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

PRINTED: 10/21/2015
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		R 10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

(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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/20/15 as alleged.	{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.

RECEIVED
OCT 13 2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE QUALITY ASSESSMENTS AND SERVICES

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

PRINTED: 09/25/2015
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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 09/08/15 and concluded on 09/11/15 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "F".	F 000	F157 Resident #1 Physician was notified of skin conditions on the coccyx and heel on 9/9/15. All Residents have the potential to be affected by this practice.	10/20/15
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	The RN Manager will audit all Resident records 5 days per week for 4 weeks, evaluating for change of condition and subsequent physician notification. After 4 weeks, upon compliance and recommendation from the QA committee audits can be reduced to 3 times per week, once per week and eventually once per month. The facility electronic medical record has been modified by IT Staff to include a work list item including a prompt to nurses for physician notification of change of condition, what the change of condition was and the time/date of notification. Facility Staff will receive education related to the requirement for physician notification of Resident change in condition. After education staff will complete a post test on educated material. Education and post-test will be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X CM Nieman
X TITLE: ADMINISTRATOR
X (X6) DATE: 10/12/15

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 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify the physician of an acquired pressure ulcer for one (1) of twelve (12) sampled residents, Resident #2. The findings include: The facility did not provide a policy regarding notification of the physician. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 08/29/15 with diagnoses of a Femoral Neck Fracture and Dementia. Review of the Weekly Skin Assessment, dated 09/06/15, revealed the facility identified new skin impairments to Resident #2's coccyx and right outer heel. The facility identified the skin issue on the heel as a fluid filled blister approximately four (4) centimeters round. The facility also identified the resident as having a red, chaffing to the coccyx area. Review of the Daily Nurses Notes, dated 09/07/15, revealed the facility documented only skin tears or bruising. Nursing did not document the blister or red, chaffing area on this document. Nursing did not document notification to the physician of the pressure areas on Resident #2. Review of nursing notes dated 08/05/15 revealed there was no breakdown on Resident #2's feet.	F 157	completed by RN Manager, Administrator, MDS Coordinator and/or Registered Nurses. Any new staff hired will receive education prior to working with Residents. Results plan of correction will be reported in a weekly meeting to evaluate compliance of facility plan of correction led by the administrator. Results of weekly meeting and plan of correction will be reported to the Quality Assurance committee.	

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F 157	Continued From page 2 Observation, on 09/10/15 at 2:35 PM, of Resident #2's skin assessment revealed a red blackened Stage II area to the coccyx with clear serosanguinous drainage and the surrounding area was pink and blanchable per Registered Nurse (RN) #2. Additionally, the RN Manager stated the right heel measured 4.4 centimeter (cm) X 1.4 cm flat blister and was non-stageable. Interview, on 09/10/15 at 2:40 PM, with the RN Manager revealed he would call it a blister, not an open pressure ulcer, but a healing blister. Interview, on 09/10/15 at 4:07 PM, with RN #2 revealed Resident #2 did not have the area to coccyx last week and considered it avoidable. RN #2 further stated the measurements from skin assessments should be on the sheets with the wound tool or on the body surface map. Review of the Physician's Orders, dated 08/01/18 through 09/11/15, revealed there were no physician orders for the treatment or prevention of pressure ulcers after nursing assessed Resident #2 with having pressure areas. Interview on 09/11/15 at 11:45 AM with Licensed Practical Nurse (LPN) #1 revealed staff should follow policy and procedure for skin assessments and measuring; and anytime anything happens they should notify the physician. LPN #1 further revealed if a resident has an open area on the skin and if a change in the resident then staff should notify the physician. Interview on 09/11/15 at 1:47 PM with RN Manager revealed the physician should be notified if there is a change in a resident's condition and anytime there is an acute change	F 157		

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F 157	Continued From page 3 notify the physician. Interview with the Case Management and Quality, on 09/11/15 at 11:45 AM, revealed the medical records for Resident #2 did not contain any evidence nursing notified the physician of the acquired pressure ulcer on the resident's foot or coccyx. She stated there were no physician orders for treatments for the new pressure areas. She stated this was a problem because the physician may have ordered additional treatments. Interview, on 09/11/15 at 9:28 AM, with Medical Director revealed the facility had protocols that needed to be followed, the protocols were to prevent issues and if they were not followed then there would be issues, and if there is a breakdown in the system it needs to be fixed. The Medical Director stated he would expect measurements to be on the Patient Flowsheet Report of Weekly Skin Assessments,and it looked like there were issues for following protocols, and once there, they are not being documented as they are supposed to be. The Medical Director stated there could be a possibility the skin issues could have been preventable if protocol had been followed. Interview with Administrator, on 09/11/15 at 2:30 PM, revealed the facility did not notify the physician of a newly acquired pressure area on Resident #2. He stated this placed the resident at risk of worsening pressure ulcer and of not receiving needed interventions to promote healing of the pressure areas.	F 157		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 4 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 observation, interview, record review and facility policy review, it was determined the facility failed to ensure staff provided care in a manner that maintained dignity for two (2) of twelve (12) sampled residents. Observation revealed the facility exposed Resident #2 and #4's bodies to common areas of the facility during the provision of care. The findings include: Review of the Resident Rights Policy, dated 10/17/14, revealed each resident would be treated with consideration, respect, and full recognition of his/her dignity and individual values and beliefs. The facility would provide care in a safe environment and ensure the personal privacy of the residents. 1. Review of the clinical record for Resident #2 revealed the facility admitted Resident #2 on 08/29/15 with diagnoses of Femoral Neck Fracture and Dementia. The facility admitted Resident #2 from the Intensive Care Unit for post-surgical rehabilitation after the resident sustained a fall in the home. Review of the Patient Care Notes, dated 08/30/15, revealed Resident #2 was confused to time, date, and place. The note stated family had	F 241	F241 Resident #2 reported no lasting effect from leaving the door open while staff provided care. Resident #4 reported no lasting effect from leaving the door open while staff provided care. Resident #4's responsible party reported no lasting effect from leaving the door open while providing care. All Residents have the potential to be affected this practice. All Residents will be audited to determine any affected by this practice and for any lasting effect. These audits will be completed by the RN Manager, Administrator, MDS Coordinator, Activity Director and/or Registered Nurses. The facility will conduct audits of all Residents or Responsible Party evaluating for Resident dignity while staff providing care. Audits will be completed by the Administrator, RN Manager, MDS Coordinator, Activity Director, RN's and LPN's 5 times per week, evaluating for Resident dignity. After 4 weeks, upon compliance and recommendation from the QA committee audits can be reduced to 3	10/20/15

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CABINET FOR HEALTH AND FAMILY SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 5 reported the resident had confusion at home prior to the hospitalization. Observation, on 09/09/15 at 10:06 AM, revealed Resident #2 was in bed in the room. Staff had positioned the door to the hallway at half-open and had not closed the curtain. The curtain was completely open allowing for observation of the resident in the room. Staff was in the room with the resident placing air boots on the resident's legs. The resident's legs were uncovered and visible from the hallway. 2. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 03/29/12 with diagnoses of Anemia, Hypertension, Neurogenic Bladder, Diabetes, Paraplegia, Indwelling catheter, Depression, Hypothyroidism, Morbid Obesity, Obsessive-Compulsive Disorder, Mononeuritis, Eczema, Dyshidrosis, and Seborrhea. Review of Resident #4's Minimum Data Set (MDS), dated 08/10/15, revealed the facility completed a Brief Interview for Mental Status (BIMS) with a score of fifteen (15) of fifteen (15) which meant the resident was interviewable. Observation, on 09/09/15 at 10:00 AM, revealed Resident #4 was in the bed receiving treatment to his/her shoulder with the door and curtain open. The resident's shoulder and arm were visible from the hallway while the nurse provided the treatment. Interview with Regisered Nurse (RN) #3, on 09/09/15 at 10:10 AM, revealed the RN did not close the door or privacy curtain when providing care for Resident #4. RN #3 stated she was	F 241	times per week and eventually once per week. Facility Staff will receive education related to the requirement for Dignity and Resident Rights. After education staff will complete a post test on educated material. Education and post-test will be completed by RN Manager, Administrator, MDS Coordinator and/or Registered Nurses. Any new staff hired will receive education prior to working with Residents. Results plan of correction will be reported in a weekly meeting to evaluate compliance of facility plan of correction led by the administrator. Results of weekly meeting and plan of correction will be reported to the Quality Assurance committee.	

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OFFICE OF INSPECTOR GENERAL
NATIONAL CENTER FOR HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 6 providing a wound treatment to the resident's right shoulder. She stated she did not close the door because the resident was not exposing body parts during the treatment. The nurse provided the treatment to the right shoulder, the shoulder farthest away from the door. However, a person in the hallway could have looked in and observed the resident receiving treatment to that shoulder. Interview with Resident #4, on 09/09/15 at 4:25 PM, revealed the resident received treatment to a chronic shoulder wound earlier in the day while the bedroom door and curtain remained open. The resident stated he/she did not prompt the nurse to close the curtain or the door. The resident also stated he/she was not upset with the nurse exposing his/her shoulder without pulling the privacy curtain, but would have been if other parts of his/her body were exposed. Observation, on 09/10/15 at 2:35 PM, of Resident #2's skin assessment revealed the hallway door was open and the privacy curtain was open giving a clear view of the skin assessment being completed on Resident #2 as well as Resident #2's body being exposed to any individuals in the hallway. Interview with RN #4, on 09/10/15 at 2:40 PM, revealed nursing staff should always close the door and/or the privacy curtain in a resident's room when providing any kind of care to a resident. If staff did not providing privacy while giving care, they were not promoting dignity to the resident. Interview, on 09/10/15 at 2:58 PM, with the Registered Nurse (RN) Manager revealed the	F 241		

