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

PRINTED: 12/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185428	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2014
NAME OF PROVIDER OR SUPPLIER CLARK REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 175 HOSPITAL DRIVE WINCHESTER, KY 40391	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 11/18/14 and concluded on 11/20/14. Deficiencies were cited with the highest Scope and Severity of an "E".

F 280 483.20(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, record review, and review of facility's policy, it was determined the facility failed to revise the Care Plan for (1) of ten (10) sampled residents (Resident #2)

F 000 F280

F 280

- 1 Resident #2 had her care plan updated on 11/18/14 by a Registered Nurse
- 2 To identify other Residents who have the potential to be affected.
 - a A Registered Nurse Manager has audited all care plans.
 - b All care plans needing revised were updated or rewritten as necessary
- 3 To ensure the deficient practice does not recur
 - a The Facility Registered Nurse Manager will educate nurses on skin assessments, required documentation and care plan requirements
 - b New nurses employed by the facility will receive the same plan of correction education during their initial competency assessment
 - c Facility nurses will complete with a minimum passing score of 80%, a post education test, demonstrating competency on educated material.
 - d The facility Registered Nurse, Infection Control Nurse or Quality Nurse will review a minimum of 25% of care plans weekly for 3 months, comparing the care plan to the Resident's condition.
- 4 The facility will monitor its performance through:
 - a The facility administrator will track performance of the plan of correction on the facility dashboard with the number of audits completed and number of care plans completed accurately.
 - b The facility administrator will submit the facility dashboard to the quality assurance committee. The quality assurance committee will review and make recommendations as

12/29/14

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

TITLE

(X8) DATE

JC CM NIEMAN

ADMINISTRATOR

1/3/15

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

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F 280 - Continued From page 1

Resident #2 was identified to have an Ulcer to the left lateral foot on 11/02/14, and on 11/03/14 the Podiatrist identified the ulcer as being a pressure ulceration and ischemic wound. However, the care plan was not revised until 11/18/14 related to the wound, and the care plan described the wound as a Stage IV instead of unstageable as per the Podiatry Consult on 11/07/14.

The findings include:

Review of Resident #2's clinical record revealed diagnoses which included Chronic Dementia, Cerebral Vascular Accident (CVA), Contractures of the Limbs, Diabetes Mellitus, and Peripheral Vascular Disease (PVD). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/12/14, revealed the facility assessed Resident #2 as having both short and long term memory loss, limitation in range of motion of all extremities, and as having a Stage I Pressure Ulcer.

Review of the Nurse's Notes dated 11/02/14 at 5:44 AM revealed Resident #2's dressings were removed from both feet and an area was noted to the left outer side of the foot described as a long reddish black area measuring three (3) centimeters (cm's) x seven (7) cm's with a black brownish area measuring one (1) cm x four (4) cm x a half (0.5) cm. Continued review of the Nurse's Notes dated 11/02/14 at 10:30 AM, revealed the Attending Physician was notified of the status of the resident's left foot.

Review of Resident #2's Physician's Orders dated 11/02/14, revealed orders for Bactroban (antibiotic) two percent (2%) topical to the left foot lateral area twice a day, and Septra (antibiotic

F 280

necessary The Quality Assurance Committee will meet no less than quarterly and include at a minimum of: Medical Director, Chief Nursing Officer, Administrator Registered Nurse Manager and Quality Director

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F 280 - Continued From page 2

F 280

medication)800/160 MG (milligrams)/20 ML(milliliters) suspension-administer twenty (20) ML every twelve (12) hours.

Review of the Podiatrist Consult dated 11/03/14, revealed the Podiatrist was asked to see the resident related to a new pressure ulceration to the lateral aspect of the left foot. Continued review revealed the left foot demonstrated a large eight and a half (8.5) cm long x one (1.0) cm wide area of hemorrhagic pre-ulcerative tissue, along the entire length of the fifth metatarsal area. Further review revealed, there was no open breaks in the skin but the skin was very atrophy, friable, and dysvascular. The Consult stated purpura was present, but only to the pressure related area of the fifth metatarsal

Review of the Podiatrist Progress Note dated 11/07/14, revealed the resident had a decubitus pressure with potential unstageable deeper tissue depth to the lateral left foot.

Review of the Comprehensive Plan of Care dated 10/11/13 and revised 11/18/14 revealed the resident had the potential for impaired skin integrity; had multiple contractures and PVD. Further revision dated 11/18/14, revealed the resident had a Stage IV area to the left foot and a Stage I area to the right great toe.

