

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

2nd SOD

PRINTED: 01/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/11/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 293 BRUCE COURT DANVILLE, KY 40423 Division of Health Care Southern Enforcement Branch		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An abbreviated standard survey (KY19406, KY19409, KY19441, KY19467) was initiated on 12/10/12 and concluded on 12/11/12. KY19406 and KY19441 were substantiated with no deficiencies. KY19409 was substantiated with deficient practice identified at "D" level. KY19467 was unsubstantiated with no deficiencies.	F 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
F 280 SS=D	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 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 observation, interview, and record	F 280	<b>F280</b>  On December 20, 2012 the violation was corrected.  Corrective action was accomplished for Resident #1 on 12-12-12 by updating the plan of care and resident information sheet to reflect LPN #1's experience with a change in physical condition relating to Resident #1. The new plan required additional assistance of two staff persons to transfer and ambulate Resident #1. This information was captured and communicated on the Care Plan and Resident Information Sheet for Resident #1 by Miranda Ruggles RN, DON. In addition the updated information pertaining to Resident #1 was relayed and discussed in detail with MDS Coordinator by Jill Brown Executive Director.  The facility did an audit of MDS assessments, Care Plans, and Resident Information Sheets to identify any other residents having the potential to be affected by the same deficient practice. The audit was ordered by Owner/Administrator Marlin K. Sparks and carried out under the direction of Joyce Andros R.N. Additional education to key employees LPN #1 and MDS	1/18/13

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

*Marlin K. Sparks*

TITLE

*Pres. / Adm.*

(X6) DATE

*1-19-13*

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

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

PRINTED: 01/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/11/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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	<p>Continued From page 1</p> <p>review, the facility failed to ensure the comprehensive plan of care for one of six sampled residents (Resident #1) was reviewed and revised when the resident experienced a change in physical condition. Resident #1 experienced a decline in physical condition in September 2012 and required the additional assistance of two staff persons to transfer and ambulate. However, the facility failed to revise the resident's comprehensive plan of care to include that the resident required the assistance of two staff persons, and the resident experienced a fall on 11/17/12, while being assisted to transfer/ambulate by only one staff person.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Care Plans-Comprehensive, dated December 2010, revealed the facility would develop and maintain a comprehensive care plan for each resident that identified the highest level of functioning each resident was expected to attain. The policy also stated the resident's care plan would be based on a thorough assessment of the resident which included but was not limited to the Minimum Data Set assessment (MDS).</p> <p>A review on 12/11/12, of the medical record for Resident #1 revealed the facility admitted the resident on 03/07/08, with diagnoses including Hypertension, Alzheimer's, and Arthritis.</p> <p>Observations conducted on 12/11/12, at 9:45 AM, revealed two Certified Nurse Aides (CNAs) (CNAs #11 and #12) were required to safely assist Resident #1 with ambulation and when</p>	F 280	<p>Coordinator was conducted by Marlin Sparks to ensure the deficient practice would not recur. LPN #1 was educated on passing on information. When he notices a change in condition the pertinence of passing on the information and to whom and why. MDS Coordinator was educated on the importance on of her professional skills. How the dynamics worked all information flowed through the facility and the importance of accuracy.</p> <p>Systemic changes have been implemented to ensure compliance and proficient care. During weekly Safety Committee Review all skin damage, and falls are currently discussed. During this meeting an additional audit will be utilized to ensure the care plan and resident information sheet has been updated. The QA nurse and or designee will be responsible for this weekly audit. All information will be reported back to the Quality Assurance Committee Weekly. In addition at the time of each MDS assessment DON and or designee will audit each assessment, change in condition, or significant change, or change in resident condition and compare information to the Resident's Care Plan making any changes necessary. Immediately updating information on the Resident Information Sheets to reflect said changes. Please see attached sheets for example of audit process.</p> <p>Facility will be monitoring performance weekly through Safety</p>	

