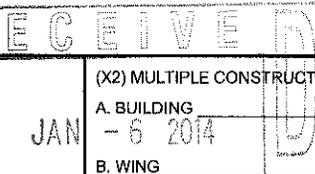


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2013
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 _____ - 6 2014 B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU	STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET 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)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>A standard health survey was conducted on 12/10-11/13. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to develop a comprehensive care plan for one of eight sampled residents. The facility failed to develop a care plan related to Resident #5's swallowing difficulties and need for an assistive device when drinking liquids.</p>	F 279	<p>The care plan of patient #5 was revised to include potential swallowing problem and use of Provale cup and no straws.</p> <p>All patients' care plans were reviewed by the interdisciplinary team (IDT) and care plans updated, if needed.</p> <p>An inservice was provided to the IDT and all SCU staff regarding development of the care plan to include issues identified within the Care Area Assessment (CAA). During weekly care plan meetings, each patient's care plan will be compared to his or her CAA to ensure that all problems have been addressed. Furthermore, care plans will be reviewed directly with the patient at the bedside whenever the patient is interviewable per the MDS to ensure that the patient has nothing to add to his or her care plan.</p>	

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

[Signature]

TITLE

Adm

(X6) DATE

1-3-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 12/27/2013
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 _____	(X3) DATE SURVEY COMPLETED 12/11/2013
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU		STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET 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)
F 279	<p>Continued From page 1</p> <p>The findings include:</p> <p>A review of the facility's policy entitled Standards of Care, revised September 2009, revealed each resident's care was based on identified needs/problems and standards of care.</p> <p>Review of Resident #5's medical record revealed the facility admitted the resident on 11/26/13, with diagnoses that included Generalized Weakness and Malnutrition.</p> <p>A review of a Nutritional Care Area Assessment (CAA) dated 12/08/13 revealed that based on a Modified Barium Swallow (MBS) test (assesses a person's ability to swallow) completed in August 2013, Resident #5 had "dysphagia" (difficulty swallowing). The CAA revealed Speech Therapy recommended staff to only provide Resident #5 thin liquids with a spoon, sips, or per Provale cup. Documentation on the CAA also revealed Resident #5 had a Provale cup at his/her bedside.</p> <p>A review of Resident #5's care plan revealed the facility failed to develop a care plan related to the resident's swallowing difficulties and need for an assistive device when drinking liquids.</p> <p>Observation of Resident #5 on 12/11/13 at 8:25 AM, during medication administration, revealed the nurse attempted to hand the resident a Styrofoam cup of liquid with a straw to drink while taking the medications. Resident #5 refused to take the cup with the straw stating, "I can't use straws, they told me not to." The nurse then removed the straw from the cup and the resident drank from the Styrofoam cup. The nurse</p>	F 279	<p>The care plan of patients who are not interviewable, per the MDS, will still be reviewed at the bedside with the IDT and, if available, a family member, unless contraindicated due to medical condition.</p> <p>The MDS Coordinator will complete an audit that compares the CAA and the care plan to ensure all items addressed in the CAA were identified on the care plan. This audit will be completed at least monthly and presented to the Performance Improvement Committee for the next six months.</p>

1-10-14

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

PRINTED: 12/27/2013
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 _____		(X3) DATE SURVEY COMPLETED 12/11/2013
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU			STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET 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)	(X5) COMPLETION DATE	
F 279	Continued From page 2 questioned Resident #5 about not utilizing straws, and again the resident stated, "They told me not to." The nurse stated to Resident #5 that a "sign should be up in your room" to alert staff that the resident could not have straws. Further interview with Resident #5 on 12/11/13 at 3:15 PM, revealed the resident had an "x-ray of my throat" and was told he/she could not utilize straws. While pointing to a Provale cup, Resident #5 stated he/she was supposed to utilize the special cup when drinking liquids. An interview with the Registered Dietitian (RD) on 12/11/13 at 3:20 PM, revealed she was responsible for completing the Nutritional CAA and the Nutritional Care Plan. The RD stated she asked Resident #5 about swallowing problems during the assessment and notified the resident's physician that a speech therapy consultation was needed. The RD stated the resident said he/she was not having difficulties with swallowing while utilizing the Provale cup. The RD explained that a Provale cup was a "Sippy cup" type cup that kept liquids from flowing out too quickly. The RD stated she was not sure who was responsible for ensuring swallowing problems and interventions were on the resident's care plan, and assumed nursing staff was aware the resident required a Provale cup because Resident #5 had a cup at the bedside.	F 279			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	The crash cart that contained expired medications was replaced.		

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

PRINTED: 12/27/2013
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 _____	(X3) DATE SURVEY COMPLETED 12/11/2013	
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU		STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET 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)	(X5) COMPLETION DATE
F 431	<p>Continued From page 3</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to ensure expired drugs were not available for resident use. Observation of medications in the facility's crash cart (contained drugs and supplies for emergencies) on 12/11/13 revealed two vials of Norepinephrine (used in life-threatening conditions to constrict blood vessels and to increase blood pressure and blood</p>	F 431	<p>The stock of medications on the unit was checked and no other expired medications were discovered.</p> <p>The crash cart will be audited by the Pharmacy Director or designee one time per month to ensure there are no expired medications contained in it. A verification of this audit has been developed by the Pharmacy Director that states there are no expired medications contained in the crash cart. This verification will be completed by the member of the Pharmacy Department who audits the crash cart for expired medications. All members of the Pharmacy have been inserviced regarding the removal of expired medications and regarding the verification of audits of the crash cart on the Special Care Unit.</p>	

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

PRINTED: 12/27/2013
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 _____		(X3) DATE SURVEY COMPLETED 12/11/2013
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU		STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET 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)	(X5) COMPLETION DATE
F 431	<p>Continued From page 4</p> <p>glucose levels) that expired on 12/01/13, ten days prior to the observation.</p> <p>The findings include:</p> <p>On 12/11/13 at 4:10 PM, observations of the locked crash cart located at the nurses' station revealed a list of medications in the cart had been taped to the side of the cart along with the expiration date of each medication. Further observation revealed documentation that the Norepinephrine identified on the list had an expiration date of 12/01/13.</p> <p>During the course of the observation, facility staff unlocked the crash cart in order for a review of the contents to be conducted. Observation of the medications in the crash cart revealed two vials of Norepinephrine 4 milliliters (1mg/4ml) that expired on 12/01/13, ten days prior to observation, and available for use.</p> <p>Interview with the Director of Pharmacy on 12/01/13 at 4:30 PM, revealed staff should review the list taped to the side of the locked crash cart on a monthly basis and should remove any medications prior to the expiration date. The Pharmacy Director stated the facility had not developed written procedures or policies to ensure expired medications were removed from the cart and not available for use and had not assigned any particular person to remove drugs before they expired. However, according to the Director of Pharmacy, it was the responsibility of everyone in the Pharmacy Department to ensure drugs were removed from the crash cart before the drugs expired.</p>	F 431	<p>A member of the Pharmacy Department will present the audit findings of the crash cart to the Performance Improvement Committee monthly for six months. At that time, if there have been no further problems identified, the audits will be done quarterly and presented to the Performance Improvement Committee.</p>	1-10-14

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

PRINTED: 03/13/2014
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 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2013
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL SCU			STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET 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)	(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</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 12/11/13, 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.