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F 241	Continued From page 7 door was open, but should not have been, and they should have ensured privacy for the resident. Interview, on 09/10/15 at 4:07 PM, with RN #2 revealed she did not know the door was open. The resident could be seen from the hall and privacy should be ensured. Interview, on 09/11/15 at 11:45 PM, with Licensed Practical Nurse (LPN) #1 revealed staff should follow policy and procedure for privacy. Interview with the Nurse Manager, on 09/11/15 at 2:05 PM, revealed staff providing care to a resident without ensuring privacy was a violation of residents' rights. He stated he had not witnessed staff providing care to any residents in the facility with the door and curtain open. However, when staff did provide care without ensuring privacy, the staff are not ensuring resident dignity. Interview with the Medical Director, on 09/11/15 at 10:45 AM, revealed the facility staff should have provided privacy when providing care for any resident. He stated the facility was the residents' home and providing care without privacy was a violation of the residents' dignity and rights.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

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F 279	Continued From page 8 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). 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 develop a comprehensive care plan for one (1) of twelve (12) sampled residents, Resident #12. The findings include: Review of the facility's policy regarding Interdisciplinary Plan of Care, dated August 2012, revealed the facility would review the contents of the resident's plan of care at a care conference after the initial assessment was completed. Upon admission to the facility, a Registered Nurse (RN) would initiate an interdisciplinary plan of care. The facility would then individualize the interdisciplinary plan of care based upon assessment and resident needs. The interdisciplinary team would use the problems identified during the assessment of the resident to develop a comprehensive plan of care.	F 279	F279 Resident #12 was discharged from the facility on 7/31/2015. Residents admitting to the facility for longer than 14 days have the potential to be affected. All Resident Care plans have been audited and care plans have been updated. An intranet based calendar was created to track admission, MDS, care plan and discharge completion and submission by an IT Clinical Analyst. Facility Staff will receive education related to the requirement for Care Plan development. After education staff will complete a post test on educated material. Education and post-test will be completed by RN Manager, Administrator, MDS Coordinator and/or Registered Nurses. Any new staff hired will receive education prior to working with Residents. Results of plan of correction will be reported in a weekly meeting to evaluate compliance of facility plan of correction, led by the administrator.	10/20/15

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITY LICENSURE AND INSPECTIONS

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F 279	Continued From page 9 Interview with the Case Management and Quality, on 09/11/15 at 11:45 AM, revealed the facility used the Resident Assessment Instrument (RAI) Manual version 3.0 as their procedure for developing care plans. Review of the RAI Manual version 3.0, revealed the facility should complete the resident care plan within seven (7) days after completing the Minimum Data Set (MDS) assessment and Care Area Assessment (CAA). The facility should have a completion date for the MDS assessment and CAA of no more than fourteen (14) days after admission to the facility. Following the CAA completion date, the facility should have a completed compressive care plan within seven (7) calendar days after the CAA completion date. Review of the clinical record for Resident #12 revealed the facility admitted the resident on 07/02/15 with diagnoses of Parkinson's Disease, Cerebellar Ataxia, Elevated Prostate Specific Antigen, and Unspecified Debility. The facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15), meaning the resident was interviewable. Further review revealed the facility discharged the resident on 07/31/15. Review of the Comprehensive MDS assessment, dated 07/15/15, revealed the facility completed the MDS and CAA within the fourteen (14) day time limitations. Review of the admission care plan, dated 07/02/15, revealed the facility completed and were to use this initial care plan for Resident #12 for up to fourteen (14) days. However, the facility was unable to provide a comprehensive care plan	F 279	Results of weekly meeting and plan of correction will be reported to the Quality Assurance committee.	

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F 279	Continued From page 10 completed after the completion of the CAA. Review of the facility's list of residents discharged within 90 days, provided by the facility on 09/09/15, revealed the facility discharged Resident #12 on 07/31/15. Interview with the MDS Coordinator, on 09/11/15 at 1:30 PM, revealed the facility did not complete a comprehensive care plan for Resident #12. She stated upon admission, a Registered Nurse (RN) completed the initial care plan. The MDS Coordinator then completed the MDS and CAA for the resident within fourteen (14) days of admission. The MDS Coordinator should have completed the comprehensive care plan within seven (7) days after the completion of the CAA. The MDS Coordinator further stated the facility admitted Resident #12 on 07/03/15 and his/her CAA was due and completed by 07/17/15. The comprehensive care plan for Resident #12 would have been due by 7/24/15. However, the MDS Coordinator stated she did not complete the comprehensive care plan for this resident. The facility later discharged the resident on 07/31/15. Therefore, the facility should have been providing care from a comprehensive care plan for seven (7) days. The MDS coordinator stated she had not completed the comprehensive care plan because she failed to realize this resident's care plan was due. Additionally, she used the Point Click Care computer system to complete the MDS assessments and Care Plans. When a review became due, the computer only alerted the MDS Coordinator if she looked at the specific page on the computer system related to assessment due	F 279		

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	185428		09/11/2015

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F 279	Continued From page 11 dates. She did not keep a calendar or other tool to trigger her to complete tasks. The MDS Coordinator stated she was doing several jobs within the facility at the time and failed to realize this resident's care plan was due. She stated she did not realize it because she probably thought the care plan was already completed. The MDS Coordinator further stated the nursing staff used care plans as a tool to provide care. Interview with the Administrator, on 09/11/15 at 2:30 PM, revealed he was unaware the facility had not developed a care plan for Resident #12. The Administrator stated the facility had weekly meetings to discuss care plan development and revisions. He did not state if care planning information for Resident #12 had been brought to the care plan meeting. The Administrator stated if the facility did not have updated care plans, the resident was at risk of not receiving care that was up to date with the resident's assessed needs.	F 279		
F 280 SS=E	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	F 280		

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F 280	Continued From page 12 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 interview, record review and review of the facility's policy, it was determined the facility failed to ensure care plans were reviewed and revised for four (4) of twelve (12) sampled residents, Residents #1, #2, #5, and #6. The facility staff failed to document on the plan of care revision dates for Resident #1, #5, and #6. The staff failed to revise the interim care plan when new skin pressure was identified for Resident #2. The findings include: Review of the facility's policy regarding Interdisciplinary Plan of Care, dated August 2012, revealed the facility would update the plan of care within each Minimum Data Set (MDS) assessment to reflect progression or decline. The policy further stated the interdisciplinary team would individualize the plan of care by adding or updating problems identified during the assessment or reassessment of the resident. The interdisciplinary team would review the contents of the plan of care at care conferences conducted at least quarterly. 1. Review of the clinical record for Resident #5 revealed the facility admitted the resident on 10/04/12 with diagnoses of Hypertension,	F 280	F280 Resident #5 had a care plan review on 9/9/15. Resident #1 had a care plan review on 9/9/15. Resident #3 had a care plan review on 9/13/15. Resident #6 had a care plan review on 9/9/15. Resident #2 had a care plan review on 9/17/15 and revisions included the coccyx and right heel. Residents requiring revisions to the plan of care have the potential to be affected. Interim Care Plans and Care plans have relocated to storage in 2 binders increasing the ease of use and access for facility nursing staff to revise care plans as necessary. The RN Manager will complete an audit of all Resident care plans 5 days per week for 4 weeks. After 4 weeks, upon compliance and recommendation from the QA committee audits can be reduced to 3 times per week, once per week and eventually once per month.	10/20/15

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F 280	Continued From page 13 Peripheral Vascular Disease, Cerebral Vascular Accident (CVA), Non-Alzheimer's Dementia, Gastro Intestinal Hemorrhage, and Myocardial Infarction. Review of the Minimum Data Set (MDS)Assessment, dated 07/15/15, revealed the facility assessed the resident's cognition using the Basic Interview for Mental Status (BIMS) with a score of three (3) out of fifteen (15), meaning the resident was not interviewable. Review of the Comprehensive Care Plans for Resident #5, dated 04/14/15, revealed the facility maintained a handwritten care plan in the resident's chart. The care plan contained no dates indicating the facility had reviewed the objectives after 04/14/15. The handwritten care plans contained columns labeled goals, approaches, discipline, date added, date discontinued, and comment/evaluation of goals. The column labeled comments/evaluation of goals revealed the date the facility wrote the document. The facility did not write any additional dates to show they had evaluated the goals or interventions. Review of the Comprehensive Care Plans for Resident #5, dated 09/09/15, revealed the facility created the care plan document electronically on 09/09/15. The Care Plan was an electronic printout and contained a date next to each intervention on the care plan. Every intervention on this care plan had 09/09/15. The MDS Coordinator reviewed the care plan for Resident #5 and stated she had last updated the care plan in May 2015 and should have updated it again in August 2015. 2. Record review revealed Resident #1 was	F 280	Facility Staff will receive education related to the requirement for Care Plan revision. After education staff will complete a post test on educated material. Education and post-test will be completed by RN Manager, Administrator, MDS Coordinator and/or Registered Nurses. Any new staff hired will receive education prior to working with Residents. Results plan of correction will be reported in a weekly meeting to evaluate compliance of facility plan of correction led by the administrator. Results of weekly meeting and plan of correction will be reported to the Quality Assurance committee.	

