

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

PRINTED: 10/26/2015  
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 10/26/2015
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NAME OF PROVIDER OR SUPPLIER  ST CLAIR 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 000}	INITIAL COMMENTS  An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 10/23/15 as alleged.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		10/02/2015

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.

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:  185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/11/2015
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

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F 000	INITIAL COMMENTS	F 000		
F 252	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252	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 compliances is prepared and executed only because state and federal law require it.	
	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252	1. The chipped paint identified on the walls and door facings in rooms 502, 503, 504, 505, 506 and 507 will be repaired utilizing a product called Inpro Vinyl Wall Protection. This product was ordered on 9/25/2015 and will be applied by our maintenance personnel. The door facings will be painted by maintenance personnel once the wall protection has been installed. 2. A walk-thru of the Transitional Care Unit was conducted on 9/15/15 by the Administrator and Nurse Manager to identify any other issues that would not provide a safe, clean, comfortable and homelike environment. Any issues identified were corrected immediately by the Administrator or Nurse Manager or forwarded to Maintenance personnel for repair.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to provide a homelike environment for six (6) of six (6) rooms (Rooms 502, 503, 504, 505, 506, and 507). Observation during the environmental tour, revealed chipped paint on the walls behind resident beds and along the door facings.			
	The findings include: Review of facility policy titled " Environmental Maintenance, " revised 05/05/15, revealed the facility would maintain the physical plant in accordance with a schedule that would serve to provide a safe, functional, and aesthetically pleasing environment. Observation during the environmental tour on 09/10/15 at 10:23 AM revealed chipped wall paint behind resident beds and along the door facings for six (6) resident rooms.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE 10/2/15

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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  09/11/2015
NAME OF PROVIDER OR SUPPLIER  ST CLARE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40361	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

F 252 Continued From page 1

Review of the facility "Work Order", dated 10/14/14, revealed a work order request was placed for " touch up paint in rooms 502, 503, 504, 505, 506, and 507 ". The work order request was documented as completed.

Interview with the Unit Manager (UM), on 09/11/15 at 8:30 AM, revealed she had placed the work order on 10/14/14 for the resident rooms to be painted. The UM stated, although the work order was documented as complete the repairs were not done. Further interview revealed she had verbally followed up with maintenance; however, did not place a second work order for the repairs. The UM stated she should have ensured the repairs were completed.

Interview with the Maintenance Manager (MM), on 09/11/15 at 8:43 AM, revealed he was responsible to ensure cosmetic repairs were completed for the facility. The MM stated the chipped paint resulted from resident beds and chairs hitting the walls. The MM was unaware if the work order request had been completed or not; however, stated work orders were documented as completed when done.

Interview with the Administrator, on 09/11/15 at 11:04 AM, revealed he would expect if a work order was placed, the repair would be completed. The Administrator stated, if the repair was not completed in a timely manner another work order should have been placed. Further interview revealed he was unaware of the chipped paint.

F 252

3. The process for submitting work orders to maintenance was reviewed by the Administrator, the Nurse Manager and the Director of Maintenance on 9/24/15 to insure all steps were being followed appropriately. If there has been no response from maintenance within five (5) working days of a work order being submitted, the Administrator or designee will follow up with a phone call and an additional work order if necessary. An in service was conducted by the Nurse Manager on 9/24/15 to review with staff, the process for submitting and following up with work orders.
4. The Administrator, the Nurse Manager or designee will conduct weekly walk through audits of the unit to ensure compliance with providing a safe, clean, comfortable and homelike environment for our residents. These audits will be conducted weekly times four weeks then monthly times three months to ensure continued compliance. The results of these audits will be brought to the quarterly Quality Assurance meeting for review. The committee will determine compliance and recommend any further actions needed.
5. Date of Compliance: October 23, 2015

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

*Accepted  
10/8/15*

PRINTED: 09/22/2015  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185430	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/09/2015
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NAME OF PROVIDER OR SUPPLIER  ST CLAIRE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 222 MEDICAL CIRCLE MOREHEAD, KY 40351
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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 (7) story Type I (332)  
Smoke Compartment: Two (2)  
Fire Alarm: Complete fire alarm  
Sprinkler System: Complete sprinkler system  
  
A Standard Life Safety Code Survey was conducted on 09/09/15. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid, Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The census on the day of the survey was three (3). The facility is licensed for ten (10) beds.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *10/2/15*

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