Observation of a skin assessment for Resident #2 with Registered Nurse (RN) #1 on 11/19/14 at 11:45 AM, revealed on the right foot, a dark area under the ball of the foot measuring one half (0.5) cm's x one half (0.5) centimeters which RN #1 explained was described as a scab prior to this skin assessment, a scab to the top of the third toe measuring one fourth (0.25) cm's x one fourth

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F 280	<p>Continued From page 3</p> <p>(0.25) cm's and a scab on the top of the fifth toe measuring one (1.0) cm x two (2.0) cm's. Continued observation revealed the left foot had an area to the lateral foot measuring eight (8.0) cm's x two (2) cm's which was black with brownish drainage with an area of redness surrounding measuring seven (7) cm x two and a half (2.5) cm's.</p> <p>Interview with the RN Manager on 11/20/14 at 3:20 PM and 5:30 PM, revealed the area on the resident's left lateral foot was pressure related by record review. She stated the staff nurses and the MDS Coordinators updated the care plans with changes in resident's condition or with any Physician's Orders related to for example; Urinary Tract Infections, diet changes, antibiotics, wounds, and dressing changes. She stated Resident #2's Care Plan should have been updated on 11/02/14 to indicate the resident had an ulcer to the left lateral foot and the care plan should at this time reflect the resident had a pressure ulcer which was unstageable</p>	F 280	
F 281 SS=0	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by.</p> <p>Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to ensure the Interim Care Plan was updated for two (2) of ten (10) sampled residents (Resident #8 and #6).</p>	F 281	

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F 281 Continued From page 4
Resident #8's Initial Skin Assessment, on 11/10/14, noted a Deep Tissue injury (DTI) on the Left heel, however, the Interim Care Plan revealed no documentation specific to the left heel DTI, such as, the presence, location, staging or measurements of the the DTI. In addition, the Interim Care Plan did not address Resident #8's incision site related to a Right Below the Knee Amputation.

Also, Resident #6 was placed on Remeron, a psychotropic medication, on 11/02/14. However, Resident #6's interim Care Plan did not address this medication with interventions for the management and monitoring of the medication.

The findings include.

Review of the facility's policy titled, "Interdisciplinary Care Plan", approved on 08/2012, revealed the Interdisciplinary (Interim) Care Plan would be initiated within twenty-three (23) to seventy-two (72) hours of a resident's admission to the facility. Continued review revealed the Care Plan would ensure continuity of care based on the resident's needs, strengths and preferences to prevent decline in function level.

1. Record review revealed the facility admitted Resident #8 on 11/10/14 with diagnoses which included Coronary Artery Disease, Diabetes Mellitus, Chronic Diarrhea, Deep Tissue Injury to the Left Heel, and a Recent Right Lower Extremity Amputation.

Review of Resident #8's Initial Skin Assessment, on 11/10/14, revealed a Deep Tissue injury (DTI) to the Left heel. Review of the Interim Care Plan

F 281
1 The facility has taken action to correct the deficient practice
a Resident #6 has discharged from the facility
b. Resident #8 has discharged from the facility
2. Other Residents admitting to the facility have the potential to be affected
a Interim Care plans have been audited by facility nurses
b. All interim care plans were reviewed by the Registered Nurse Manager
c. All interim care plans needing revised were updated or rewritten as necessary.
3. To ensure the deficient practice does not recur
a. The facility Registered Nurse Manager will educate nurses on interim care requirements and plan of correction
b New nurses employed by the facility will receive the same plan of correction education during their initial competency assessment.
c Facility nurses will complete with a minimum passing score of 80%, a post education test, demonstrating competency on educated material.
d. Facility nurses will complete interim care plans on admission.
e. Facility nurses working the shift after admission will audit interim care plans for completeness and accuracy
f. New Admissions will be audited weekly by Registered Nurse Manager or another registered nurse, comparing the interim care plan with the Resident's condition
4 The Facility will monitor its performance of plan of correction through:

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F 281 : Continued From page 5
dated 11/10/14 revealed Pressure Sores/Skin Care was checked with interventions initiated to; follow facility skin care protocol, turn every two (2) hours and as needed, and report any redness or skin breakdown immediately. However, review of the Interim Care Plan, dated 11/10/14, revealed no documented evidence it addressed the resident's Left Heel DTI to include the presence of the the DTI, the location of the DTI, the staging of the DTI or the measurements of the DTI.