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F 280	Continued From page 14 admitted to the facility on 09/01/15 with diagnoses to include: Urinary Tract Infections, Choledocholithiasis, Septicemia, Hypertension, Anemia, Orthostatic Hypotension, Alzheimer Disease, Malnutrition, Hypopotassemia, Coronary atherosclerosis, Atrial Fibrillation, Unstageable Pressure Sore, Osteoporosis, Peripheral Vascular Disease, Coronary Artery disease, and Dehydration. Review of the Significant Change MDS, dated 06/08/15, revealed the facility assessed Resident #1 as requiring extensive to total assistance with activities of daily living, and was assessed to have moderate cognitive impairment with a Brief Interview for Mental Status (BIMs) score of ten (10) of fifteen (15) meaning the resident was interviewable. Review of the Comprehensive Care Plan, dated 12/31/14, with a review date of 04/22/15, revealed handwritten careplans in Resident #5's chart. However, the Activity careplan had a goal date of 09/03/15 (the only careplan to have this date), but the comments/evaluation of goals was dated as reviewed on 03/11/15 and 06/03/15 above the reviewed date of 04/22/15 . Resident #1's handwritten Comprehensive Care Plans contained columns labeled goals, approaches, discipline, date added, date discontinued, and comments/evaluation of goals. The facility failed to document any additional dates of evaluation for the careplans beyond the date of 04/22/15. Review of the Comprehensive care plans for Resident #1, with date of 09/09/15 revealed the electronic care plans were initiated on 09/09/15	F 280		

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F 280	Continued From page 15 and revised on 09/09/15. The electronic comprehensive care plans contained columns of Focus, Goal, and Interventions/Tasks. The focus column was dated 09/09/15 for date of initiation and revision. The Goal column was dated 09/09/15 for date of initiation and revision, with a target date of 12/08/15. The Interventions/Tasks column was dated 09/09/15 for date of initiation and revision. The MDS Coordinator reviewed the care plan for Resident #1 and stated she had last updated the care plan in April 2015. She stated she should have updated the care plan again in July 2015. 3. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 04/30/13 with diagnoses of Depression, Allergies, Nutrition, Gastroesophageal Reflux Disease, Osteoporosis, Atrill-fibrillation, Anemia, Hypertension, Dementia, Alzheimer, Coronary Artery Disease, Peripheral Vascular Disease, Insomnia, Anorexia, and Hip Joint Replacement. Review of the Quarterly MDS, dated 08/05/15, revealed the facility assessed Resident #3 as requiring extensive assistance with activities of daily living and to have severe cognitive impairment with a BIMs of (6) six of fifteen (15) meaning the resident was not interviewable. Review of the Comprehensive Care Plans, dated 12/18/14 and 01/19/15, with review dates of 04/22/15 and 05/13/15, revealed handwritten careplans in Resident #3's chart. However, the potential for altered Nutrition careplan had an update of monthly weights on 08/10/15 (the only careplan to have this date), but the	F 280		

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F 280	Continued From page 16 comments/evaluation of goals had a review date of 04/22/15 and 05/13/15 . Resident #3's handwritten Comprehensive Care Plans contained columns labeled goals, approaches, discipline, date added, date discontinued, and comments/evaluation of goals. The facility did not document any additional dates of evaluation for the careplans beyond the date of 05/13/15. Review of Comprehensive care plans for Resident #3, with date of 09/08/15 and 09/09/15, revealed the electronic care plans were initiated on 09/08/15 and 09/09/15 and a revision date of 09/08/05 and 09/09/15. The electronic comprehensive care plans contained columns of Focus, Goal, and Interventions/Tasks. The focus column was dated 09/08/15 and 09/09/15 for date of initiation and revision. The Goal column was dated 09/08/15 and 09/09/15 for the date of initiation and revision, with a target date of 12/07/15. The Interventions/Tasks column was dated 09/08/15 and 09/09/15 for the date of initiation and 09/08/15 and 09/09/15 for the date of revision. 4. Review of the clinical record for Resident #6 revealed the facility admitted the resident with diagnoses of Left Ventricular Heart Failure, Hypertension, Pacemaker Placement, Diverticulosis, Cholecystectomy, Compression fracture of L1,L2, L4, Hyponatremia, Ascites and Bilateral Pleural Effusions secondary to Congestive Heart Failure, Anorexia, and End Stage Cardiomyopathy. Review of the Quarterly MDS, dated 08/07/15, revealed the facility assessed Resident #6 as needing extensive assistance with activities of daily living, and to be	F 280		

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F 280	Continued From page 17 cognitively intact with a BIMs of (13) thirteen of fifteen (15) and interviewable. Review of the Comprehensive Care Plans, dated 11/08/14, with reviewed dates of 05/04/15 and 05/05/15. Resident #6's handwritten Comprehensive Care Plans contained columns labeled goals, approaches, discipline, date added, date discontinued, and comments/evaluation of goals. The facility failed to document any additional dates of evaluation for the careplans beyond the date of 05/05/15. Review of Plan of Care/Comprehensive Assessment (from Hospice) for Resident #6, revealed the electronic Hospice plan of cares were updated by the Interdisciplinary team (IDT) on 08/26/15. The electronic Hospice plan of care contained columns containing: personal resident information, medications, care plan problems related to, goals, and interventions with the last electronic edit date to be 02/05/15. The MDS Coordinator reviewed the care plan for Resident #6 and stated she had last reviewed and updated the care plan in May 2015 and should have updated it again in August 2015. Interview with Certified Nursing Assistant (CNA) #6, on 09/09/15 at 3:00 PM, revealed CNAs accessed care plans via the computers in the residents rooms and used the care plan to know what care to give each resident. The facility communicated changes and updates to CNAs about treatments and care plans at report each day.	F 280		

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F 280	Continued From page 18 Interview with Registered Nurse (RN) #4, on 09/10/15 at 2:40 PM, revealed nurses did not update or make changes to the comprehensive care plans. The RN stated nurses completed and made changes to the initial care plan for newly admitted residents. Once the MDS Coordinator completed the comprehensive care plan, only the MDS Coordinator or the Nurse Manager would update the care plan. The nurses used care plans to drive the care of the residents. Interview with the MDS Coordinator, on 09/11/15 at 1:30 PM, revealed she completed the comprehensive care plans for residents in the Point Click Care computer system. She stated this was a new system. As residents' annual MDS assessments become due, the MDS Coordinator was entering the care plan into the Point Click Care system. Prior to the Point Click Care system, the MDS Coordinator hand wrote care plans and placed those care plans into the residents' charts. Residents who had not yet had an annual MDS assessment continued to have care plans in their medical charts. Once a resident's care plan is in Point Click Care, the system prompts the MDS Coordinator when reviews were due. However, she stated she did not have a calendar or other system to keep track of when hand written care plans were due for review. The MDS Coordinator further stated she should have been reviewing care plans every three months per facility policy. However, she stated she was behind in completing the care plan updates. When she reviewed and updated a care plan, the MDS Coordinator initialed and dated when reviewed. Care Plans she updated in	F 280		

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F 280	Continued From page 19 April she should have updated again in July. The MDS Coordinator stated that she knew she was behind in reviewing care plans, but did not know how far behind she was. She stated she used to maintain a calendar that kept track of when each item was due for each resident. She no longer maintained such a calendar because Point Click Care did this for her. The MDS Coordinator stated the nursing staff used the care plans as a tool to provide care. The MDS Coordinator further stated nursing staff using care plans that were not reviewed and updated on time placed the residents at risk of receiving the wrong care. Interview with the Administrator, on 09/11/15 at 2:30 PM, revealed he was not aware the MDS Coordinator was not revising care plans every three (3) months. The Administrator stated the facility had weekly meetings to discuss care plan development and revisions, but did not know the MDS Coordinator was not revising some of the care plans. If the care plans are not up to date, there was a potential for the facility to give care that was not up to date with the resident's current assessed needs. Interview, on 09/10/15 at 4:20 PM and 5:45 PM, with MDS Coordinator #1 revealed quarterly careplans were supposed to be done every ninety (90) days, and the RN Manager, case Manager and Quality, and the Administrator was made aware that she was behind and in a state of transition. MDS Coordinator #1 further stated the careplan was like a "recipe card" for the care of the residents; and the careplans for Resident #1, Resident #5, Resident #6, Resident #7 had not been revised.	F 280		

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F 280	Continued From page 20 Interview, on 09/11/15 at 11:45 PM, with Licensed Practical Nurse (LPN) #1 revealed the careplan was supposed to be updated every three (3) months and she would expect it to be updated because it shows the condition of the resident and what care to provide for the residents problems and if it helps. Interview, on 09/11/15 at 12:15 PM, with Certified Nurse Aide (CNA) #3 revealed care plans should be updated as things change to something that works for the resident. Interview, on 09/11/15 at 1:47 PM, with the Registered Nurse (RN) Manager revealed the care plan tells about the care provided to the resident and he expected them to be updated in a timely manner with any change in status and the quarterly careplans should be done every three (3) months. Interview, on 09/11/15 at 2:32 PM, with Administrator revealed the validation reports were pulled for the careplans and the MDSs and it showed that 15%-20% are managed and that 80% were showing they were late, so something was remiss in the computer system, and the careplans were not updated timely. Interview, on 09/11/15 at 9:28 AM, with Medical Director revealed that if careplans are not completed in a timely fashion then it would affect the care of the residents.	F 280		

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F 280	Continued From page 21 5. Review of the facility's policy regarding Interdisciplinary Plan of Care, dated August 2012, revealed the facility would individualize the interdisciplinary plan of care based upon assessment and resident needs. The facility would identify the resident's prior risks of skin breakdown and implement interventions to address the individual's risks. Review of the clinical record for Resident #2 revealed the facility admitted Resident #2 on 08/29/15 with diagnoses of Femoral Neck Fracture and Dementia. Review of the Weekly Skin Assessment, dated 09/06/15, revealed the facility identified new skin impairments to Resident #2's coccyx and right outer heel. The facility identified the skin issue on the heel as a fluid filled blister approximately four (4) centimeters round. The facility also identified the resident as having a red chaffing to the coccyx area. Review of the care plan for Resident #2, initiated 08/29/15, revealed the facility did not alter the care plan regarding the pressure ulcer or about skin care after the facility identified new pressure areas on the resident. The facility identified and implemented interventions to prevent or heal pressure sores and skin breakdown on 08/29/15 including following the facility skin care protocol, turning the resident every two (2) hours, using Optifoam (adhesive foam wound dressing) and reporting any skin breakdown to the charge nurse. The care plan contained no interventions dated after 08/29/15. Interview with Certified Nursing Assistant (CNA)	F 280		

