

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

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/12/2013
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An offsite revisit was conducted and based on the acceptable POC the facility was deemed to be in compliance as alleged on 11/11/13.	{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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F 000 INITIAL COMMENTS

F 000

A Standard Recertification Survey was initiated on 10/01/13 and concluded on 10/03/13. Deficiencies were cited with the highest scope and severity of an "F"

F 278 483.20(g) (j) ASSESSMENT
SS=D ACCURACY/COORDINATION/CERTIFIED

F 278

1. Resident #2's MDS was revised on 10/3/2013 by the MDS coordinator to reflect the diagnoses of UTI, anxiety, and hip fracture. In addition, the MDS coordinator reviewed resident #2's chart on 10/3/2013 to ensure nothing else had been overlooked.
2. A 100% audit of all residents was initiated on 10/3/2013 by the MDS coordinator and the Nurse Manager to properly assure residents MDS's were coded accurately. No other issues were identified.
3. The MDS coordinator was counseled by the Nurse Manager and the Administrator regarding the accuracy of the MDS on 10/22/13. MDS coordinator was instructed to take her time and not "rush

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced



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

TITLE

(X6) DATE

Administrator

10/25/13

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 278 Continued From page 1

F 278

by:

Based on record review, interview and review of the facility's policy, it was determined the facility failed to ensure that each resident received an accurate assessment by staff that was qualified to assess relevant care areas and knowledgeable about the residents status and needs for one (1) of five (5) sampled residents (Resident #2). Record Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 09/30/13, revealed section I, did not accurately reflect the status of the resident.

The findings include:

Review of facility's policy titled "Medicare/MDS Assessment Process", policy number 14-0909-223, effective date 09/28/98, review date 06/08/09, revealed a resident's MDS must be timely and accurately completed.

Review of Resident #2's clinical record revealed the facility admitted Resident #2 on 09/18/13 with diagnoses which included Status Post Left Hemi-Arthroplasty (surgical procedure to correct a femoral neck fracture), Dementia, Diabetes, Urinary Tract Infection (UTI), Alzheimer's and Anxiety. Further review of the record revealed the resident had fallen at home and was admitted to the hospital on 09/14/13, with a fractured hip and was also diagnosed with a UTI and the treatment of Cipro was started.

Review of Resident #2's admission MDS revealed section I areas 12300 (UTI), 13900 (Hip Fracture), and 15700 (Anxiety) were not coded as active diagnoses, however, they were listed on the resident's "History and Physical" from the acute care unit of the hospital. Resident #2 was

through" the process so that the MDS completely and accurately reflect the status of the resident. An in-service will be conducted on 10/24/2013 by the Nurse Manager, the MDS coordinator and the Administrator for all clinical staff to discuss the MDS process and the importance of properly assessing the residents.

- The Nurse Manager or designee will conduct a weekly audit times eight weeks on 50% of the charts, to ensure residents receive a complete assessment and that the MDS's accurately reflect the status of the residents. In addition, the Nurse Manager and MDS coordinator will review weekly the facility's 672/802 to ensure accuracy. The Administrator, Nurse Manager and the MDS coordinator will review the results of these audits monthly times two months. Any issues

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F 278 Continued From page 2
not assessed as having a UTI in the last 30 days, a hip fracture, or anxiety, resulting in inaccurate coding of the MDS.

Interview with the MDS Coordinator, on 10/03/13 at 1:30 PM, revealed she rushed the admission MDS assessment process and that section I of the MDS was not coded correctly. She confirmed that the diagnoses of UTI, anxiety, and hip fracture should have been coded on the admission MDS. Further interview revealed that the admission MDS was also used to initiate resident's care plans.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure that services provided met professional standards for one (1) of five (5) sampled residents, Resident #2. Record review of Resident #2's clinical record revealed components of his/her care plan was not developed in a timely manner. Further review of Resident #2's clinical record revealed an order for an oral antibiotic and an oral pain medication that did not contain the required elements of a medication order, the "duration" element.

The findings include:

1. Review of the facility policy titled, "Care Plan

F 278 identified will be addressed and corrected appropriately. The quality assurance committee will review all audits and any issues identified as a result of these audits, during the quarterly quality assurance meeting to determine compliance with this regulation and any further recommendations.

5. Date of Compliance: November 11,

F 281 2013

F 281

1. Resident #2's care plan was reviewed and revised by the MDS coordinator on 10/3/2013 to ensure the care plan and MDS accurately reflected the status of resident #2.

Resident #2's IV Cipro was discontinued on 10/2/2013. Resident was discharged to a nursing home with an order for PO Cipro on 10/2/2013.

