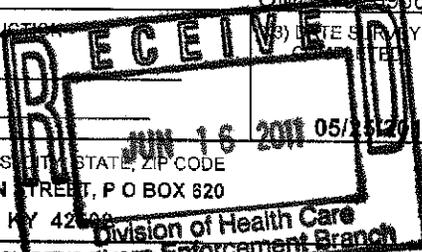


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011
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 _____		
NAME OF PROVIDER OR SUPPLIER LAKE CUMBERLAND REGIONAL HOSPITAL-SCU			STREET ADDRESS, CITY, STATE, ZIP CODE 305 LANGDON STREET, P O BOX 820 SOMERSET, KY 40389		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER CORRECTIVE ACTION (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 survey was conducted on May 24-25, 2011. Deficient practice was identified with the highest scope and severity at "E" 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 interview, medical record review, and facility policy review, it was determined the facility failed to develop a comprehensive care plan for two of eight sampled residents (residents #2 and #6) related to the residents' history of a positive tuberculin (TB) skin test.</p>	F 279	<p>I. Resident #2 and Resident #6 have been discharged.</p> <p>II. No other residents were affected by the alleged deficient practice. All residents currently residing on the Special Care Unit (SCU) have been reviewed to ensure that the plan of care for each resident includes measurable objectives and time tables to meet each residents medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment. This review was completed by the SCU Director 06/15/11.</p> <p>III. A care plan form to address the history of positive PPD has been developed to be utilized by the interdisciplinary team. This care plan includes the history of positive TB skin test as well as the monitoring of the resident for signs and symptoms of active disease. All SCU staff members will be inserviced by the SCU director regarding the care plan form and process for developing the plan of care for each resident. This education will be completed by 6/24/11.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Angela White-Hard* TITLE *RN BSN NHA* (X6) DATE *6/16/11*

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: 08/10/2011
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 05/25/2011
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)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 1</p> <p>The findings include:</p> <p>A review of the facility's Care Plan policy/procedure (revised September 1, 2009) revealed the resident's plan of care would contain problems that had been identified by any discipline as a result of the initial assessment or subsequent reassessment of a resident. The policy further noted the plan of care would include consideration of the physical, psychosocial, environmental, nutritional, self-care, educational, and discharge planning factors that affected the resident's care needs.</p> <p>1. A review of the medical record revealed resident #2 was admitted to the facility on May 19, 2011, with diagnoses of Acute Renal Failure, Dementia, Hypertension, and Deep Tissue Injury. A review of the facility's Tuberculosis Screening Sheet dated May 19, 2011, revealed the resident had been identified to have a history of a positive TB skin test.</p> <p>A review of the resident's comprehensive care plan dated May 19, 2011, revealed no evidence the facility had developed a plan of care to address resident #2's history of the positive TB skin test to include monitoring the resident for signs and symptoms of active disease.</p> <p>An interview conducted with the Minimum Data Set (MDS)/Care Plan Coordinator on May 25, 2011, at 2:30 p.m., revealed she was responsible to develop/update a plan of care for each resident after the comprehensive assessment had been completed. The MDS/Care Plan Coordinator stated the admitting nurse was responsible for the</p>	F 279	<p>IV.</p> <p>The SCU Director, or MDS Coordinator, will audit 100% of admissions for three months to ensure that all residents admitted to SCU have a plan of care established that includes measurable objectives and time tables to meet medical, nursing, mental, and psychosocial needs as identified by the comprehensive assessment. The outcome of this audit will be reported to the Quality Assurance Committee each month for three months for additional review and follow up as indicated.</p>	06/30/11	

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

PRINTED: 06/10/2011
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 05/25/2011
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)	(X5) COMPLETION DATE
F 279	Continued From page 2 development of the initial plan of care for the residents. The MDS/Care Plan Coordinator further stated care plans had been developed to address residents with a history of positive TB skin test. 2. A review of the medical record revealed resident #6 was admitted to the facility on May 6, 2011, with diagnoses to include Diabetes Mellitus, Dementia, Hypertension, Status Post Fracture of the left wrist, and history of Pulmonary Embolism. Further record review revealed a Tuberculosis (TB) Screening was conducted upon admission for resident #6. The screening identified resident #6 to have a history of a positive TB skin test. The screening further noted the resident had tuberculosis "20 years ago." However, a review of the resident's plan of care initiated on May 6, 2011, revealed no evidence the facility had developed a plan of care to address the resident's history of positive TB. An interview conducted with the Director of Nurses (DON) on May 25, 2011, at 6:00 p.m., revealed the facility had not developed a plan of care to monitor residents identified with a history of a positive TB skin test. The DON stated the resident was monitored daily through lung assessments for any symptoms of active lung disease.	F 279		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