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F 280	Continued From page 22 #6, on 09/09/15 at 3:00 PM, revealed CNAs accessed care plans via the computers in the residents rooms and use the care plan to know what care to give each residents. The CNA stated nursing instructed CNAs about any updates to the care plan and treatment during report each day. CNA #6 was able to state what interventions were in place for Resident #6 to prevent skin breakdown. CNA #6 further stated she was unaware of any current skin breakdown on Resident #2. Interview with RN #4, on 09/10/15 at 2:40 PM, revealed nurses completed the initial interim care plan for newly admitted residents. Nurses then updated the care plans as the needs of the resident changes. When a nurse updated an initial care plan, they placed their initials and the date next to the new intervention. Interview with the Minimum Data Set (MDS) Coordinator, on 09/11/15 at 1:30 PM, revealed nursing completed the initial interim care plans for newly admitted residents. Nurses updated the initial interim care plans as they identify care needs. The MDS Coordinator stated initial interim care plans are hand written and located in the resident's chart. The MDS Coordinator stated the nursing staff used the care plans as a tool to provide care. Interview with the Nurse Manager, on 09/11/15 at 2:05 PM, revealed he did not ensure nursing had updated the care plan for Resident #2 after nursing assessments found a new pressure area. The Nurse Manager stated he had been in this position a short time and was not aware he should have been reviewing all of the skin assessments. He described the procedure	F 280		

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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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

(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 280	Continued From page 23 nurses were supposed to follow when identifying a new pressure area, including updating the initial care plans for newly admitted residents. The Nurse Manager stated because he did not yet know to check the skin assessments, he was unaware of the pressure area, and subsequently did not ensure nursing completed the appropriate documentation and put interventions in place to reduce further skin breakdown. This placed the resident at risk of further development of skin breakdown. Interview with the Administrator, on 09/11/15 at 2:30 PM, revealed the facility did not follow the protocol for updating the initial interim care plan for Resident #2 after discovering a new pressure area. He further stated he was unaware nursing did not update the initial interim care plan for Resident #2. The care plan was used to care for the resident. However, if the care plans are not up to date, there was a potential for the facility to give care that was not up to date with the resident's current assessed needs.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility policy review, it was determined the facility failed to follow the comprehensive care plan regarding skin assessments for one (1) of	F 282		

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DIVISION OF HEALTH DEPARTMENT AUDITS AND SURVEYS

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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

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F 282	Continued From page 24 twelve (12) sampled residents, (Resident #3). The staff failed to complete every shift skin assessments as care planned for Resident #3. The findings include: Review of facility's policy regarding Skin Assessment and Treatment, revised July 2013, the purpose was to promote a thorough, comprehensive assessment for early identification of those residents at risk for loss of skin integrity. This was done to promote prevention, promote healing, prevent infection and prevent development of pressure sores. The Prevention care plan must be individualized and utilized to structure the delivery of care. All residents would be assessed for skin integrity utilizing the modified Braden Pressure Ulcer Risk Assessment Tool on admission and monthly; if the score was more than eighteen (18) the patient was low risk for loss of skin integrity, if the Braden score was less than fourteen (14) there would be interventions, which included keeping the resident's skin clean and interventions must be careplanned. Review of at the clinical record for Resident #3 revealed the facility admitted the resident on 04/30/13 with diagnoses of Depression, Nutrition, Gastroesophageal Reflux Disease, Osteoporosis, Atrill-fibrillation, Anemia, Dementia, Alzheimer, Coronary Artery Disease, Peripheral Vascular Disease, Insomnia, and Anorexia. Review of the Quarterly Minimum Data Set (MDS), dated 08/05/15, revealed Resident #3 required extensive assistance with activities of daily living; and was assessed to have a Brief Interview for Mental Status (BIMS) of six(6) of fifteen (15)	F 282	F282 Resident #3's skin assessment was updated on 10/4/15 and Braden scale was updated on 10/2/15 Residents requiring skin assessments have the potential to be affected by this practice. All Residents skin assessments will be audited for completeness and accuracy. Interim Care Plans and Care Plans have been relocated to storage in 2 binders increasing ease of use and access for facility nursing staff. The RN Manager, Administrator, MDS Case Manager, Activity Director, RN or LPN will complete an audit evaluating following Resident care plans 5 days per week for 4 weeks. After 4 weeks, upon compliance and recommendation from the QA committee audits can be reduced to 3 times per week and once per week. After floor nurse completes skin assessment RN Manager, MDS Coordinator or Registered Nurse will complete a follow audit all skin assessments 5 days each week, evaluating for accurate skin assessment. After 4 weeks, upon compliance and	10/20/15

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 25 signifying severe cognitive impairment and not interviewable. Review of the comprehensive care plan titled activities of daily living (ADL) with a Self Care Performance Deficit related to Dementia, Limited Mobility, Confusion, and Impaired Balance with a date of initiation 09/08/15 and revised on 09/09/15. Intervention directed staff to complete skin inspections every shift and as needed; observe for redness, open areas, scratches, cuts, bruises, and report changes to the nurse; and complete a Monthly Braden scale per the nurse. Review of the clinical record revealed there was no documented evidence of every shift skin inspections. Review of the Braden Skin Assessment, dated July 2015, revealed a skin risk of fifteen (15), with a potential problem with friction and shear, and has a high degree of skin exposure to moisture. The facility did not provide Braden Skin Assessments for August 2015 or September 2015. Review of the Physician Orders, dated 05/25/15, 07/20/15, 08/24/15, revealed skin assessments were to be completed weekly. Review of the All Orders Report, dated 08/25/15 through 09/11/15 revealed skin assessment were to be completed weekly. Interview, on 09/11/15 at 1:47 PM, with the	F 282	recommendation from the QA committee audits can be reduced to 3 times per week and once per week. Facility Staff will receive education related to the requirement of skin assessments, Braden scale, following Resident care plans. Education and post-test will be completed by RN Manager, Administrator, MDS Coordinator and/or Registered Nurses. Any new staff hired will receive education prior to working with Residents. Results plan of correction will be reported in a weekly meeting to evaluate compliance of facility plan of correction led by the administrator. Results of weekly meeting and plan of correction will be reported to the Quality Assurance committee.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 26 Registered Nurse (RN) Manager revealed careplans revealed the care that was to be provided to the resident. Interview, on 09/10/15 at 4:20 PM, with Minimum Data Set (MDS) Coordinator revealed the careplan was the "recipe card" for the care provided to the residents. Interview, on 09/09/15 at 2:50 PM, with the Case Management and Quality revealed it was the responsibility of the nursing staff and Nursing Manger to do audits on skin assessments. Interview, on 09/11/15 at 9:28 AM, with Medical Director revealed he expected staff to follow the careplan.	F 282	F314 For Resident #1 the facility updated the skin assessment , wound drawing, wound description, physician notification, physician orders, incident report, Braden scale and work list updated. For Resident #2 the facility updated the skin assessment , wound drawing, wound description, physician notification, physician orders, incident report, Braden scale and work list updated. For Resident #3 the facility updated the skin assessment , wound drawing, wound description, physician notification, physician orders, incident report, Braden scale and work list updated. For Resident #5 the facility updated the skin assessment , wound drawing, wound description, physician notification, physician orders, incident report, Braden scale and work list updated. For Resident #6 the facility updated the skin assessment , wound drawing, wound description, physician	10/20/15
F 314 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was	F 314		

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DIVISION OF HEALTH CARE FACILITY INVESTIGATIONS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 27 determined the facility failed to ensure staff monitored the progression and/or development of pressure areas for six (6) of twelve (12) sampled residents. (Resident #1, #2, #3, #5, #6, and #7). The facility failed to conduct weekly skin assessments and review the skin assessments for Residents #1, #3, #5, #6 and #7. Additionally, the facility failed to report or review skin assessments for Resident #2 after the resident acquired a new stage two (2) pressure wound at the facility. The findings include: Review of the facility's policy regarding Skin Assessment and Treatment Policy, revised July 2013, revealed the facility would complete a Braden Assessment upon admission and weekly skin assessments on all residents. If the resident's Braden score was less than fourteen (14), the facility considered the resident at increased risk for loss of skin integrity. The policy stated the facility would use interventions that included, but were not limited to, turning the resident every two (2) hours, limited sitting time, dietary consult, pressure relieving devices, lotions and protective barriers, monitoring and keeping the resident clean and dry. The policy stated if a new skin condition developed, the nurse would document the following within the shift that the nurse discovered the skin alteration: a complete wound tracing; a pressure ulcer assessment; and, an accurate record of location, stage, size, dressing, wound edges, drainage, and character of the wound. If a pressure ulcer was present, the facility must monitor and evaluate the ulcer daily for the	F 314	notification, physician orders, incident report, Braden scale and work list updated. For Resident #7 the facility updated the skin assessment , wound drawing, wound description, physician notification, physician orders, incident report, Braden scale and work list updated. All Residents at risk for developing a pressure ulcer have the potential to be affected. RN Manager will complete a skin assessment of all Residents. All Residents identified to have pressure ulcer prevention measures or at risk for developing pressure ulcers will receive a weekly audit completed by the RN Manager, MDS Coordinator or RN evaluating a Braden scale has been completed, a timely skin assessment has been completed, physician notification, orders received, followed care plan initiated and followed. Facility Staff will receive education on prevention and treatment of pressure ulcers, facility policies for	

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F 314	Continued From page 28 presence and status of the wound dressing, status of the area surrounding the ulcer, pain management, and presence of complications. The policy went on to state the nurse may begin a treatment if the physician had not already prescribed a treatment. When starting a new treatment, the nurse would select the proper care on the treatment plan, and alert the physician to the condition so he or she may re-evaluate and possibly alter the treatment. The facility would also consult with the Dietician for any Stage I or greater pressure area. 1. Review of Resident #2's clinical record revealed the facility admitted the resident on 08/29/15 with diagnoses of Femoral Neck Fracture and Dementia. The facility admitted Resident #2 from the Intensive Care Unit for post-surgical rehabilitation after the resident sustained a fall in the home. Review of nursing notes dated 08/05/15 revealed Resident #2's feet had no skin breakdown. Review of the Patient Care Notes, dated 08/30/15, revealed Resident #2 was confused to time, date, and place. The note stated family had reported the resident had confusion at home prior to hospitalization. Review of the initial care plan for Resident #2, dated 08/29/15, revealed the facility identified four (4) interventions for the section of the care plan called pressure sores/skin care. The interventions included nursing to follow the facility skin care protocol, turn the resident every two (2) hours, use Optifoam (adhesive foam wound dressing), and report any redness or skin breakdown to the charge nurse immediately.	F 314	treatment of Residents at risk for developing pressure ulcers. Education and post-test will be completed by RN Manager, Administrator, MDS Coordinator and/or Registered Nurses. Any new staff hired will receive education prior to working with Residents. Results plan of correction will be reported in a weekly meeting to evaluate compliance of facility plan of correction led by the administrator. Results of weekly meeting and plan of correction will be reported to the Quality Assurance committee.	