2. A 100% percent audit of all patient care plans was initiated on 10/3/2013 by the MDS coordinator to ensure care plans

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F 281 Continued From page 3
category III", Policy Number 14-0910-33, Effective Date 09/01/96, review date 09/18/13 revealed that on the day of admission, the admitting nurse would enter the most important problems on the care plan, each discipline would complete the assigned section of the Minimum Data Set (MDS) and other assessments and formulate a plan prior to the Interdisciplinary Care Plan Meeting.

Review of Resident #2's clinical record revealed the facility admitted Resident #2 on 09/18/13 with diagnoses which included Status Post Left Hemi-Arthroplasty (surgical procedure to correct a femoral neck fracture), Dementia, Diabetes, Urinary Tract Infection (UTI), Alzheimer's and Anxiety.

1. Record review of Resident #2's Admission assessment dated 09/18/13 at 6:28 PM revealed Resident #2 was admitted to the unit with diagnoses of Diabetes, Alzheimer's, Status Post Hip Surgery, was disoriented and confused, had a left hip surgical wound that was red with a moderate amount of pink drainage, had a score of fourteen (14) on the Braden Skin Risk assessment which indicated a high risk and was functionally totally dependent on staff.

Record review of admission care plan, dated 09/18/13 revealed Resident #2's diagnoses of Alzheimer's and Diabetes, mental status, surgical wound, skin breakdown risk and care deficit were not integrated into the care plan until 10/02/13. Resident #2 was transferred to a Nursing Home closer to family on this day.

Record review of the Interdisciplinary Care Plan Meeting form entitled TCU-048-1 from 09/24/13

F 281 were timely and accurately completed per facility policy. Any issues identified were corrected appropriately.

A 100% audit of resident medications was conducted on 10/23/2013 by the Nurse Manager and clinical staff to ensure medications were properly labeled. Any issues identified were corrected appropriately.

- An in-service is scheduled for all clinical staff on 10/24/2013 to discuss the MDS process and the importance of accurate and timely assessments of the residents. This will be conducted by the Nurse Manager and the MDS coordinator. Per facility policy, the admitting nurse will continue to enter the most important problems on the care plan; each discipline will complete their assigned section of the MDS prior to the Interdisciplinary Care Plan Meeting. The MDS coordinator will review the cardex daily as well as communicate with the clinical staff daily to ensure all new orders, diagnoses or

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and 10/01/13 revealed these care areas were not addressed at these meetings.

Interview with Licensed Practical Nurse (LPN) #3, on 10/03/13 at 10:00 AM, revealed that with the current electronic system the facility was using, the only way to tell the difference between the initial care plan and the comprehensive care plan was the date the problem was entered into the system.

Interview with the Unit Manager, on 10/03/13 at 2:00 PM, revealed the MDS Coordinator was responsible for the care plans.

Interview with the MDS Coordinator/Educator, on 10/03/13 at 1:30 PM, revealed she was responsible for the accuracy of all MDS sections so that the care plan would developed correctly. She further stated that the nurses were responsible for implementing the initial care plan and revising the care plan as changes occurred. She further stated that no specific entity was responsible for the correctness of the care plan and that she did not check the care plan for accuracy

2. Review of the facility's policies titled, "Orders for Medications, Treatments and Procedures", Policy Number A10-0205-01, dated 04/26/13 and "Medication Orders", Policy Number 12-0209-32, dated 08/01/13 revealed that dosing frequency was a required element of medication orders.

Review of Resident #2's Physician Orders, dated 09/30/13, revealed an order for Ciprofloxacin HCL (Cipro), an antibiotic medication used to treat UTI's, 500 milligrams by mouth daily. Further review of the medication order for Cipro revealed

F 281 condition changes are captured and care planned accordingly.

An in-service is scheduled for all clinical staff on 10/24/2013 to review receiving and verifying orders for medications and treatments. When a nurse receives an order from the physician, per policy, they ensure orders contain the route, dosage, frequency, and duration of the medication.

- The Nurse Manager or designee will complete a weekly audit of 50% of the units charts for eight weeks to ensure resident care plans are completed according to the facility's policy and to ensure the care plans accurately reflect the status of residents. The MDS coordinator and the Director of Nursing will review weekly the facility's 672/802 for accuracy. The Nurse Manager or designee will also conduct a weekly audit times four weeks then monthly times two months to ensure medications are correctly labeled with the route, the dosage, the frequency and the duration. The Administrator, the Nurse Manager and the MDS

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it did not contain all the required elements of a medication order per facility policy, the "duration" element was missing.