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

PRINTED: 01/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/11/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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	<p>Continued From page 2 being transferred to the shower.</p> <p>Interview with LPN #1 on 12/11/12, at 10:50 AM, revealed "approximately two months ago" (unsure of exact date) Resident #1 was assessed to have experienced a decline in condition, and required two staff members to assist when being transferred or ambulated in the facility. The LPN stated he had informed the staff working on that shift that Resident #1 had experienced a change in condition and two staff members were required to safely transfer the resident. LPN #1 stated he had not informed any other staff members of the change in condition that occurred approximately two months ago for Resident #1. The LPN also stated he was not responsible to review or revise the resident's care plan to reflect a change in condition.</p> <p>A review on 12/11/12, of an incident report for Resident #1, revealed on 11/17/12, the resident experienced a fall while being transferred with the assistance of one CNA (CNA #10).</p> <p>An interview on 12/10/12, at 4:15 PM, with CNA #10, who assisted Resident #1 when the resident experienced a fall on 11/17/12, confirmed she had been the only staff member present when the fall occurred on 11/17/12. The CNA stated on 11/17/12, that the information sheet referred to daily for the resident's care needs informed staff to provide one-person assistance when transferring or ambulating the resident.</p> <p>Interviews with CNAs #11 and #12 on 12/11/12, at 9:55 AM, revealed both CNAs were required to physically assist Resident #1 related to an unsteady gait and weakness. The CNAs stated</p>	F 280	<p>Committee Meetings and Weekly through Quality Assurance Meetings. Safety Committee members are QA nurse, MDS coordinator, DON, Executive Director, RN, member of rehab. Facility will also be monitoring during each resident's assessment period or window, sooner or periodically revised is there is a change in condition that warrants a change to any clinical documentation.</p> <p>The two employees LPN #1 and MDS Coordinator were both in serviced on 12/12/12. The facility ensured all staff on the Safety Committee was aware of the systematic changes related to resident incidents/changes in condition by having a training/meeting on 12-20-12.</p> <p>Additionally, the facility ensured all staff was communicating resident accidents/and changes in condition by having an in-service with all nursing department staff including KMA's LPN's and RN's on 1/18/13.</p> <p>All training 12/12/12, 12/20/12 &amp; 1/18/13 reviewed communication when there is a change in condition how and what to do and listed examples. (Please see attachment for more information.)</p> <p>Nursing staff is to report any change in condition verbally during normal business hours directly to the DON and or designee. After hours it is to be documented on the 24 hour shift report form. The DON and or designee</p>	

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

PRINTED: 01/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/11/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 3 Licensed Practical Nurse (LPN) #1 had instructed them in September 2012 (unsure of exact date) that Resident #1 had experienced a decline in condition and two staff members were required to safely transfer and or ambulate the resident.  A review on 12/11/12, of the Nurse Aide's Information Sheet, utilized by CNAs to provide daily care to the residents , revealed when the fall occurred for Resident #1 on 11/17/12, facility staff had been instructed to provide one staff member when the resident required assistance with transfers or ambulation.  A review on 12/11/12, of the comprehensive care plan for Resident #1 revealed staff had assessed the resident to be at high risk for falls. The resident's care plan had been updated on 11/15/12, related to falls. Staff identified that Resident #1 utilized a walker and the assistance of staff for ambulation; however, the care plan failed to identify the number of staff required to safely provide assistance to the resident.  An interview with the Director of Nursing (DON) on 12/11/12, at 2:30 PM, revealed LPN #1 had failed to notify her of the decline in Resident #1, related to the change in the number of staff required to safely transfer the resident. The DON stated she was responsible to update the care plans and staff should have notified her when Resident #1 experienced a change in condition which required an update to the plan of care.	F 280	currently reviews the 24 hours shift report.  Each day (Monday thru Friday) 24 hour shift reports will be reviewed by DON and or designee to identify any change in condition to residents that would warrant a revision to the resident's care plan or MDS. Additionally, QA nurse and or designee checks daily (Monday thru Friday) for any resident whom has had a change in skin condition, or fall. She reviews and updates care plans related to skin condition and falls if necessary daily (Monday thru Friday). QA nurse and or designee is also responsible to check Resident information Sheet's with each change in skin condition and fall to update any changes needed. DON and or designee checks MDS with care plans to audit for compliance. MDS are checked as they become available for review.  Safety Committee team meets weekly. During safety committee the team will check using an audit process to identify if care plans have been updated for each resident identified having a change during that week. The safety committee reports all information to the quality assurance committee weekly.  By having DON, QA Nurse daily, Safety Committee and QA Committee reviewing clinical information and comparing to care plan weekly. The facility is pleased to announce desired compliance has been reached since 12/20/12.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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