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F 314	Continued From page 29 Review of the Braden Skin Screen, dated 09/02/15, revealed the facility assessed Resident #2 to have a Braden score of 12, placing the resident at high risk for loss of skin integrity. Review of the Patient Care Notes, 08/01/15 through 09/11/15, revealed the facility observed a red area the size of a half dollar on the right buttocks and applied Calazyme and Optifoam for treatment and protection. On 08/31/15, Nursing noted they placed Optifoam on the red area of Resident #2's buttocks. On 09/01/15, nursing observed and documented an intact blister on the resident's right heel. The nurse placed Optifoam on the heel. The same note stated the resident's buttocks remained red, but with no breakdown and the nurse applied Calazyme lotion. On 09/05/15, nursing reported Resident #2 had a blister to the right outer heel area. Nursing applied a heel protector and Optifoam, secured by Kerlix. Nursing also applied green heel lift boots while the resident was in bed. Review of the Physician's Orders for Resident #2 for 08/01/15 through 09/11/15, revealed no physician's orders for Calazyme lotion, Optifoam, or green heel lift boots. Review of the Weekly Skin Assessment, dated 08/29/15, revealed Resident #2 had no skin issues on the right heel or buttocks. Review of Weekly Skin Assessment for Resident #2, dated 09/06/15, revealed nursing identified new skin impairments to the resident's coccyx and right heel. On the coccyx, nursing documented the resident had red chaffing. The document did not describe size, dressing, or	F 314		

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F 314	Continued From page 30 other characteristics of the area. On the heel, nursing documented the resident had a fluid filled blister approximately four centimeters (4 cm) round. Nursing documented the use of heel protectors and green heel lift boots. Review of the Weekly Skin Assessment for Resident #2, dated 09/10/15, revealed nursing identified a pressure ulcer on the resident's coccyx measuring 2.4 centimeters (cm) by 1.1 cm. Nursing applied optifoam to the area. Observation, on 09/10/15 at 2:35 PM, of Resident #2's skin assessment revealed a red blackened Stage II area to the coccyx with clear serosanguinous drainage and the surrounding area was pink and blanchable per Registered Nurse (RN) #2. Additionally, the RN Manager measured the area at 4.4 centimeter (cm) X 1.4 cm flat blister non-stageable on the right heel. Additionally Resident #2's heels were soft and boggy. Interview, on 09/10/15 at 2:40 PM, with the RN Manager revealed he would call it a blister, not an open pressure ulcer, but a healing blister. Interview, on 09/10/15 at 4:20 PM, with Minimum Data Set (MDS) Coordinator #1 revealed heels being soft was an issue, blistering was unstageable, and if the fluid was gone it was still unstageable. Interview, on 09/10/15 at 3:15 PM, with Family Member #3 revealed Resident #2 "has a bedsore on the heel", and had been at the facility a week, but had no knowledge of a pressure sore to Resident #2's coccyx. Interview, on 09/10/15 at 4:07 PM, with RN #2	F 314		

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F 314	Continued From page 31 revealed Resident #2 did not have the area to coccyx last week and considered it avoidable. RN #2 further stated the measurements from skin assessments should be on the sheets with the wound tool or on the body surface map. Interview with CNA #6, on 09/09/15 at 3:00 PM, revealed Resident #2 is care planned for repositioning every two (2) hours. However, sometimes if the daughter was in the room and the resident was sleeping, the daughter would ask nursing staff to come back later instead of disturbing the resident for repositioning. Resident #2 had a lot of pain due to a broken hip followed by surgery. Interview with CNA #3, on 09/10/15 at 11:18 AM, revealed she was unaware of Resident #2 having a pressure ulcer. Then stated she did remember the Night Tech stating the resident had a red area on the bottom. If a CNA saw a red area on a resident, they were to report it immediately to the nurse. Interview with the Nurse Manager, on 09/10/15 at 4:05 PM, revealed the nurse manager did not review nursing skin checks and was unaware of the new Stage II pressure ulcer on Resident #2. The Nurse Manager stated nursing should have informed him of the wound and started an incident report. The Nurse Manager stated the nurses should have then updated the resident's interim care plan and contacted the resident's physician to obtain orders for treatments. Further, he stated he would have recommended a Dietary consult to ensure the resident was receiving all the nutritional options for residents with skin issues.	F 314		

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F 314	Continued From page 32 Interview with the Nurse Manager, on 09/11/15 at 2:05 PM, revealed the facility did not consult with the nutritionals about Resident #2 after the development of the stage 2 pressure wound. He stated the resident had been on supplements due to weight loss and declining overall health, however, those supplements are not necessarily the same as the nutritional regimen for skin ulcers. The nurse manager stated he consulted with dietary on 09/10/15 and started a new nutritional supplement regimen for Resident #2. Interview with RN #4, on 09/10/15 at 2:40 PM, revealed RN #4 reviewed the skin assessments completed identifying new pressure areas on Resident #2. The nurse stated the skin assessments did not describe the wounds or the interventions put in place. She stated if nursing found a new pressure ulcer, nursing should have measured the wound and placed the measurements in the chart. Additionally, nursing should have completed an incident report and notified the physician of the new wound. 2. Review of the clinical record for Resident #5, revealed the facility admitted the resident on 10/04/12 with diagnoses of Hypertension, Peripheral Vascular Disease, Cerebral Vascular Accident (CVA), Non-Alzheimer's Dementia, Gastro Intestinal Hemorrhage, and Myocardial Infarction. Review of the Minimum Data Set (MDS) Assessment, dated 07/15/15, revealed the facility assessed the resident's cognition using the Basic Interview for Mental Status (BIMS) with a score of three (3) out of fifteen (15), meaning the resident was not interviewable.	F 314		

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F 314	Continued From page 33 Observation of a skin assessment, on 09/10/15 at 12:08 PM, with Registered Nurse #2 and the Case Management and Quality Registered Nurse revealed soft boggy heels bilaterally (blanchable) to Resident #5's heels and an unstageable scab with crust to Left outer foot (blanchable). There were no measurements taken during this observation. Interview, on 09/10/15 at 12:08 PM, with the Case Management and Quality Registered Nurse revealed a scab with brownish purple dry crust, not open and with no drainage, woild be called unstageable because they do not know what was underneath it. Interview with CNA #3, on 09/10/15 at 11:18 AM, revealed Resident #5 uses heel protectors and a bandage on one heel due to an old pressure wound that was healing. Interview with CNA #6, on 09/09/15 at 3:00 PM, revealed Resident #5 was care planned for repositioning every two (2) hours and had a putty pillow for his/her foot as a pressure-relieving device. Interview with RN #4, on 09/10/15 at 2:40 PM, revealed Resident #5 had a pressure ulcer on his/her foot. The nurse stated the facility provided wound care and the wound was improving. The facility also prevented pressure ulcers for Resident #5 by turning every two (2) hours and providing a pressure-relieving mattress. The resident had pressure-relieving devices such as air boots, a putty pillow for his/her foot, and received daily dressing changes and supplements. 3. Review of the clinical record for Resident #1	F 314		

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITY SURVEYS

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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

(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 314	Continued From page 34 revealed the facility admitted the resident on 09/01/15 with diagnoses of Urinary Tract Infections, Choledocholithiasis, Septicemia, Hypertension, Anemia, Orthostatic Hypotension, Alzheimer Disease, Malnutrition, Hypopotassemia, Coronary Atherosclerosis, Atrial Fibrillation, Unstageable Pressure Sore, Osteoporosis, Peripheral Vascular Disease, Coronary Artery disease, and Dehydration. Review of the Significant MDS, dated 06/08/15, revealed the facility assessed Resident #1 as requiring extensive to total assistance with activities of daily living, and was assessed to have moderate cognitive impairment with a Brief Interview for Mental Status (BIMs) score of ten (10) of fifteen (15) and interviewable. Resident #1 refused a skin assessment, on 09/10/15 at 10:40 AM, stating "one was done yesterday by the nurses", on 09/09/15 a Wednesday. Review of the weekly skin assessment schedule revealed Resident #1 was not due a skin assessment until 09/12/15 on Saturday. Review of the monthly Braden Skin Screens, dated 09/01/15, revealed nutrition to be probably inadequate with potential problem for friction and shear and score of skin risk to be sixteen (16). Review of the care plan for potential for impaired skin integrity and high risk for skin integrity issues, with a review date of 04/22/15, included the following approaches: apply protective barrier cream as needed; Optifoam to the coccyx for protection as needed; change every three (3) days and as needed; skin assessment weekly;	F 314		

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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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

