

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

PRINTED: 03/29/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		DATE SURVEY COMPLETED 03/15/2012
NAME OF PROVIDER OR SUPPLIER  LAKE CUMBERLAND REGIONAL HOSPITAL-SCU			STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET, P O BOX 620 SOMERSET, KY 42502		
(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)	COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 241 SS=C	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's policy, it was determined the facility failed to provide care that promoted the resident's dignity and respect for five of five sampled residents (Residents #1, #2, #3, #4, and #5). Observation of the lunch and supper meals on 03/13/12 revealed all residents were delivered meal trays that had plastic disposable silverware and disposable food containers.</p> <p>The findings include: A review of the policy titled, "Resident Rights," (no date) revealed residents have the right to be treated with dignity and respect as an individual who has personal needs, feelings, preferences, and requirements. The policy also stated the residents have the right to a dignified existence.</p> <p>Observation of the lunch meal service on 03/13/12, at 12:00 PM, revealed ten meal trays</p>	F 241	<p>I. Residents #1, #2, #3, #4, and #5 have been discharged.</p> <p>II. All residents residing on the Special Care Unit are currently receiving meals with regular silverware and dishes to facilitate a homelike environment to ensure that residents are treated with dignity and respect ensuring the right to a dignified existence. The implementation of regular silverware and dishes was completed 3/14/12 and was reported to the survey Team Leader who completed follow up with residents at that time.</p> <p>III. Dietary Team Members, Registered Dieticians, Licensed Nurses, and SRNA's working with the Special Care Unit are being educated regarding the requirements for facilitating a homelike environment for residents through a dignified dining experience. This education will be completed by April 11, 2012.</p>		

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03/15/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cheryl Nelson* TITLE: RN NHA (X8) DATE: 4/6/12

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 patient. (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 241	<p>Continued From page 1 (including the trays for the five sampled residents) were on the tray cart and all ten trays had plastic disposable eating utensils on the trays. The trays were also observed to have dessert in plastic disposable containers.</p> <p>Observation of the supper meal service on 03/13/12, at 5:20 PM, revealed ten meal trays (including the trays for the five sampled residents) were observed on the meal cart and all ten meal trays were observed to have plastic disposable eating utensils on the trays. The trays were also observed to have dessert in disposable plastic containers.</p> <p>An interview conducted on 03/13/12, at 3:20 PM, with the Hospital Assistant Administrator (HAA) revealed the HAA was responsible for overseeing the Dietary Department. The HAA stated he was unsure why the facility was using disposable eating utensils. The HAA stated it may have been a timesaving issue because the staff could grab a packet of silverware and place it on the tray.</p> <p>An interview conducted on 03/13/12, at 3:45 PM, with the Dietary Manager (DM) revealed the facility had silverware and regular dishes that could be sent up on the food trays.</p> <p>A group interview conducted on 03/14/12, at 10:00 AM, with four residents (Resident #1, Resident #3, and unsampled Residents #6 and #7) who had been assessed by the facility to be interviewable revealed the residents had received plastic silverware and disposable plastic food containers on every meal tray. The residents stated it was not homelike and that they would like to have regular silverware and dishes,</p>	F 241	<p>IV. The Food Services Supervisor, or Charge Nurse, will audit 100% of meal trays for one month to ensure that all meals are prepared with regular silverware and dishes according to facility policy. An additional review of 25% of trays will be completed monthly for an additional two months. This review will include three months of audits and will be reported to the Quality Assurance Committee for additional review and follow up as indicated.</p>	04/13/12
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F 241	Continued From page 2 however, the residents stated they had not reported their concern to the facility.  An interview conducted with the Administrator on 03/14/12, at 2:45 PM, revealed the Administrator had been aware regular silverware and dishes should have been used instead of plastic silverware and disposable plastic containers; however, the Administrator revealed she had not attempted to correct the problem. The Administrator stated she was unsure how long the facility had been using plastic silverware and disposable containers but that it had been for a while.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to follow physician's orders for one of five sampled residents (Resident #3). A physician's order dated 03/07/12 revealed Resident #3 was not to drink liquids with a straw, however, on 03/13/12, a bottle of Ensure (dietary supplement) was observed on the resident's bedside table, within the resident's reach, and a straw was observed in the bottle of Ensure.  The findings include:  A review of the policy titled, "Care Planning/ Interdisciplinary," (with a revision date of	F 281	I. Resident #3 has been discharged.  II. No other residents were affected by the alleged deficient practice. All residents currently residing on the Special Care Unit have been reviewed to ensure that the facility is following physician's orders for all residents. This review was completed April 5, 2012.  III. Licensed nurses, SRNA's and Registered Dieticians working on the Special Care Unit are being educated regarding the requirements for following physician's orders for all residents. This education includes the process for reviewing physician's orders, transcribing the information to the interdisciplinary care plan and	