Interviews with Registered Nurse (RN) #1, RN #2 and Unit Manager, on 10/02/13 at 11:00 AM, 11:10 AM and 11:20 AM revealed they were unaware that "duration" was a required element of medication orders.

Interview with the Pharmacy representative, on 10/03/13 at 11:45 AM, revealed the pharmacy was not concerned about the medication "duration" requirement. Further interview revealed the pharmacy monitored resident profiles on a daily basis. This monitoring included what medication a resident was on and how long they had been on it. Further review revealed that after an extended amount of time, the pharmacy would notify the physician of the monitoring results and ask what they wanted done. She further stated the pharmacy did not follow the policies of the Transitional care Unit.

F 371 483.35(i) FOOD PROCURE,
SS=F 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

F 281 coordinator will meet monthly times two months to review the results of these audits. Any issues identified will be addressed and corrected appropriately. The Quality Assurance Committee will review all audits and any issues identified as a result of these audits during the quarterly assurance meeting to determine compliance with this regulation and any further recommendations.

5. Date of Compliance: November 11, 2013

F 371 F 371

1. Cook/supervisor was in- serviced by the Food Service General Manager on 10/4/2013 regarding proper sanitation of thermometers to prevent cross-contamination.
2. All residents were monitored on 10/3/2013 for any signs or symptoms of infection resulting

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F 371 Continued From page 6

by:

Based on observation, interview and review of the facility policy, it was determined the facility failed to prepare and serve food under sanitray conditions as evidenced by staff not sanitizing thermometer stem between food products and promoting cross contamination between foods on the tray line. Observation revealed staff using a kitchen cloth to wipe off surfaces of equipment and pulled the thermometer out of her pocket and wiped the thermometer stem with the cloth, before taking temperatures of foods on the tray line promoting cross contamination. Observation further revealed a staff member placed thermometer directly into the food products before sanitizing the thermometer, promoting cross contamination of food products. Observation of staff member revealed the staff used one wipe to sanitize thermometer before testing two food products and not between food products promoting cross contamination.

The findings include:

Record review of facility policy titled Food Safety and Sanitation, Policy number 19-501-02 with an effective date of 08/22/03, revealed The Food Service Director is responsible for the implementation of all Aramark's policies, procedures, and systems regarding food safety and sanitation as well as ensuring that the department complies with Federal, State, and local regulations.

Record review revealed the policy and procedure concerning the sanitizing of food thermometers was requested and not provided.

Record review of Serve Safe Training manual,

F 371 from possible cross contamination. None were identified.

3. The Food Service General Manager conducted an in-service for all tray line staff on 10/4/2013 regarding the sanitation guidelines to be utilized during tray line. Special focus was given on the proper sanitization of thermometers between food items to avoid cross contamination. Per facility policy, thermometers must be washed, rinsed, sanitized and air dried. Storage cases will be kept clean as well. When utilizing a sanitizing solution, verify the solution is appropriate for food-contact services. This must performed before and after utilizing thermometers in order to prevent cross-contamination.
4. The Food Service General Manager will conduct a weekly audit of the tray line procedures weekly times

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F 371 Continued From page 7
page 5-8, with no effective date; revealed under Title General thermometer Guidelines: the cleaning and sanitizing of thermometers. Thermometers must be washed, rinsed, sanitized and air dried. Keep storage cases clean as well. Do these things before and after using thermometers to prevent cross-contamination. Be sure the sanitizing solution you are using is for food-contact surfaces. Always have plenty of clean and sanitize thermometers on hand.

Observation, on 10/02/13 at 11:15 AM, revealed Cook/supervisor #3 wiping off equipment with cloth and taking thermometer out of pocket, with no storage case, and wiping thermometer stem with cloth before testing the food on the tray line.

Observation, on 10/02/13 at 11:17 AM, Cook/supervisor #3 continuing to place food onto the tray line and checked the temperature of the whole white potatoes and green peas without sanitizing the thermometer stem before checking the potatoes and before checking the green peas.

Observation, on 10/02/13 at 11:20 AM, Cook/supervisor #3 used one sanitizing wipe for the thermometer stem between foods on the tray line.

Interview, on 10/03/13 at 8:45 AM, Cook/supervisor #3 revealed she had been off for a while and she messed up because she was nervous and she should have sanitized the thermometer between each food product. She further revealed thermometers are sanitized between every food product.

Interview, by phone on 10/03/13 at 11:05 AM, with the Food Service General Manager revealed

F 371 four weeks then monthly times two months to ensure proper sanitation procedures are being utilized correctly by personnel. Any issues identified will be addressed accordingly. The Administrator and the Food Service General Manager will review the results of these audits monthly to ensure compliance and any further recommendations. The Quality Assurance committee will review the results of these audits quarterly to determine compliance with this regulation and to offer any further recommendations.