(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 314	Continued From page 35 monitor intake and output; and, dietary consult as needed. Review of the Pressure Ulcer Comprehensive Care Plan, initiated 09/09/15, revealed the following interventions: administer treatments as ordered; monitor for effectiveness; assess/record/monitor wound healing (FREQ) measure length, width and depth where possible; assess and document status of wound perimeter, wound bed and healing progress; report improvements and declines to the medical doctor; follow facility policies and protocols for the prevention and treatment of skin breakdown; and monitor/document/report to medical doctor as needed changes in skin status, appearance, color, wound healing, sign and symptoms of infection and wound size. Review of weekly Patient Flowsheet Report for weekly Skin Assessments, dated 09/06/15, revealed Resident #1 had skin impairment already existing and new skin impairment identified and the upper and lower extremities with a bluish discoloration. Review of the Patient Anatomical Assessment Report, dated 09/06/15, revealed the following: assessment site sacrum with red and dry scales and no measurements detailed. Other areas were back of right leg, front of upper arm, front of left leg, front of head with bruising, scars, and abrasions and no measurements related to any skin findings. Interview with CNA #3, on 09/10/15 at 11:18 AM, revealed the Nursing staff placed Optifoam on Resident #1's buttocks when it started to get red, but did not use it all of the time. Nursing also	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185428	A. BUILDING _____ B. WING _____	09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 314	Continued From page 36 used cream and repositioning to prevent pressure ulcers. 4. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 04/30/13 with diagnoses of Depression, Nutrition, Gastroesophageal Reflux Disease, Osteoporosis, Atrill-fibrillation, Anemia, Dementia, Alzheimer, Coronary Artery Disease, Peripheral Vascular Disease, Insomnia, and Anorexia. Review of the Quarterly MDS, dated 08/05/15, revealed the facility assessed Resident #3 as requiring extensive assistance with activities of daily living; and was assessed to have a BIMs of (6) six of fifteen (15), signifying severe cognitive impairment and not interviewable. Observation of a skin assessment, on 09/10/15 at 11:05 AM,conducted by Registered Nurse (RN) #4 and the Case Management and Quality Registered Nurse revealed red blanchable soft boggy heels with heel foam protectors on Resident #3 and red blanchable area to coccyx with a soft Optifoam to coccyx and bony prominence of the back. During this skin observation no measurements were taken of the areas to the coccyx or the heels. Review of the All Orders Report, dated 05/25/15-09/09/15 revealed weekly skin assessment start date and time of 06/05/15 at 8:00 PM. No orders were documented for Optifoam to back or coccyx nor were there any orders for heel foam protectors for the heels of Resident #3. Review of the All Orders Report, dated 06/22/15-09/09/15, revealed a weekly skin assessment start date of 07/03/15 at 8:00 PM.	F 314		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 314	Continued From page 37 No orders were documented for Optifoam to back or coccyx nor were there any orders for heel foam protectors for the heels of Resident #3. Review of the All Orders Report, dated 07/20/15-09/09/15 revealed a weekly skin assessment start date and time of 08/07/15 at 10:00 PM. An order for dressing change every seventy-two (72) hours, cleanse coccyx, apply light layer of Calzime and apply Optifoam every three (3) days and PRN with a start date of 08/02/15 at 10:00 AM for Resident #3. There were no orders documented for Optifoam for bony prominence of the back or foam protectors for the heels of Resident #3. Review of the Braden Skin Screen, dated 07/07/15 revealed Resident #3 had very moist skin and slightly limited mobility with a potential problem for friction and shear with a skin risk total of 15. The facility did not provide any other Braden Skin Screens. Review of the All Orders Report, dated 08/24/15-09/09/15 revealed a weekly skin assessment start date and time of 09/05/15 at 10:00 AM. No orders were documented for the Optifoam to back or coccyx nor were there any orders for foam protectors for the heels of Resident #3. Review of the All Orders Report, dated 08/24/15-09/11/15, revealed a weekly skin assessment with a start date of 08/25/15 and Optifoam to the lower spine and coccyx for preventative measures, change weeklyn and as needed (PRN), and heel protectors daily. The order start date was 09/10/15 at 10:00 AM	F 314		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

(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 314	Continued From page 38 Review of the comprehesive care plan for thin fragile skin at risk for impaired skin integrity, dated 12/18/14 and reviewed 04/22/15 revealed the staff was to perform skin assessments every week and PRN; and report to charge nurse every shift of any noted changes in skin during care. The resident used Aspirin daily and had a potential for increased bruising; remind the resident to avoid hitting self against bedrail; and perform Braden Scale assessment every month and PRN. Review of the skin grid, dated 08/22/15, revealed a red area to the middle of the back on a bony area of 1.5 cm X 1.5 cm. Review of the skin grid, dated 09/06/15, revealed an area of redness with Optifoam applied to the mid back and to the right heel with no measurements documented. Review of the Patient Flowsheet Report, dated 09/06/15, revealed a weekly skin assessment with skin impairment already existing at the T-Spine (thoracic) with a red area 2 cm wide x 4 cm long and applied Optifoam; left heel pressure ulcer approx 5 cm round with reddness, applied heel Optifoam with sock over to keep in place; right heel pressure ulcer entire heel is pink, no measurements documented, Optifoam heel dressing to prevent breakdown, sock over to keep in place; Back of upper arm bruised the size of a quarter. 5. Review of the clinical record for Resident #6 revealed the facility admitted the resident with diagnoses of Left Ventricular Heart Failure, Hypertension, Pacemaker Placement, Diverticulosis, Cholecystectomy, Compression	F 314		

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CABINET FOR HEALTH AND FAMILY SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 39 Fracture of L1,L2, L4, Hyponatremia, Ascites and Bilateral Pleural Effusions secondary to Congestive heart Failure, Anorexia, and End Stage Cardiomyopathy. Review of the Quarterly MDS, dated 08/07/15, revealed the facility assessed Resident #6 as needing extensive assistance with activities of daily living, and to be cognitively intact with a BIMS score of (13) thirteen of fifteen (15) and interviewable. Observation of a skin assessment, on 09/10/15 at 10:20 AM, by RN #4 and Certified Nursing Assistant (CNA) #3 and CNA #5 revealed soft mushy slow to blanch heels with RN #4 stating do not measure unless there is no blanching or the area is open. Review of the All Orders Report, dated 05/25/15-09/09/15, revealed a weekly skin assessment with start date of 06/03/15 and a dressing change every 7 days and as needed for Optifoam heel protectors to bilateral feet, change every week with skin assessment, start date of 06/03/15 at 10:00 AM and no other orders for Resident #6 related to dressing changes. Review of the All Orders Report, dated 06/22/15-09/09/15, revealed a weekly skin assessment with a start date of 07/01/15 and a dressing change every 7 days and as needed (did not specify the location on the orders), with a start date of 07/01/15 at 10:00 AM and no other orders for Resident #6 related to dressing changes. Review of the All Orders Report, dated 07/27/15-09/09/15, revealed a weekly skin assessment with a start date of 08/05/15 and no other orders for Resident #6 related to dressing changes.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

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F 314	Continued From page 40 Review of the All Orders Report, dated 08/24/15-09/09/15, revealed a weekly skin assessment with a start date of 09/02/15 and heel protectors with a start date of 09/07/15 and no other orders for Resident #6 related to dressing changes. Review of comprehensive care plan, dated 11/18/14 with review date of 05/05/15, for potential for impaired skin integrity revealed the following approaches: perform skin assessment upon admit, weekly, and PRN; and, Optifoam heel protectors on bilateral heels for protection and preventative measures every seven (7) Days. Review of the Hospice Plan of care/Comprehensive Assessment for impaired skin integrity, dated 08/26/15 and last revised on 09/26/14, revealed the following interventions: assess/monitor for changes in skin integrity; and wound application of Silvadene to right ear every shift with date of 03/17/15 at 11:44 AM. Review of the skin grid in Resident #6's chart revealed the left heel had a "healing blister 2 x 3 cm". Review of the Patient Flowsheet Report, dated 09/09/15, revealed a weekly skin assessment with no skin impairments identified and a body surface chart with skin assessed and no abnormalities found. 6. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 10/16/09 with diagnoses of Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, Hyperlipidemia, Thyroid Disorder, Osteoporosis,	F 314		

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OFFICE OF INSPECTOR GENERAL
KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 41 Alzheimers Disease, Cerebrovascular Accident, and Non-Alzheimer's Dementia. Review of the Quarterly MDS, dated 06/26/15, revealed the facility assessed Resident #7 as requiring extensive assistance with activities of daily living and to have moderate cognitive impairment with a BIMS score of (11) eleven of fifteen (15) and interviewable.. Observation of a skin assessment, on 09/11/15 at 2:30 PM, with the Case Management and Quality Registered Nurse revealed a "Stage II with serous sanguinous drainage" to the left achilles heel. Review of the Patient Flowsheet Report for weekly skin reports, dated 09/11/15 at 2:24 PM, revealed skin impairment already existed with location of site to be left heel, scab, pink and red in color with no drainage and dressing to have been changed, dry and intact with Bactroban applied and Optifoam placed over. Additional sites: red excoriated Perineum, no measurments; Right Buttock with purplish pink area with scratches and Calzyme applied; and body surface chart with areas marked to coccyx, left heel, and peri area. Review of the Skin grid, dated 09/10/15, revealed the left lower extremity (LE) with a small scab and pink surrounding tissue, no measurements documented and another skin grid with healed across it, with no date. Interview, on 09/11/15 at 10:00 AM, with the Case Management and Quality Registered Nurse reveled Resident #7 had developed a Stage II to his/her foot from a recliner in the room. The Case Management and Quality Registered Nurse	F 314		

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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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 42 further stated the facility did not have a wound nurse. Interview, on 09/11/15 at 2:24 PM, with a family member of Resident #7 revealed the resident's foot had been rubbing on the recliner in the room. Review of the All orders report, dated 05/25/15 through 09/11/15 revealed a dressing change every seven (7) days and PRN with Optifoam heel protectors to bilateral feet change every week with skin assessment, and skin assessment weekly with a start date of 06/03/15. Review of the All Orders report, dated 06/22/15 through 09/11/15 revealed a dressing change every seven (7) days and PRN with no area documented for the dressing and skin assessment weekly with a start date of 07/01/15. Review of the All Orders report, dated 07/27/15 through 09/11/15, revealed a skin assessment weekly with a start date of 08/05/15, and no documentation of a dressing change ordered. Review of the All Orders report, dated 08/24/15 through 09/11/15, revealed heel protectors; Hospice resident; health shakes; and magic cup with a date of 09/01/15 and skin assessment weekly with a start date of 09/02/15. Review of the Diabetes Mellitus Comprehensive care plan, initiated 07/08/15 for Resident #7 revealed following interventions: inspect feet daily	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 43 for open areas, sores, pressure areas, blisters, edema or redness; refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. Continued review of the clinical record for Resident #7 revealed a Stage II pressure ulcer on the left dorsal ankle and was at risk for potential pressure ulcer development Comprehensive careplan, initiated 09/09/15 for Resident #7 revealed the following interventions: requires supplemental protein, amino acids, vitamins, minerals, as ordered to promote wound healing; administer medications as ordered; monitor/document for side effects and effectiveness; needs moisturizer applied (FREQ) to skin; do not massage over bony prominences and use mild cleansers for peri-care/washing; and, Resident #7 needs assistance per two to turn/reposition at least every 2 hours, while in bed and PRN. Review of the Braden Skin Screen, dated 08/18/15, revealed Resident #7 had slightly limited sensory perception and mobility, was very moist and had a potential problem with friction and shear and had a skin risk score of 16. Review of the Patient Care Notes, dated 07/06/15, revealed an order to place Optifoam to areas and keep pressure off of the legs. However, no additional care notes were provided for August or September by the facility. Review of the Patient Flowsheet Report, for	F 314		