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F 281	<p>Continued From page 3</p> <p>November 2004) revealed an initial plan of care was generated from the admission history and assessment for each resident. The policy also revealed the plan of care would be individualized, addressing identified resident needs, and would also contain any problems that had been identified by any discipline as a result of an initial assessment or from subsequent reassessments.</p> <p>A review of the medical record for Resident #3 revealed the facility had admitted the resident on 03/07/12 with diagnoses that included Advanced Chronic Obstructive Pulmonary Disease, Atrial Fibrillation, Seizure Disorder, and Anxiety.</p> <p>A review of the admission orders for Resident #3 dated 03/07/12 revealed the resident had a physician's order for the resident to have a mechanical soft diet with pureed meats, no straws, and small spoon sips of liquids. The physician's order also revealed the head of the resident's bed should be elevated 90 degrees during meals and for 30 minutes after eating.</p> <p>A review of a report of a Modified Barium Swallow completed on 02/22/12, revealed a recommendation for the resident to receive chopped mechanical soft foods with ground meats and gravy, small sips of thin liquids, and straws were not recommended due to an increase in the resident's pharyngeal residue (food and liquids left in the pharynx after swallowing). The report also revealed the resident was required to sit upright at 90 degrees during meals and for 30 minutes after having any oral intake.</p> <p>A review of the Comprehensive Care Plan for</p>	F 281	<p>nursing kardex to facilitate following physician's orders. This education will be completed by April 11, 2012.</p> <p>The policy titled "Nutritional Assessment" has been revised to include the following information: The Dietitian will verify the current diet order for accuracy. If a discrepancy is found, the resident's nurse and/or SCU Manager will be notified so that the diet order can be corrected. This policy revision was completed 3/26/2012. Licensed nurses, SRNA's and Registered Dietitians working on the Special Care Unit will receive education regarding the "Nutritional Assessment" policy. This education will be completed by April 11, 2012.</p> <p>IV. The Nursing Director, or MDS Coordinator, will monitor the implementation and following of physician's orders by auditing 100% of admissions for three months to ensure that all residents admitted to the Special Care Unit have physician's orders implemented. An additional audit of 50% of current residents will be completed weekly to ensure that physician's orders are being followed. This review will continue for</p>	

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F 281	<p>Continued From page 4</p> <p>Resident #3 dated 03/07/12 revealed the resident required a Mechanical Soft diet. However, there was no documentation on the care plan that indicated Resident #3 was restricted from the use of straws with liquid drinks.</p> <p>A review of a nutritional assessment completed on 03/08/12 by the Registered Dietitian (RD) revealed the resident had been assessed to have difficulty swallowing and chewing. The RD recommended to continue the resident on the same diet and to maintain the current therapy.</p> <p>Observation of Resident #3 during the initial tour on 03/13/12, at 10:20 AM, revealed the resident had a sign posted above the head of the resident's bed which stated to keep the head of the bed elevated at 90 degrees during oral intake and for 30 minutes after eating. The sign also indicated Resident #3 was to have small bites of food when eating and was not to use straws for drinking. However, observation revealed a bottle of Ensure was on the resident's bedside table, within the resident's reach, and a straw was observed in the bottle of Ensure.</p> <p>An interview conducted with Certified Nursing Assistant (CNA) #2 on 03/13/12, at 11:35 AM, revealed the CNA provided care for Resident #3 and acknowledged the resident should not have straws provided with liquid drinks. The CNA stated she was unaware of how the resident acquired the straw.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 03/13/12, at 2:35 PM, revealed the LPN provided care to Resident #3 on 03/13/12 and stated the resident drank Ensure</p>	F 281	<p>three months. The outcome of these audits will be reported to the Quality Assurance Committee for additional review and follow up as indicated.</p>	4/13/12	

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F 281	Continued From page 5 with a straw on that date. The LPN stated she obtained information related to resident care from the care plan and also from the Kardex which was used to relay information to the next shift. The LPN also stated it was the responsibility of the nurse to update the care plan and stated she was unaware of the physician's order for Resident #3 to not have straws.  An interview conducted on 03/15/12, at 5:50 PM, with the facility's Registered Dietitian (RD) revealed she developed the nutritional portion of the care plan. The RD stated she had failed to review the physician's orders and, as a result, failed to develop an intervention on the care plan related to the physician's request to restrict the use of straws for the resident when the resident received liquids.  An interview conducted with the Director of Nursing (DON) on 03/15/12, at 5:55 PM, revealed the care plan should state exactly what was going on with the resident. The DON stated Resident #3's care plan should have reflected the resident was not to drink fluids with a straw. The DON further stated she reviewed all medical records, including the care plans, three times every week for accuracy but had failed to identify that Resident #3's care plan was not accurate.	F 281			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	I. Resident #1 has been discharged.  II. No other residents were affected by the alleged deficient practice. All residents currently residing on the Special Care Unit, who are receiving wound care services,		