Review of the History and Physical dated 11/11/14, revealed the resident was hospitalized from 10/13/14 until 11/10/14, and underwent a Right Below the Knee Amputation (BKA) on 10/13/14, and was to have Physical Therapy and Occupational Therapy at the facility.

Review of the Nurse's Note dated 11/11/14 at 7:00 PM, revealed the dressing change to the right lower extremity was done earlier that day, and the staples were intact, with a scant bloody drainage and the area was cleansed with wound Cleanser, Vaseline Guaze applied, four (4) by four (4) to each side and wrapped with Kling gauze.

However, further review of the Interim Care Plan, dated 11/10/14, revealed no documented evidence the incision site with staples to the resident's RLE was addressed on the Interim Care Plan.

Interview, on 11/20/14 at 3:00 PM and 4:45 PM, with Registered Nurse (RN) #2, who admitted the resident on 11/10/14, revealed she had completed the Interim Care Plan for Resident #8. She stated on admission on 11/10/14, the resident had a bruised area on the back of his/her

F 281
a. The facility Administrator will track performance of audits including the number of interim care plans completed compared with the number completed accurately on the facility Dashboard.
b. The facility submit the facility dashboard to the Quality Assurance Committee. The Quality Assurance Committee will review and make recommendations as necessary

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F 281	<p>Continued From page 6</p> <p>heel and it was determined by RN #2 and the RN Manager to have been a DTI. Further interview with RN #2 revealed the resident also had an incision site with staples to the right lower extremity amputation site. She stated Resident #8's Interim Care Plan for pressure ulcers/skin should have been more specific and addressed Resident #8's DTI on the left heel, and incision site for the below the knee amputation.</p> <p>Interview with the RN Manager, on 11/20/14 at 5:45 PM revealed Interim Care Plans should be specific related to pressure ulcers, or DTI's and include their location, and staging if applicable, and also should address any surgical incision sites.</p> <p>2. Review of Resident #6's medical record revealed the facility admitted the resident on 11/02/14, with diagnoses which included Anemia, Septicemia, Cerebrovascular Accident (CVA), and Atrial Fibrillation. An additional diagnosis of Depression was included on the Physician's Orders dated 11/07/14 and signed on 11/16/14.</p> <p>Review of Resident #6's Physician's Orders dated 11/02/14 revealed the resident was prescribed Remeron (an antidepressant medication) fifteen (15) milligrams (MG's) by mouth at bedtime nightly. Resident #6's Interim Care Plan dated 11/02/14 revealed no documented evidence the resident was care planned for psychotropic drug use or antidepressants even though the medication was ordered 11/02/14.</p> <p>Interview with RN #3/Charge Nurse, who admitted the resident on 11/20/14 at 11:23 PM, revealed it was the responsibility of the Minimum Data Set (MDS) Coordinator and the staff nurses</p>	F 281		

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F 281 Continued From page 7
to ensure the Interim Care Plan was accurate and updated. She stated it was her expectation antidepressants be addressed on the resident's Interim Care Plan.

F 281

Interview with the RN Nurse Manager on 11/20/14 at 5:30 PM, revealed the admission nurse was to complete the Interim Care Plans, and any nurse who took off additional orders should update the Interim Care Plan related to the orders as needed. She stated the Remeron should have been addressed on the Interim Care Plan.

F 314 483.25(c) TREATMENT/SVCS TO
SS=D PREVENT/HEAL PRESSURE SORES

F 314

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to ensure a resident having pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for two (2) of ten (10) sampled residents (Resident #2 and #8).

Resident #2 was identified to have an Ulcer to the

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F 314. Continued From page 8

left lateral foot on 11/02/14, and the Physician was notified for treatment. On 11/03/14 the Podiatrist assessed the resident and identified the resident had a pressure ulceration and ischemic wound to the lateral fifth metatarsal region of the left foot; however, the subsequent skin assessments on 11/06/14 and 11/13/14 did not indicate the ulcer was present. In addition, although the wound was identified on 11/02/14, the care plan was not revised until 11/18/14, related to the wound, and the care plan described the wound as a Stage IV instead of unstageable as per the Podiatry Consult on 11/07/14.

In addition, Resident #8 was admitted by the facility on 11/10/14, with a Deep Tissue Injury (DTI) to the Left Heel and a surgical incision with staples to the Left Below the Knee Amputation site. However, the Initial Skin Assessment dated 11/10/14, did not indicate the measurement of the DTI and did not address the resident's surgical site with staples to the right lower extremity amputation site. Also, the subsequent skin assessment dated 11/17/14, did not address the DTI to the Left Heel. In addition, the Interim Care Plan dated 11/10/14 did not address either the DTI to the Left Heel nor the surgical site of the right lower extremity.