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DHSUA-OIG-LOW-LONG TERM CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 314	Continued From page 44 weekly skin reports, dated 09/03/15, revealed skin impairment already existed with location of the site as the heel with red open wound, bloody drainage and no measurements noted. Location of another site was a red labia; middle buttock was pink with old scar tissue not opened and Calazyme applied with no measurements documented. The body surface chart had areas marked to coccyx, left heel, and peri area. Interview, on 09/11/15 at 11:45 AM, with Licensed Practical Nurse (LPN) #1 revealed staff should follow policy and procedure for skin assessments and measuring. Interview, on 09/10/15 at 4:07 PM, with RN #2 revealed staff needed to check for the implementation of the interventions,if the residents heels are soft and boggy. Interview, on 09/10/15 at 4:00 PM, with RN #4 revealed if four (4) of five (5) skin assessments completed had the resident's heels as soft and boggy, it did not look good and the resident needed something besides heel boots, foam protectors. Interview, on 09/11/15 at 1:47 PM, with the RN Manager revealed his expectation was there should be measurements on the skin assessments because if it was thorough it would allow one to know if the resident was digressing or progressing and the better care there would be and if the interventions being done are not working then the care would need to be changed. The RN Manager further stated when the skin areas were found he would expect it to be documented and the more thorough the better.	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 45 He had learned of a log of skin assessments he was required to look at, but the information had not been located. The RN Manager stated he would have expected this to be brought to his attention before now, and the repercussion could be really bad such as more skin breakdown; and he was very concerned that four (4) of five (5) skin assessments done had soft, boggy heels and that was unacceptable. The RN Manger stated the Patient lowset report for weekly skin assessments should have been filled out and thorough. Interview, on 09/11/15 at 2:32 PM, with the Administrator revealed four (4) out of five (5) assessments with soft and boggy feet was concerning and he expected the skin assessments to be accurate, and the skin assessments were incomplete, and with an incomplete skin assessment one could not take the next step and it did not follow policy and procedure. Interview, on 09/11/15 at 9:28 AM, with the Medical Director revealed the facility had protocols that needed to be followed, the protocols were to prevent issues and if they are not followed then there will be issues, and if there is a breakdown in the system it needs to be fixed. The Medical Director further revealed if skin is fine when a resident comes in they should not have a stage II two weeks later; they do treat pressure sores aggressively and as soon as this was known there should have been immediate notification. The Medical Director stated he would expect measurements to be on the Patient Flowsheet Report of Weekly Skin Assessments, and it looked like there were issues for following protocols, and once there they are not being	F 314		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 46 documented as they are supposed to be; the Medical Director stated there could be a possibility the skin issues could have been preventable if protocol had been followed. Additional interview with the Medical Director, on 09/11/15 at 10:45 AM, revealed the facility did not follow the protocol for notification of new pressure ulcers. The Medical Director stated if the facility had followed protocol, the resident may have received different physician orders for nutritional and wound care that may or may not have prevented the worsening of the pressure ulcer. Interview with Administrator, on 09/11/15 at 2:30 PM, revealed the facility did not follow protocol in conducting weekly skin assessments and treatments.	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 observation, interview, record review and facility policy review, it was determined the facility failed to have an effective system in place to ensure assistive devices were used and in	F 323		

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OCT 13 2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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		09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	175 HOSPITAL DRIVE WINCHESTER, KY 40391

(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	Continued From page 47 good operating order to prevent accidents for one (1) of twelve (12) sampled residents and one (1) of two (2) unsampled residents, (Resident #1, and Unsampled Resident A). Staff failed to intervene when Resident #1's pressure alarm to the bed and chair continued to beep due to a low battery. The staff failed to use a gait belt during assisted transfers with Resident #1 and Unsampled Resident A. In addition, the facility failed to ensure all unsupervised areas of the facility were locked when not in use. The facility's shower room was unlocked and unattended. The shower room contained personal care items that were not in a locked or secured location. Further, the facility failed to store potentially hazardous material to prevent accidents. Oxygen (O2) tanks were left in two (2) residents' rooms, room 227 and 228. The findings include: Review of the facility's policy regarding Fall Prevention, revised May 2011, revealed the facility assessed each resident's risk for falls and would implement fall precautions for residents who the facility determined were at risk of falling. The facility used bed and chair alarms for residents assessed as high risk for falling. Interview with the Case Management and Quality, on 09/11/15 at 11:45 AM, revealed the facility did not have a policy regarding locking the shower room or locked areas of the facility. Interview with the Case Management and Quality, on 09/11/15 at 11:45 AM, revealed the facility did	F 323	F323 The Facility has ordered a key coded lock for the shower door. Resident #1's batteries were replaced by the RN Manager on 9/9/15. On 9/9/15 Staff transferring Resident #1 and unsampled Resident A received education on transferring Residents with gait belts. A replacement locking cabinet has been ordered. A call light in the shower room was relocated near the toilet. Batteries in the alarms were replaced. Staff were immediately educated on ambulating Residents with gait belts. Oxygen tanks secured in holders were immediately relocated to the storage area. All Residents have the potential to be affected. Administrator, RN Manager, MDS Coordinator, Activity Director, RN's or LPN's will complete rounds 5 days	10/20/15

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F 323	Continued From page 48 not have a policy regarding routinely inspecting or changing the batteries in the chair or bed alarms. Review of the facility's policy regarding Gait Training, revised September 2013, revealed the facility would place a gait safety belt around each resident's waist for ambulation or return to the resident's room or chair. The staff would use the gait belt with residents unless the facility assessed the resident as contraindicated for the use of the gait belt. Contraindications included residents whose condition limited their being out of bed and/or in an upright position. 1. Observation, on 09/09/15 at 9:00 AM, revealed the facility had left the shower room door unlocked and unsupervised. The shower floors were dry. There was one call light present in the room on the wall near the door to exit the shower room. Additionally, the room contained a cabinet that contained four (4) small bottles of shampoo, two (2) small bars of deodorant, and two (2) small cans of shaving cream. The cabinet was unlocked and a lock sat on the top of the cabinet. The cabinet ring for the lock was broken. Interview with CNA #3, on 09/10/15 at 11:18 AM, revealed the facility did not leave the shower room door unlocked. She stated there was a key located at the nursing station. She said leaving the shower room unlocked would be a risk because a resident could potentially wander into the shower room and fall. There was a pull chord on the wall near the door, but if the resident was not near the bell the resident could not use it and staff may not know the resident was in there. Interview with RN #4, on 09/10/15 at 2:40 PM, revealed staff should have locked the door to the	F 323	each week, after 4 weeks upon compliance and recommendation from the QA committee audits can be reduced to 3 times per week and once per week. Bed and Chair alarms have been numbered and will be placed on a monthly schedule for battery replacement according to the manufacturer guidelines. Facility Staff will receive education on prevention of accidents and supervision related to prevention of injuries. Education and post-test will be completed by RN Manager, Administrator, MDS Coordinator and/or Registered Nurses. Any new staff hired will receive education prior to working with Residents. Results plan of correction will be reported in a weekly meeting to evaluate compliance of facility plan of correction led by the administrator. Results of weekly meeting and plan of correction will be reported to the Quality Assurance committee.	

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F 323	Continued From page 49 shower room when not in use. The nurse stated the facility kept resident items such as curling irons and bathing supplies in the shower room. The nurse stated if a resident went into the shower room the staff would not know where the resident was and this put the resident at increased risk of falls. Interview with the Nurse Manager, on 09/10/15 at 4:05 PM, revealed the shower rooms were supposed to have remained locked when not in use. She stated this was a safety risk to residents for falls. In addition, the facility had a cabinet in the shower room containing residents' personal care supplies such as shaving cream, mouthwash, and soap. Staff should have locked the cabinet as well. He was unaware the latch on the cabinet door was broken and the lock for the door was placed on top of the cabinet. Interview with the Administrator, on 09/11/15 at 2:30 PM, revealed the facility had no wandering residents as defined by the MDS. However, he stated some residents with confusion and a low BIMS score do ambulate throughout the facility in wheelchairs. If a resident were to go into the shower room, they would be at increased risk of falling. 2. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 09/01/15 with diagnoses of Urinary Tract Infections, Choledoncholiathiasis, Septicemia, Hypertension, Anemia, Orthostatic Hypotension, Alzheimer Disease, Malnutrition, Hypopotassemia, Coronary Atherosclerosis, Atrial Fibrillation, Unstageable Pressure Sore, Osteoporosis, Peripheral Vascular Disease, Coronary Artery disease, and Dehydration.	F 323		

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F 323	Continued From page 50 Review of the Significant Change Minimum Data Set (MDS), dated 06/08/15, revealed the facility assessed Resident #1 as requiring extensive to total assistance with acitvities of daily living, and was assessed to have moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of ten (10) of fifteen (15) and interviewable. Observation, on 09/09/15 at 10:20 AM, 10:50 AM, 11:16 AM, 11:45 AM, 12:20 PM, revealed Resident #1's chair alarm was beeping/chirping. Observation of Resident #1, on 09/09/15 at 10:20 AM, revealed the resident used a pressure alarm to his/her wheelchair. The resident was ambulating around the facility independently in the wheel chair. At the time of the observation, Resident #1 ambulated into the activity room, then to his/her room. There was a beeping noise coming from the chair alarm every seventeen (17) seconds. At 10:22 AM, the resident used the call button to call for a nurse to come to the room. At 10:25 AM, a nurse entered Resident #1's room and spoke with the resident. Continued observation, at 11:00 AM, revealed the wheelchair pressure alarm continued to beep. Observation, on 09/09/15 at 10:50 AM, 11:16 AM, 11:45 AM, 12:20 PM, revealed Resident #1's chair alarm was beeping/chirping. Observation of Resident #1, on 09/09/15 at 1:30 PM, revealed the resident was in a wheelchair with the pressure alarm. The alarm continued to emanate an audible beep every seventeen (17) seconds.	F 323		