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F 441	<p>Continued From page 6</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to establish and maintain an effective infection control program to prevent the</p>	F 441	<p>have been reviewed to ensure that wound care is being performed by the licensed nursing staff in a manner to establish and maintain effective infection control; preventing the development and transmission of disease and infection. This review will be completed by April 11, 2012.</p> <p>III. Licensed nurses working on the Special Care Unit are being educated regarding the procedures for hand hygiene during wound care. The education includes the procedure for completing dressing changes along with a review of the facility policy titled, "Hand Hygiene" which includes the process for decontamination of hands during patient care. This education will be completed by April 11, 2012.</p> <p>IV. The Nursing Director, Administrator, and Wound Care Nurse will complete observations of hand hygiene during wound care weekly. This review will include a review of 50% of residents receiving dressing changes for one month and then decrease to 25% of dressing</p>	

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F 441	<p>Continued From page 7</p> <p>development and transmission of disease and infection for one of five sampled residents (Resident #1). Observation of wound care on 03/14/12 revealed the nurse failed to wash/sanitize her hands between glove changes.</p> <p>The findings include:</p> <p>A review of the facility policy titled, "Hand Hygiene," (with a revision date of 11/20/08) revealed staff was required to decontaminate hands after removing gloves, with either plain or antiseptic-containing soap and water, or the use of alcohol based products that do not require the use of water.</p> <p>A review of the medical record for Resident #1 revealed the facility had admitted the resident on 01/07/12, with diagnoses that included Bilateral Ischial Tuberosity Ulcers which had undergone an incision and drainage, Diabetes Mellitus, and Spina Bifida.</p> <p>Observation of wound care for Resident #1 on 03/14/12, at 1:25 PM, revealed Registered Nurse (RN) #1 washed/sanitized her hands and applied gloves prior to wound care. RN #1 was then observed to remove a soiled dressing from the wounds to the upper buttocks of Resident #1, discard the dressings in the trash, remove her soiled gloves, and apply clean gloves. RN #1 failed to wash/sanitize her hands after removing soiled gloves and prior to applying clean gloves. Continued observation revealed RN #1 cleansed the wound to the resident's left upper buttock with a cleansing solution and a 4x4 gauze sponge. The RN disposed of the soiled gauze sponge in the trash, removed her gloves, and applied clean gloves but failed to wash/sanitize her hands</p>	F 441	<p>changes for two additional months. This review will include three months of observations and will be reported to the Quality Assurance Committee for additional review and follow up as indicated.</p>	4/13/12	

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F 441	Continued From page 8 between glove changes. The RN was then observed to cleanse the wound to the resident's right upper buttock with a cleansing solution and a 4x4 gauze sponge, placed the soiled gauze sponge in the trash, removed her soiled gloves, and placed them in the trash. The nurse was observed to apply clean gloves without washing/sanitizing her hands. At that time, the RN was observed to apply a skin protectant paste to the area of skin surrounding the wound of the left upper buttocks using a cotton swab. The RN disposed of the cotton swab in the trash, removed her gloves, and placed them in the trash, applied clean gloves, and failed to wash/sanitize her hands. The RN then applied a skin protectant paste to the right upper buttock wound with a cotton swab, disposed of the cotton swab in the trash, applied clean gloves, and failed to wash/sanitize her hands. Continued observation of the wound care revealed the RN applied a normal saline soaked dressing to the wound of the left upper buttock, disposed of gloves in the trash, applied clean gloves, and failed to wash/sanitize her hands. The RN was then observed to apply a normal saline soaked dressing to the wound of the right upper buttock, dispose of the gloves in the trash, apply clean gloves, and failed to wash/sanitize her hands. The RN was then observed to cover the wound to the left upper buttock with a dressing, dispose of the soiled gloves in the trash, apply clean gloves, and failed to wash/sanitize her hands. The RN then applied a dressing to the wound to the right upper buttock, disposed of her gloves in the trash, and washed/sanitized her hands.  An interview conducted with RN #1 on 03/15/12, at 11:45 AM, revealed the RN was not aware she	F 441			

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F 441	<p>Continued From page 9</p> <p>was required to wash/sanitize her hands after removing gloves. The RN stated she thought changing her gloves had been sufficient and to wash/sanitize her hands when the wound care had been completed. The RN stated she had completed in-services provided by the facility on hand washing and wound care, however, she did not remember what the in-service had covered.</p> <p>An interview with the Infection Control Nurse (ICN) on 03/15/12, at 1:40 PM, revealed hand hygiene should be done any time an employee changes his/her gloves. The ICN also stated she had not previously identified this as a problem. The ICN revealed hand hygiene was a part of all employees' initial orientation and was also completed on an annual basis.</p> <p>An interview conducted with the Director of Nursing (DON) on 03/15/12, at 3:40 PM, revealed employees were expected to wash/sanitize their hands after changing gloves. The DON revealed she conducted "spot checks" to monitor staff for proper hand washing and had not observed concerns related to staff failing to wash hands between glove changes. The DON confirmed staff was to wash/sanitize their hands after every glove change.</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185407</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE CUMBERLAND REGIONAL HOSPITAL-SCU</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>305 LANGDON STREET, P O BOX 620 SOMERSET, KY 42502</b>		
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: 4-story, Type 11 (222)</p> <p>SMOKE COMPARTMENTS: 2</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system</p> <p>GENERATOR: Type I diesel generator</p> <p>A life safety code survey was initiated and concluded on 03/15/12, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	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.