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F 371 Continued From page 8
staff was not to use one thermometer from one food to another food to prevent cross contamination and to prevent potential harm to the residents. Thermometers were to be sanitized between each food product with wipes. He further revealed there was a policy and procedure for sanitizing the thermometer correctly.

F 441 483.65 INFECTION CONTROL, PREVENT SS=F SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

- (a) Infection Control Program
The facility must establish an Infection Control Program under which it -
- (1) Investigates, controls, and prevents infections in the facility;
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
 - (3) Maintains a record of incidents and corrective actions related to infections.

- (b) Preventing Spread of Infection
- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
 - (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
 - (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted

F 371 F 441

1. The seven residents who were identified as having Infections on TCU were monitored on 10/4/2013 for any adverse side effects relating to the identified infections. None were noted. The Nurse Manager and the Infection Control Nurse reviewed each patient's medical record to ensure the treatment was in place and that the physician was aware. The Infection Control policy was revised on 10/22/2013 to include a log of all infections identified on the TCU. It will be maintained by the MDS Coordinator and communicated to the Infection Control Nurse.

Note: The Infections identified during this survey were not originated on TCU. All seven residents were admitted with the infection.

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F 441 Continued From page 9
professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on record review, interview and review of facility's policy, it was determined the facility failed to develop, implement and maintain an Infection Prevention and Control Program in order to prevent, and control, to the extent possible, the onset and spread of infection within the facility. According to the Roster Matrix from 10/01/13 seven (7) of the eight (8) residents on the TCU had infections; of those infections five (5) of those were Urinary tract infections.

The findings include:

Review of the facility's Transitional Care Unit's (TCU) Infection Control policy, dated 09/01/06, revealed the infection control committee was responsible for organizing a program to prevent the development and transmission of infections and provide services necessary to maintain a sanitary and comfortable environment. Further review of the facility's policy revealed, techniques and systems were developed for identifying and reporting infections in the TCU.

Review of the Position Description for Infection Prevention Manager (no date) revealed, the Manager of Infection Prevention was responsible for the St. Claire Regional Infection Control

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2. All patients were assessed and monitored by clinical staff for any signs or symptoms of Infections on 10/4/2013. No other issues were identified.

3. A log of all infections identified on the TCU will be maintained by the MDS Coordinator and communicated to the Infection Control Nurse weekly for review and any recommendations. This log will include the patients name, the type of infection, the origin of the infection, what treatment is in place and acknowledgement that the physician is aware of the infection. An in-service will be conducted on 10/24/2013 for all TCU staff by the Administrator and Nurse Manager to review the Infection Control Policy and to inform them of the new infection log.

Note: The application on a cellular phone observed during the survey, is not an infection tracking tool. It is a hand sanitation tracking tool used during staff observation by the Infection Control Nurse.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2013
NAME OF PROVIDER OR SUPPLIER ST CLAIRE MEDICAL CENTER		STREET ADDRESS CITY STATE ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
(X4) D 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)

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Program to prevent, minimize or eliminate the risk of infection, this included surveillance, analysis, interpretation, educating staff about infection prevention, and the development of policies and procedures to ensure rigorous infection control standards are met. Further review revealed, she was responsible for evaluation and updating the infection prevention and control plan.

Record review of the Census and Condition on 10/01/13 revealed six (6) of the eight (8) current resident are on antibiotics.

Interview with Unit Manager, on 10/03/13 at 5:15 PM, revealed she monitored staff infection control practices and when problems were identified she contacted the Infection Control Nurse. Further interview revealed the Minimum Data Set (MDS) Coordinator was responsible for notifying the Unit Manager of the current in-house Urinary Tract Infections and monitoring. The urinary tract infections were monitored on the unit, using an infection control log as a tool. Identification and monitoring of infections were done by the pharmacy and the Physician.

Interview with Infection Control Nurse, on 10/03/13 at 3:05 PM, revealed the system for monitoring and investigating causes of infection, was that all positive cultures were reviewed every day and the unit origination of the infection was discussed with the unit manager either with an e-mail or phone call. The tracking system utilized for the causative agent, the origin of the infection and the measures taken to prevent the spread included daily review of the labs, utilizing a tracking tool via an application on cellular phone, that was not approved by the hospital. Further interview revealed, she was not aware that five

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4. The Nurse Manager or designee will audit all patients admitted to the TCU weekly times four weeks then monthly times three months to ensure all infections on the TCU have been logged and tracked accordingly. The Administrator and Nurse Manager will review the results of these audits monthly to ensure compliance with the regulation. Any issues resulting from these audits will be addressed appropriately and discussed during the quarterly Quality Assurance meeting to determine compliance with this regulation and for any further recommendations.