The findings include:

Review of the facility "Skin Assessment and Treatment Policy", revised 07/13, revealed the purpose of the policy was to promote a thorough, comprehensive assessment for early identification of those patients at risk for skin integrity loss to promote prevention, promote healing, prevent infection and prevent additional development of pressure sores. Further review

F314
F 314

1. The facility has taken action to correct the deficient practice

- Resident #2 had skin assessment completed accurately on 11/19/14 by a facility Registered Nurse
- Resident #8 has discharged from the facility.

2. The Facility will identify other Residents with the potential to be affected through

- All skin assessments have been audited by the Registered Nurse Manager, comparing the Residents condition with the documented skin assessment
- All skin assessments needing revision were revised or completed accurately

3. To ensure the deficient practice does not recur

- The facility Registered Nurse Manager will educate nurses on skin assessment, required documentation and related wound care requirements
- New nurses employed by the facility will receive the same plan of correction education during their initial competency assessment
- Facility nurses will complete with a minimum, passing score of 80%, a post education test, demonstrating competency on educated material.
- The facility Registered Nurse Manager, Infection Control Nurse or Quality Nurse will review a minimum 50% skin assessments weekly for three months, comparing the documented assessment with the Residents condition.

4. The facility will monitor its performance of plan, of correction through.

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F 314	<p>Continued From page 9</p> <p>revealed skin assessments would be done weekly to include an accurate description of the location and stage, size, current dressing, description of the wound, drainage, undermining/tunneling, and character (granulation, slough, eschar)</p> <p>1. Review of Resident #2's medical record revealed diagnoses which included Chronic Dementia, Cerebral Vascular Accident (CVA), Contractures of the Limbs, Diabetes Mellitus, and Peripheral Vascular Disease (PVD). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 10/12/14, revealed the facility assessed the resident as having both short and long term memory loss, limitation in range of motion of all extremities, and as having a Stage I Pressure Ulcer.</p> <p>Review of the Nurse's Notes dated 11/02/14 at 5:44 AM revealed the dressings were removed from both feet and an area was noted to the left outer side of the foot described as a long reddish black area measuring three (3) centimeters (cm's) x seven (7) cm's with a black brownish area measuring one (1) cm x four (4) cm x a half (0.5) cm. Further review of the Nurse's Notes on 11/02/14 at 10:30 AM revealed the Attending Physician was notified of the status of the resident's left foot.</p> <p>Review of the Physician's Orders dated 11/02/14 revealed orders for Bactroban (antibiotic) two percent (2%) topical to the left foot lateral area twice a day, and Septra (antibiotic medication) 800/160 MG (milligrams)/20 mL (milliliters) suspension-administer twenty (20) mL every twelve (12) hours.</p>	F 314	<p>a. The facility Administrator will track number of skin assessments completed with number of accurately completed skin assessments on the facility Dashboard</p> <p>b. The facility submit the facility dashboard to the Quality Assurance Committee. The Quality Assurance Committee will review and make recommendations as necessary.</p>	

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Review of the Podiatrist Consult dated 11/03/14, revealed she was asked to see the resident related to a new pressure ulceration to the lateral aspect of the left foot. Further review revealed the left foot demonstrated a large eight and a half (8.5) cm long x one (1.0) cm wide area of hemorrhagic pre-ulcerative tissue, along the entire length of the fifth metatarsal area. The Consult stated, there was no open breaks in the skin but the skin was very atrophy, friable, and dysvascular. Further review revealed purpura was present, but only to the pressure related area of the fifth metatarsal.

Review of the skin assessments dated 11/06/14, completed by Licensed Practical Nurse (LPN) #3 indicated there was redness across the top of the 2nd, 3rd, 4th, and 5th left toes, the coccyx was red, and the right cheek had a red rash. However, there was no indication of a pressure ulcer to the lateral aspect of the left foot

Review of the Braden Skin Screen completed 11/06/14 revealed the resident's risk factors included; bedfast, completely immobile, probably inadequate nutrition, and friction and shear was a problem which placed the resident at risk for skin breakdown.

Review of the Podiatrist Progress Note dated 11/7/14, revealed the resident was assessed to have a decubitus pressure with potential unstageable deeper tissue depth to the lateral left foot.

Further review of the skin assessment dated 11/13/14, completed by LPN #3 revealed there was redness to the top of the 2nd, 3rd, 4th, and 5th left toes, the coccyx was red, and the right

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cheek had a red rash. However, there was no indication of a pressure ulcer on the area to the lateral aspect of the left foot.