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

PRINTED: 06/10/2011
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 05/25/2011
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)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 3 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policies, the facility failed to distribute and serve food under sanitary conditions to residents. During the noon meal on May 24, 2011, facility staff was observed to distribute/serve trays to six of twelve residents. The food items (grapes, tossed salad, pears, and cake) served to the residents were observed to be uncovered.</p> <p>The findings include:</p> <p>A review of the facility's Tray Delivery policy/procedure (reviewed by the facility on June 7, 2010) revealed resident trays were to be delivered to the resident areas as rapidly as possible after the trays were assembled in the kitchen. The policy noted Nursing Services was to be notified when the trays arrived at the Unit and the trays were to be transported/delivered to the residents in a closed cart to ensure food temperatures were maintained and to keep foods sanitary.</p> <p>Observations during the noon meal on May 24, 2011, revealed the closed meal cart was delivered from the kitchen to the resident floor at 11:55 a.m., and was placed in the hallway near room 361. Two staff members were observed to</p>	F 371	<p>I. No residents were noted in the deficiency to have been adversely affected by this practice.</p> <p>II. To ensure that food is distributed and served under sanitary conditions to residents, trays are being delivered as the meal cart is transported from room to room.</p> <p>III. To ensure that food is consistently distributed and served under sanitary conditions to residents, trays will continue to be delivered as the meal cart is transported from room to room. Additionally, all food items placed on trays will be covered prior to being placed in the meal cart and delivered to the unit. All Special Care and Dietary staff members will be inserviced regarding this process. Inservicing will be completed for nursing team members by the SCU Director. All dietary team members will be educated by the Food Services Director. All education will completed by 06/24/11.</p>		

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

PRINTED: 06/10/2011
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 05/25/2011
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)	(X5) COMPLETION DATE
F 371	<p>Continued From page 4</p> <p>begin passing trays to the residents. At 12:04 p.m., a resident tray was removed from the food cart and was transported by facility staff to room 362 (approximately 10 feet) from the food cart. The tray was observed to contain an uncovered dish of grapes.</p> <p>The facility staff was observed to push the food cart down the hallway and place the cart near the nurses' station. At 12:05 p.m., facility staff was observed to remove a tray containing an uncovered dessert and salad from the food cart and carry the tray to the resident's dining room located approximately 70 feet from where the cart was parked.</p> <p>The staff continued to distribute resident trays without moving the food cart from the location near the nurses' station and at 12:07 p.m., a resident's tray was delivered to room 366 (approximately 50 feet from the food cart) and contained a bowl of uncovered pears. At 12:10 p.m., staff was observed to deliver a tray to room 367 (approximately 26 feet from the food cart). The tray contained an uncovered bowl of grapes and tossed salad. At 12:12 p.m., staff was observed to deliver a tray containing an uncovered slice of cake to room 369 (approximately 54 feet from the food cart). At 12:14 p.m., a tray was observed to be delivered to room 371 (approximately 80 feet from the food cart sitting near the nurses' station). The tray contained an uncovered dish of pears.</p> <p>An interview conducted with Registered Nurse (RN) #1 on May 24, 2011, at 12:23 p.m., revealed the closed food cart should be pushed down the hallway and stopped near each resident's room to</p>	F 371	<p>IV.</p> <p>The MDS Coordinator, or Charge Nurse, Will audit 100% of trays delivered to the unit for three months to ensure that all trays are delivered and served under sanitary conditions. The outcome of this audit will be reported to the Quality Assurance Committee each month for three months for additional review and follow up as indicated.</p>	06/30/11

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

PRINTED: 06/10/2011
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 05/25/2011
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)	(X6) COMPLETION DATE
F 371	Continued From page 5 ensure food items remained sanitary during delivery. An interview conducted with Certified Nurse Aide (CNA) #1 on May 24, 2011, at 3:20 p.m., revealed the food cart was to be moved from room to room during tray delivery to the residents. CNA #1 stated food items should not be transported past the food cart without the items being covered. The Director of Nurses (DON) stated in an interview conducted on May 25, 2011, at 11:05 a.m., the facility practice was to move the food cart from room to room to ensure foods were delivered to the residents in a sanitary manner. The DON stated staff had not followed the routine tray delivery process during the noon meal on May 24, 2011.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and a review of facility policies, the facility failed to ensure pharmacy irregularities were reported to the	F 428	I. Resident #5 and Resident #6 have been discharged from the facility. II. No other residents were affected by the alleged deficient practice. All residents currently residing on the Special Care Unit (SCU) have been reviewed to ensure that any irregularities identified during the drug regimen review by the pharmacist have been reported to the attending physician. This review was completed by the SCU Director on 06/15/11.	