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F 323	Continued From page 51 Interview, on 09/09/15 at 10:50 AM, with CNA #4 revealed the batteries would beep when they were getting low. Interview, on 09/11/15 at 12:15 PM, with CNA #3 revealed when the alarms beeped or chirped the battery needed to be replaced and if it continually chirped than the battery needed to be changed, and it should be checked that it was on at all times before staff left the room. CNA #3 further stated there was no log to review to know when to change the batteries, but that would be nice. CNA #3 stated alarms should be checked that it is on at all times before staff leaves the room. Interview, on 09/09/15 at 11:40 PM, with LPN #2 revealed the alarms beeped/chirped when the battery was getting low. Interview, on 09/11/15 at 9:55 AM, with the RN Manager revealed if the alarms were chirping/beeping then that meant the battery was low and it needed changing. The facility did not have a log of when the batteries needed to be changed. Interview, on 09/11/15 at 11:45AM, with LPN #1 revealed staff checked the alarms in the morning and evening when they came on shift and go off shift and when the alarms beeep/chirp that meant the battery was getting low and there was no log for the changing of the batteries. Interview, on 09/11/15 at 1:47 PM, with the RN	F 323		

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DIVISION OF HEALTH CARE HOLDING AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 52 Manager revealed the alarms made chirping sounds when batteries needed changing and he was not aware of a log to change the batteries. Staff should verify alarms are working properly and in place and Resident #1's alarm battery had been changed that morning because it was beeping. Interview with Administrator, on 09/11/15 at 2:30 PM, revealed the resident alarms chirp when the batteries needed changeing and the facility did not have a log to know when to change the batteries. The facility did not currently have a schedule for routinely monitoring, checking, or replacing the batteries in the pressure alarms. The wheel chair alarms would beep when the batteries needed to be changed. He stated the facility changed the pressure pads on the alarms monthly. Nursing was to check the functioning of the alarm each time it was turned on to ensure it was working to prevent falls. A low battery beep on the alarm for several hours indicated the resident was at increased risk of falling. 3. Observation of room 227, on 09/08/15 at 6:43 PM and at 7:25 PM, and on 09/08/15 at 6:46 PM and 7:30 PM, in room 228 revealed oxygen canisters in the room not in use and not secured to prevent being tipped over. Interview, on 09/08/15 at 7:50 PM, with CNA #2 revealed an oxygen canister in resident rooms, not in use, should not be there, but should be in storage when not in use, as they could fall over and explode.	F 323		

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTHCARE INSPECTIONS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 53 Interview, on 09/11/15 at 12:15 PM, with CNA #3 revealed oxygen canisters should not be in the resident rooms only when in use with a Bipap, but there are certain kinds of canisters when not in use they go in the supply room, because they can be knocked over and explode and can be a tripping hazard. Interview, on 09/11/15 at 11:45 AM, with LPN #1 revealed the oxygen tanks were only to be in the room of a resident when therapy was working with the resident. Otherwise it should not be in the room because it is a danger of being knocked over and could explode. Interview, on 09/11/15 at 1:47 PM, with the RN Manager revealed there should not be oxygen canisters in resident rooms because there is piped in oxygen available. The canister could fall and the valve come off and it would be a torpedo and it could be a tripping hazard. Interview with the Administrator, on 09/11/15 at 2:30 PM, revealed the facility staff placed Oxygen (O2) tanks in holders in resident rooms. He stated staff should not have placed the O2 tanks in the resident rooms for storage. The residents had activities planned with therapy to walk out of their rooms as part of the therapy care plan. It would have been appropriate to take the O2 tanks to the resident's rooms for the activities and then remove them after. The Administrator stated it was not appropriate for staff to leave the tanks in the resident rooms due to potential for explosion hazard. At 2:32 PM, the Administrator	F 323		

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F 323	Continued From page 54 stated he had only been told about one oxygen canister being in a resident room. Interview, on 09/11/15 at 9:28 AM, with the Medical Director revealed oxygen canisters should not be in the resident rooms, they could explode or become a missle. 4. Observation, on 09/09/15 at 10:10 AM, with Physical Therapy Assistant (PTA) #1 revealed an assisted transfer of Resident #1 from the bed to a rocking chair without the use of the gait belt. Interview, on 09/09/15 at 1:50 PM, with PTA #1 revealed he did not normally work with Resident #1 and he/she had instability with their gait and he did not use the gait belt when he transferred the resident. He stated he had turned the alarm off when transferring Resident #1 that AM. Observation and interview on 09/09/15 at 1:40 PM with RN #3 revealed she transferred Resident #1 from rocking chair to the bed without a gait belt and then left the room. The alarm did not go off when the resident was placed in the bed. Interview with RN #3 revealed she should have checked the alarm before she left the room, she checked the alarm and stated the alarm had been turned off. Observation, on 09/10:15 at 8:55 AM, of RN #4 revealed she transferred Unsampled Resident A from bed to chair without use of gait belt.	F 323		

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F 323	Continued From page 55	F 323		

Interview, on 09/10/15 at 4:00 PM, with RN #4 revealed she should have used the gait belt when transferring Unsampled Resident A from the bed to the chair.

Interview, on 09/11/15 at 11:45 AM, with LPN #1 revealed the gait belts are to be used with the resident because of instability.

Interview, on 09/11/15 at 1:47 PM, with the RN Manager revealed the gait belt should always be utilized when transferring residents.

Interview, on 09/11/15 at 2:32 PM, with the Administrator revealed gait belts should be utilized when transferring the residents.

Interview, on 09/11/15 at 9:28 AM, with Medical Director revealed he expected staff to follow policy and procedure when transferring and ambulating residents.

Interview with the Administrator, on 09/11/15 at 2:30 PM, revealed nursing staff should have used a gait belt when ambulating residents. He stated the use of a gait belt was standard with all residents unless the resident was contraindicated for the use of the gait belt. The facility assessed both Resident #1 and Unsampled Resident A as indicated for the use of a gait belt when ambulating with assistance. The Administrator

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F 323	Continued From page 56 stated staff placed residents at risk of falling and injury to both the resident and the staff person if they do not use the gait belt.	F 323	F497 CNA #3 has received 12 hours of education for the current annual period. 10/20/15 CNA #7 has received 12 hours of education for the current annual period. All Residents have the potential to be affected by this practice. The Administrator has completed education on nurse aid regular in-service education. The facility has added a electronic, web based system to track nurse aid education based on hire date and for any nurse not completing the required education an automatic email will generate to notify the Administrator 30 days before nurse aid education is due based on hire date. Results plan of correction will be reported in a weekly meeting to evaluate compliance of facility plan of correction led by the administrator. Results of weekly meeting and plan of correction will be reported to the Quality Assurance committee.	
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's education records, it was determined the facility failed to provide evidence of the required twelve (12) hours per year of continued education for two (2) of eleven (11) Certified Nursing Assistants (CNA). CNA #3 and #7. The findings include: Review of the facility's policy regarding Nurse Aide Training Criteria and Registry, undated, revealed the facility would provide and document at least twelve (12) hours of ongoing staff development training given annually to each	F 497		

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OFFICE OF INSPECTOR GENERAL
CABINET FOR HEALTH AND FAMILY SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 497	Continued From page 57 nurse aide employed by the facility. Review of the facility's policy regarding Organizational Personnel Education Plan, dated August 2014, revealed the Administrator was responsible for providing educational information to employees. The Administrator was also responsible for maintaining a record of in-service programs. The staff education department would have maintained records of attendance of educational programs. Review of the facility employee records revealed CNA #3 had a hire date of 05/25/12 and had 6:33 hours. CNA #7 had a hire date of 02/06/12 with 3:25 hours. Review of the Schedule of Hours, dated 08/16/15 through 09/26/15, revealed CNA #3 and CNA #7 were on the schedule to work at the facility. Interview with the Director of Staff Development, on 09/10/15 at 10:45 AM, revealed she did not track the number of CNA education hours. Staff Development maintained the computer training database, Life Talent, and tracked attendance to training only. When an employee missed a required training, she would send an e-mail to the Administrator. However, Staff Development did not track the number of CNA hours. The Administrator may have also conducted training on the long-term care unit in other ways, such as in-service training. Staff Development did not track in-services. The Administrator or Director of each unit was responsible for tracking the training hours for each CNA. Interview with the Administrator, on 09/10/15 at 10:00 AM, revealed he was responsible for	F 497		

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F 497	Continued From page 58 tracking the CNA hours. He stated he calculated the continued education hours based on 12 (twelve) months from the date of the last survey, not from hire date to hire date. He indicated he was aware some of the CNAs did not have the required educational hours. He also stated both of the CNAs had worked in the facility without having the required educational hours.	F 497		

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES INVESTIGATIONS

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - CLARK REGIONAL MED CENTER NF** B. WING _____	(X3) DATE SURVEY COMPLETED
	185428		**09/10/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REGIONAL MEDICAL CENTER	**175 HOSPITAL DRIVE** **WINCHESTER, KY 40391**

(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	INITIAL COMMENTS CFR: 42 CFR §483.70 Building: 01 Survey under: NFPA 101 (2000 Edition) New Health Care Plan approval: 01/17/2011 Facility type: Hospital Smoke Compartments: Eight (8) Type of structure: One (1) story Type II (222) Fire Alarm: Complete Fire Alarm installed new. Sprinkler System: Complete sprinkler system (wet) installed new. Generator: Two (Type 1) Diesel A Life Safety Code Survey using a 2786S (Short Form) was conducted on 09/10/15. The facility was found to meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70. The census the day of the survey was twenty-five (25). The facility is licensed for twenty-five (25) beds.	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.