PRINTED: 01/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 12/11/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
(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 4 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, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of six sampled residents (Resident #1). Observations conducted on 12/11/12, revealed two staff members were required to safely transfer Resident #1. Resident #1 experienced a decline in physical condition in September 2012 and required the additional assistance of two staff members for transfers and ambulation. The facility failed to ensure Resident #1's plan of care was revised to include the required assistance of two staff persons. Resident #1 experienced a fall on 11/17/12, when being assisted to transfer/ambulate by only one staff person.  The findings include:  A review of the facility's policy titled Fall Procedure, no date noted, revealed staff was instructed on how to provide emergency care to residents when a fall occurred. However, the policy provided no direction to facility staff related to identifying causative factors to prevent further falls from occurring.  A review of the medical record on 12/11/12, for	F 323	<b>F323</b>  On December 20, 2012 the violation was corrected.  Corrective action was accomplished for Resident #1 on 12-12-12 by updating the plan of care and resident information sheet to reflect LPN #1's experience with a change in physical condition relating to Resident #1. The new plan required additional assistance of two staff persons to transfer and ambulate Resident #1. This information was captured and communicated on the Care Plan and Resident Information Sheet for Resident #1 by Miranda Ruggles RN, DON. In addition the updated information pertaining to Resident #1 was relayed and discussed in detail with MDS Coordinator by Jill Brown Executive Director.  The facility did an audit of MDS assessments, Care Plans, and Resident Information Sheets to identify any other residents having the potential to be affected by the same deficient practice. The audit was ordered by Owner/Administrator Marlin K. Sparks and carried out under the direction of Joyce Andros R.N. Additional education to key employees LPN #1 and MDS Coordinator was conducted by Marlin Sparks to ensure the deficient practice	1/18/13	

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

PRINTED: 01/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/11/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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	<p>Continued From page 5</p> <p>Resident #1 revealed the facility admitted the resident on 03/07/08, with diagnoses including Alzheimer's, Arthritis, and Hypertension.</p> <p>A review of an incident report on 12/11/12, for Resident #1 revealed the resident experienced a fall on 11/17/12, while being transferred with one Certified Nurse Aide (CNA), CNA #10.</p> <p>An interview on 12/10/12, at 4:15 PM, with CNA #10, who assisted Resident #1 on 11/17/12, when the resident experienced a fall, confirmed she had been the only staff member present when the fall occurred on 11/17/12. CNA #10 stated she had not routinely been assigned to provide care to Resident #1; however, on 11/17/12, the information sheet referred to daily for the resident's care needs, informed staff to provide one-person assistance when transferring or ambulating the resident.</p> <p>Interview with LPN #1 on 12/11/12, at 10:50 AM, revealed he had assessed Resident #1 "approximately two months ago" (unsure of exact date) to have experienced a decline in condition. The LPN stated he had informed the staff working on that shift that Resident #1 had experienced a change in condition and that two staff members were required to safely transfer the resident. The LPN stated he had not informed any other facility staff members of the change in condition that occurred approximately two months ago for Resident #1. Further interview with LPN #1 revealed he was Resident #1's nurse when the fall occurred on 11/17/12. The LPN stated Resident #1 should have had two staff members present when the fall occurred on 11/17/12.</p>	F 323	<p>would not recur. LPN #1 was educated on passing on information. When he notices a change in condition the pertinence of passing on the information and to whom and why. MDS Coordinator was educated on the importance on of her professional skills. How the dynamics worked all information flowed through the facility and the importance of accuracy.</p> <p>Systemic changes have been implemented to ensure compliance and proficient care. During weekly Safety Committee Review all skin damage, and falls are currently discussed. During this meeting an additional audit will be utilized to ensure the care plan and resident information sheet has been updated. The QA nurse and or designee will be responsible for this weekly audit. All information will be reported back to the Quality Assurance Committee Weekly. In addition at the time of each MDS assessment DON and or designee will audit each assessment, change in condition, or significant change, or change in resident condition and compare information to the Resident's Care Plan making any changes necessary. Immediately updating information on the Resident Information Sheets to reflect said changes. Please see attached sheets for example of audit process.</p> <p>Facility will be monitoring performance weekly through Safety Committee Meetings and Weekly through Quality Assurance Meetings.</p>	