5. Date of Compliance: November 11, 2013

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NAME OF PROVIDER OR SUPPLIER ST CLARE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
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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 441 Continued From page 11 F 441

(5) of the eight (8) residents on the TCU had urinary tract infections. She stated she would expect to have been notified of the urinary tract infections. Further interview revealed she was not aware that seven (7) of the residents had infections. She stated the last policy update for infection control was 2009 and she had not reviewed the infection control policy yet. She stated she had only been there since December 2012, and it needed fixed. She further stated the policy for Infection control was not an effective infection control policy.

Further interview with Infection Control Nurse, on 10/03/13 at 4:30 PM, revealed the guidelines for standard of practice utilized was Center Disease Control and the Association for Professional in Infection Control and Epidemiology. Monitoring staff infection control practices was done through observations. Infection rates was monitored utilizing a data base and then she ran reports that interrupted days of callher use, etc. She stated the Infection Control Nurse should monitor infections on the TCU unit but she had not been monitoring them regularly.

Acceptable
11/12/13

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NAME OF PROVIDER OR SUPPLIER ST CLAIRES MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351	
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			(X5) COMPLETION DATE

K 000 INITIAL COMMENTS

K 000:

CFR: 42 CFR 483.70(a)
 Building: 01
 Plan approval date: 1976
 Survey under: NFPA 101 (2000 Edition)
 Facility type: SNF
 Type of structure: Seven story Type I (332)
 Smoke Compartment: Two
 Fire Alarm: Complete fire alarm
 Sprinkler System: Complete sprinkler system
 A standard Life Safety Code survey was conducted on 10/03/13. Saint Claire Medical Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was six (6). The facility is licensed for ten (10) beds.

This prepared plan of correction and creditable allegation of compliance does not constitute an admission or agreement to the alleged stated deficiencies by the provider or its management company. This plan of correction and creditable allegation of compliance is prepared and executed only because state and federal law require it.

RECEIVED
OCT 25 2013

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "D" level.

K 029

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

1. The TCU staff immediately removed the chairs from 508 and relocated them properly throughout the unit after the surveyor brought this to our attention on 10/3/2013. Room

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 10/25/13

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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K 029	Continued From page 1 The approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure areas used as storage, was protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of two (2) smoke barriers, two (2) of ten (10) residents, staff and visitors. The findings include: Observation on 10/03/2013 at 11:50 AM, revealed room 508 was being used for storage. The room contained 9 resident chairs. Further observation revealed the room was not equipped with a self-closer on the door. Rooms used for storage must meet the requirements for hazardous areas. The observation was confirmed with Assistant Maintenance Director. Interview on 10/03/2013 at 11:50 AM, with the Administrator and Assistant Maintenance Director, revealed the room had been used since April for storage and the facility had failed to identify the room as needing a self-closer on the door.	K 029	508 is not one of the unit's designated storage rooms; therefore a self-closer device was not placed on the door. The Administrator informed staff which rooms were designated as storage and that empty patient rooms were not to be utilized as holding areas for equipment. 2. The Administrator and the Director of Nursing conducted a walk-through of unit on 10/3/2013. Any items located in unapproved areas were removed and placed in proper storage rooms. 3. The Administrator or Director of Nursing will conduct daily walk-through rounds for four weeks to ensure compliance with this regulation. An in-service will be conducted on 10/24/2013 by the Administrator and Director of Nursing to educate all TCU staff on the proper designated storage areas		

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K 029 Continued From page 2

Reference: NFPA 101 (2000 edition)
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
- (3) Paint shops
- (4) Repair shops
- (5) Soiled linen rooms
- (6) Trash collection rooms
- (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction
- (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard

Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.

K 029

on the unit and to reinforce the issue of not using empty patient rooms as holding areas for equipment.

4. The Administrator and the Director of Nursing will review the results of these walk-through rounds monthly times two months to ensure compliance with this regulation. The results of these walk-throughs and any other issues identified as a result of these walk-throughs will be discussed quarterly at during the quality assurance meeting to determine compliance with this regulation and to discuss further recommendations.
5. Date of Compliance: November 11, 2013

Note: Daily walk-throughs of the unit by the Administrator or Director of Nursing is a standard of care for the TCU and will continue even if no further issues are discovered as a result of these walk-through audits.