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

PRINTED: 06/10/2011
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 05/25/2011
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)	(X5) COMPLETION DATE
F 428	<p>Continued From page 6 attending physician for two of eight sampled residents.</p> <p>The findings include:</p> <p>A review of the facility policy/procedure related to the Drug Regimen Review (reviewed by the facility on September 2009) revealed drug regimen review recommendations would be reported to the physician and the Director of Nurses (DON) within seven working days of the medication review. The policy noted the physician and nursing personnel would provide a written response to the pharmacist's review/report and a copy of the report would be maintained by the facility.</p> <p>1. A review of the medical record for resident #5 revealed the resident was admitted to the facility on May 13, 2011, with diagnoses to include Status Post Total Knee Replacement, Hyperlipidemia, Hypothyroidism, and Fluid Retention.</p> <p>A review of the current physician's orders revealed resident #5 had orders to receive Lasix 40 milligrams (mg) daily, Micro K 10 micrograms (mcg) daily, Synthroid 25 mcg daily, and Zocor 80 mg daily.</p> <p>A review of the medication regimen review conducted on May 16, 2011, revealed the consultant pharmacist made recommendations to the physician to update resident #5's lipid panels and thyroid-stimulating hormone (TSH) levels. The consultant pharmacist noted the most recent lab tests available were in 2002. However, there was no evidence the physician or Nursing</p>	F 428	<p>III. The Skilled Nursing Unit-Medication Regimen Review form has been modified to include physician agreement/disagreement with pharmacy recommendations. All Special Care Unit RN and LPN's will be educated regarding the policy for Consultant Pharmacy Review. Additionally, SCU team members will be educated regarding the process for completion of physician notification of consultant pharmacist recommendations. This education will be completed by 06/24/11.</p> <p>IV. The MDS Coordinator, or Charge Nurse, will monitor the Skilled Nursing Unit-Medication Regimen Review form to ensure that all physician recommendations have been addressed with the physician according to the Consultant Pharmacy Review policy. This information will be reported to the quality assurance committee monthly for three months then will be re-evaluated.</p>	06/30/11

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

PRINTED: 06/10/2011
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 05/25/2011
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)	(X5) COMPLETION DATE	
F 428	<p>Continued From page 7</p> <p>Services had reviewed/acted upon these recommendations.</p> <p>An interview conducted with Registered Nurse (RN) #1 on May 25, 2011, at 2:10 p.m., revealed nurses were responsible to review the pharmacy review/recommendations and to ensure the recommendations were reviewed by the resident's physician. Based on the interview, the resident's physician acknowledged receipt/review of the pharmacist's recommendation by the physician's signature on the recommendations. RN #1 stated based on documentation the pharmacy recommendations for resident #5 had not been reviewed by the resident's attending physician.</p> <p>2. A review of the medical record revealed resident #6 was admitted to the facility on May 6, 2011, with diagnoses to include Diabetes Mellitus, Type II, Status Post Left Wrist Fracture with Infection, Arthritis, Osteoarthritis, Gastroesophageal Reflux Disease (GERD), Coronary Artery Disease, Gout, and History of Pulmonary Embolism.</p> <p>A review of the current physician's orders revealed resident #6 had orders to receive Coumadin (anti-coagulant) 5 mg daily, Coreg (anti-hypertensive) 3.125 mg (2 tabs) twice a day, and Indomethacin (non-steroid anti-inflammatory drug) 25 mg daily.</p> <p>A review of the medication regimen review conducted by the consultant pharmacist on May 9, 2011, revealed the pharmacist recommended to "consider" the risk of gastrointestinal (GI) bleeding with the use of Indomethacin and</p>	F 428			

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

PRINTED: 06/10/2011
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 05/25/2011
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)	(X5) COMPLETION DATE	
F 428	Continued From page 8 Coumadin. The pharmacist noted Indomethacin would also decrease the anti-hypertensive effect of Coreg more than other non-steroid anti-inflammatory drugs (NSAIDs). The pharmacist recommended the physician consider "switching" resident #6 to an alternate NSAID other than Indomethacin. However, there was no evidence the resident's physician or Nursing had acted upon or reviewed this recommendation for resident #6. An interview conducted with the Director of Nurses (DON) on May 25, 2011, at 2:50 p.m., revealed the medication regimen reviews should be left on the resident's chart for the physician and Nursing to review. The DON stated the nurse was responsible to call the resident's attending physician to follow up on the pharmacist's recommendations if the physician failed to sign the medication regimen review.	F 428			

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

PRINTED: 08/31/2011
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 05/25/2011
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)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on May 25, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.	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.