a break and saw a wheelchair turned over and on top of the resident. Housekeeper #1 stated she ran first to the resident and then to the back door and yelled inside for help. RN #1, RN #2, and State Registered Nurse Aide (SRNA) #1 responded and came outside to assist Resident #4 back into the wheelchair. Housekeeper #1 stated Resident #4 was found approximately three quarters of the way down the steep ramp and was lying face down on the pavement, with the wheelchair up in the air and on top the resident.</p> <p>An interview with SRNA #4, on 06/23/10 at 11:05 AM, revealed she was on break at approximately 8:45 AM, when Resident #4 fell while in his/her wheelchair. SRNA #4 stated she heard a page announced overhead and went to the nurse's station, at which time she was informed Resident #4 had fallen. SRNA #4 stated she went outside to assist the other staff and observed Resident #4 lying on the ground and his/her "arms and legs were going everywhere". The wheelchair was flipped over. The resident had "a skinned place" on his/her head which was bleeding.</p> <p>An interview with the Maintenance Director, on 06/23/10 at 2:15 PM, revealed after the fall he</p>	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 10</p> <p>placed a chain across the entrance to the ramp.</p> <p>An interview with RN #2, on 06/23/10 at 9:28 AM, revealed she was on break when Resident #4 fell. She was walking up the back stairs from break and heard someone yell and say Resident #4 had fallen out of the wheelchair. RN #2 stated she found Resident #4 lying "all the way down the ramp" on his/her left side with the wheelchair located beside the resident. She conducted a neuro assessment of the resident.</p> <p>2. A closed record review revealed Resident #10 was admitted to the facility, on 10/26/09, with diagnoses Alzheimer's Disease. A review of the initial MDS assessment, dated 11/04/09, revealed the facility assessed the resident as having poor decision making skills and he/she required cues and supervision.</p> <p>A review of the Comprehensive Care Plan, dated 12/11/09, revealed the facility developed a care plan for the resident's risk for injury related to wandering behaviors and attempts to exit the facility unassisted. The facility's goal was for the resident to exit the facility less than twice per day. The interventions the facility developed were to monitor placement of the ankle transmitter every shift, permit the resident to wander in a safe environment and to respond to the transmitter signal promptly.</p> <p>A review of the nurse's notes revealed Resident #10 exited the building through the South Porch exit on numerous occasions, on 11/08/09 at 4:00 PM and 6:00 PM, on 11/22/09 at 8:15 AM, several occasions on 11/30/09, on 12/03/09, on 12/05/09 at 7:00 PM, on 12/10/09 at 8:10 AM, on 12/09/09 at 6:00 PM, four times on 12/10/09, on 12/14/09</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 11</p> <p>at 12:30 PM, on 12/15/09 at 5:40 AM and 6:10 AM and on 12/17/09 at 7:50 AM and 8:30 AM. Each time Resident #10 exited the building, the wanderguard alarm on the door sounded; however, by the time staff responded the resident was found on the concrete porch or descending the concrete steps. On 11/08/09, the resident was found in the parking lot at the bottom of the concrete steps. Further record review revealed there was no evidence the facility identified that Resident #10 was able to exit the South Porch exit door before staff could respond and failed to identify the concrete ramp, steps and/or break between the concrete porch and deck as accident hazards for Resident #10 due to his/her confusion and unsteady gait. Record review revealed the resident was transferred to a behavior center on 12/17/09.</p> <p>Interviews with LPN #1, SRMA #2, SRNA #1 on 06/23/10 at 3:00 PM and on 06/24/10 at 9:58 AM, 10:00 AM and 1:45 PM, respectively, revealed Resident #10 frequently exited the South Porch door and staff retrieved the resident from the area. The alarm sounded when the resident went out the door and by the time staff responded the resident was usually on the steps located beside the ramp, leading down to the parking lot.</p> <p>3. A record review revealed Resident #12 was admitted to the facility, on 06/05/09, with diagnoses which included Alzheimer's Disease and Anxiety State. A review of a significant change MDS assessment, dated 03/01/10, revealed the facility assessed the resident as having poor decision making and needing cues and supervision. The resident was able to propel him/herself in a wheelchair for locomotion and he/she had fallen in the last 30-180 days. A</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 308 S. WASHINGTON ST. CLINTON, KY 42031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 12</p> <p>review of the falls risk assessment, dated 01/07/10, revealed the resident was identified as at high risk for falls.</p> <p>A review of the Comprehensive Care Plan, dated 09/01/09, revealed the facility developed a care plan for the resident's identified risk for falls and injury, due to attempts to exit the building unattended. The goal the facility developed was for the resident to have no falls or injury as a result of the resident exiting the building without assistance. The interventions the facility developed were to apply a wanderguard bracelet to the resident's ankle and to monitor the placement of the bracelet every shift.</p> <p>A review of the nurse's notes revealed Resident #12 exited the facility through the South side exit door, on 03/04/10 at 4:00 PM, on 03/21/10 at 12:20 PM, on 03/23/10 at 6:00 PM, on 03/24/10, two occasions on 03/31/10, on 04/03/10 at 10:45 AM and on 04/11/10 at 4:00 PM. The nurse's notes revealed each time the staff responded to the alarm they found the resident outside on the concrete porch. On 03/21/10 at 12:20 PM, Resident #12 was found "attempting to unhook the chain and go down the ramp to the parking lot". Further record review revealed there was no evidence the facility identified Resident #12 was able to exit the door before staff could respond and failed to identify the ramp, steps and break between the concrete porch and deck as accident hazards for Resident #12, due to his/her confusion and use of a wheelchair.</p> <p>4. A record review revealed Resident #8 was admitted to the facility, on 06/04/09, with a diagnosis of Cerebral Vascular Accident with left sided hemiplegia. A review of the annual MDS</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 360 S. WASHINGTON ST. CLINTON, KY 42031
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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 323	<p>Continued From page 13</p> <p>assessment, dated 06/04/10, revealed the facility assessed the resident as able to make decisions that were consistent and reasonable. Resident #10 was able to propel him/herself in a wheelchair throughout the facility. A review of the Fall Risk Assessment, dated 04/14/10, revealed the resident was identified at high risk for falls.</p> <p>A review of the Comprehensive Care Plan, dated 12/16/09, revealed the facility developed a care plan for smoking. Interventions included the resident's use of the South deck, when weather allowed to smoke.</p> <p>An observation and interview with Resident #10, on 06/24/10 at 2:30 PM, revealed the resident was in a wheelchair propelling him/herself down the hallway. The resident stated he/she smoked on the deck outside the South Porch exit. The resident stated he/she was aware of the break between the concrete porch and deck, but he/she was usually able to cross over it with no problems. Resident #8 stated he/she tried to keep the wheels of the wheelchair away from the ramp and steps.</p> <p>Further record review revealed there was no evidence the facility identified the ramp, steps and break between the porch and ramp as possible accident hazards for the resident, due to his/her left sided weakness and use of the wheelchair.</p>	F 323		
F 369 SS=D	<p>483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS</p> <p>The facility must provide special eating equipment and utensils for residents who need them.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 369		