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

PRINTED: 01/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/11/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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	<p>Continued From page 6</p> <p>Interviews with CNAs #11 and #12 on 12/11/12, at 9:55 AM, revealed Licensed Practical Nurse (LPN) #1 had instructed them in September of 2012, unsure of exact date, that Resident #1 had experienced a decline in condition; therefore two staff members were required to safely transfer and/or ambulate the resident.</p> <p>A review on 12/11/12, of the comprehensive care plan for Resident #1 revealed staff had identified the resident to be at high risk for falls. Further review revealed the care plan had been updated on 11/15/12, related to falls. Staff identified that Resident #1 utilized a walker and the assistance of staff for ambulation; however on 11/15/12, the care plan failed to identify the number of staff required to safely assist the resident.</p> <p>A review on 12/11/12, of the Nurse Aide's Information Sheet, utilized by CNAs to provide daily care to the residents, revealed when the fall occurred for Resident #1 on 11/17/12, staff had been instructed to provide one staff member when the resident was assisted with transfers or ambulation.</p> <p>Observations conducted on 12/11/12, at 9:45 AM, revealed two CNAs (CNAs #11 and #12) were required to safely assist Resident #1 with ambulation and when transferred to the shower.</p> <p>An interview with the Director of Nursing (DON) on 12/11/12, at 2:30 PM, revealed LPN #1 had failed to notify her of the decline in Resident #1, related to the change in the number of staff required to safely transfer the resident. The DON stated she was responsible to update the care plans and staff should have notified her when</p>	F 323	<p>Safety Committee members are GA nurse, MDS coordinator, DON, Executive Director, RN, member of rehab. Facility will also be monitoring during each resident's assessment period or window, sooner or periodically revised is there is a change in condition that warrants a change to any clinical documentation.</p> <p>The two employees LPN #1 and MDS Coordinator were both in serviced on 12/12/12. The facility ensured all staff on the Safety Committee was aware of the systematic changes related to resident incidents/changes in condition by having a training/meeting on 12-20-12.</p> <p>Additionally, the facility ensured all staff was communicating resident accidents/and changes in condition by having an in-service with all nursing department staff including KMA's LPN's and RN's on 1/18/13.</p> <p>All training 12/12/12, 12/20/12 &amp; 1/18/13 reviewed communication when there is a change in condition how and what to do and listed examples. (Please see attachment for more information.)</p> <p>Nursing staff is to report any change in condition verbally during normal business hours directly to the DON and or designee. After hours it is to be documented on the 24 hour shift report form. The DON and or designee currently reviews the 24 hours shift report.</p>	

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

PRINTED: 01/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/11/2012
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423	
(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 7 Resident #1 experienced a change in condition which required an update to the plan of care.	F 323	<p>Each day (Monday thru Friday) 24 hour shift reports will be reviewed by DON and or designee to identify any change in condition to residents that would warrant a revision to the resident's care plan or MDS. Additionally, QA nurse and or designee checks daily (Monday thru Friday) for any resident whom has had a change in skin condition, or fall. She reviews and updates care plans related to skin condition and falls if necessary daily (Monday thru Friday). QA nurse and or designee is also responsible to check Resident information Sheet's with each change in skin condition and fall to update any changes needed. DON and or designee checks MDS with care plans to audit for compliance. MDS are checked as they become available for review.</p> <p>Safety Committee team meets weekly. During safety committee the team will check using an audit process to identify if care plans have been updated for each resident identified having a change during that week. The safety committee reports all information to the quality assurance committee weekly.</p> <p>By having DON, QA Nurse daily, Safety Committee and QA Committee reviewing clinical information and comparing to care plan weekly. The facility is pleased to announce desired compliance has been reached since 12/20/12.</p> <p>The facility was in substantial compliance on January 18, 2013</p>	