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031
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F 369	<p>Continued From page 14</p> <p>by: Based on observation, interview, and record review, it was determined the facility failed to provide one resident (#5) in the selected sample of 10, special eating equipment and utensils. Resident #5 was ordered a plate guard and deep spoons for meals and observations revealed the plate guard and deep spoon were not provided for lunch and supper on 06/22/10. Findings include:</p> <p>Resident #5 was admitted to the facility with diagnoses to include Trans Cerebral Ischemia, Hypertension, Senile Dementia and Esophageal Stricture.</p> <p>An observation in the dining room, on 06/22/10 at 11:40 AM, revealed Resident #5 was served a lunch tray, without the provision of a plate guard and deep spoon. An observation during the evening meal service, on 06/22/10 at 5:05 PM, revealed the resident was served a supper tray, without the provision of a plate guard and deep spoon.</p> <p>An interview with the Dietary Manager, on 06/23/10 at 10:20 AM, revealed she monitored the tray line and tried to review the tray cards daily on return from the dining room. She completed random checks of 12-14 tray cards during meal service. If she identified an error, she talked with the staff at the time and made the correction. The Dietary Manager stated the resident was ordered a plate guard and deep spoon for all meals. The plate guard was not returned to the dining room after breakfast, on 06/22/10 and the spoon provided was a regular spoon. She stated the staff did not notice the plate guard was unavailable, until they were</p>	F 369	<p>Resident # 5 plate guard was in place on June 23, 2010.</p> <p>All residents self help feeding devices were in place on 6-23-2010.</p> <p>Policy revised on self help feeding devices and dietary staff was in-serviced on policy changes by Dietary manger on 6-23-2010. All Dietary staff reported to Dietary Manager for in-service on policy changes prior to reporting for work. Food service workers will check all food trays for adaptive feeding equipment prior to leaving dietary department.</p> <p>A QA monitor has been implemented to audit Dietary staff randomly for compliance on self help feeding devices. The first QA was completed on 7-6-2010 and was found with no deficient practices. The QA will be completed by Dietary Manger or designee monthly for three months and then quarterly for one year.</p>	7/10/10
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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031
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F 369	<p>Continued From page 15</p> <p>preparing the resident's lunch plate. The Dietary Manager stated the plate guard and deep spoon should have been provided for all meals.</p> <p>An interview with SRNA #4, on 06/23/10 at 10:50 AM, revealed she fed the resident on 06/22/10 during breakfast. The resident had trouble feeding him/herself at times and spilled food. SRNA #4 stated she left the plate guard on the plate, while she assisted the resident to eat. She did not remove it from the plate during the meal.</p>	F 369		
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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY,	STREET ADDRESS, CITY, STATE, ZIP CODE 368 S. WASHINGTON ST. CLINTON, KY 42031
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K 000 INITIAL COMMENTS

A Life Safety Code survey was initiated and conducted on 06/23/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an 'F'.

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

This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 06/23/10, it was determined the facility failed to ensure decorations used in the facility were flame-retardant as required by NFPA 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.

The findings include:

Observations during the Life Safety Code tour conducted, on 06/23/10 at 2:15 PM, revealed doors and walls throughout the facility were decorated with wreaths.

An interview conducted with the Maintenance Director, on 06/23/10 at 2:30 PM, revealed the wreaths had been put on the doors by family members. The facility did not have any documentation that would indicate the flame rating of the wreaths on the doors or walls. The facility did not have any documentation indicating

K 000

K 073 Furnishings and decorations of highly flammable character in resident rooms and public areas will be treated with a flame retardant by 7/30/10.

Policy has been written regarding application of flame retardant to highly flammable furnishings and decorations in resident rooms and public areas on 7/15/10.

Maintenance staff was inserviced by Maintenance Supervisor regarding fire retardant policy on 7/16/10.

Q.A. will be completed by Maintenance Supervisor on 8/1/10 to audit highly flammable furnishings and decorations for flame retardant in resident rooms and public areas. Q.A. will be completed monthly for three months and quarterly for one year by Maintenance Supervisor or designee.

8/2/10



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>William B. [Signature]</i>	TITLE Administrator	(X6) DATE 7/19/10
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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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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 386 S. WASHINGTON ST. CLINTON, KY 42031		
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K 073	Continued From page 1 the wreaths had been treated with a flame retardant.	K 073			