Review of the Comprehensive Plan of Care dated 10/11/13 and revised 11/18/14, revealed the resident had the potential for impaired skin integrity; had multiple contractures and PVD. Further revision dated 11/18/14, revealed the resident had a Stage IV area to the left foot and a Stage I area to the right great toe.

Observation of Resident #2 during a skin assessment on 11/19/14 at 11:45 AM, revealed on the right foot; a dark area under the ball of the foot measuring one half (0.5) cm's x one half (0.5) centimeters, a scab to the top of the third toe measuring one fourth (0.25) cm's x one fourth (0.25) cm's and a scab on the top of the fifth toe measuring one (1.0) cm x two (2.0) cm's. Further observation revealed the left foot had an area to the lateral foot measuring eight (8.0) cm's x two (2) cm's which was black with brownish drainage with an area of redness surrounding measuring seven (7) cm x two and a half (2.5) cm's. Registered Nurse (RN) #1 described the area as an arterial ulcer which she explained could not be staged.

Interview with RN #1 on 11/19/14 at 4:15 PM, revealed she had documented all the areas on the residents lower extremities as venous ulcers, and had received information in report as just ulcers. She stated she thought the ulcers were all venous related to the residents diagnosis of PVD.

Interview on 11/20/14 at 3:20 PM with the RN Manager, revealed LPN #3 completed the skin

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assessments on 11/06/14 and 11/13/14 and should have measured and documented the area to the left lateral foot as unstageable. She stated all wounds either venous or pressure were to be measured and pressure ulcers were to be staged. She further stated the area on the left lateral foot was pressure by record review. Further interview revealed she noted during the survey the skin assessments were not being done properly and this was a concern because the nurses had been through pressure ulcer training twice this year. She further stated Resident #2's Care Plan should have been revised on 11/02/14 to indicate the resident had an ulcer to the left lateral foot and the care plan should at this time reflect the resident had a pressure ulcer which was unstageable.

Phone Interview on 11/20/14 at 4:45 PM with Licensed Practical Nurse (LPN) #3 who had completed the skin assessments on 11/06/14 and 11/13/14, revealed she received a yearly inservice and competency related to skin assessments. She stated there was no wound nurse; however, there was a schedule for skin assessments to be done weekly, and whichever nurse was assigned to the resident on the scheduled day would do the skin assessment. Further interview revealed she did not normally do this resident's dressing change because the dressing was changed on day shift and she worked the night shift. LPN #3 stated, when she did a skin assessment, she removed all the dressings and assessed the entire body. She stated she must not have seen the resident's ulcers on the lateral aspect of the left foot when she completed the skin assessments on 11/06/14 and 11/13/14.

Interview with the Attending Physician on

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F 314	<p>Continued From page 13</p> <p>11/19/14 at 2 30 PM, revealed the resident's ulcers were unavoidable related to the resident's diagnosis of PVD, contractures, and poor nutrition. He stated the etiology of the linear ulcer to the lateral aspect of the left foot's etiology was uncertain; however, he felt the area was a pressure ulcer.</p> <p>2. Record review revealed Resident #8 was admitted to the facility on 11/10/14, with diagnoses including Coronary Artery Disease, Diabetes Mellitus, Diabetic Neuropathy, Deep Tissue Injury (DTI) to the Left Heel, and Recent Right Lower Extremity Amputation on 10/13/14.</p> <p>Review of the History and Physical dated 11/11/14, revealed Resident #8 was hospitalized from 10/13/14 until 11/10/14, and underwent a Right Below the Knee Amputation (BKA) on 10/13/14. Further review revealed Resident #8 was to have Physical Therapy and Occupational Therapy at the facility.</p> <p>Review of Resident #8's Initial Skin Assessment, on 11/10/14, revealed a DTI on the resident's left heel; however, there was no documented evidence of measurements noted. In addition, although Resident #8 was admitted to the facility after a right BKA, on 11/10/14, there was no documented evidence to address his/her incision site.</p> <p>Further record review of Resident #8's subsequent skin assessment, on 11/17/14, revealed documentation of the right BKA incision site; however, there was no documented evidence of the Left heel DTI or measurements of the DTI.</p>	F 314
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In addition, the Interim Care Plan dated 11/10/14, revealed no documented evidence the resident had a Left Heel DTI as there was no information to address the location of the DTI, the staging of the DTI or the measurements of the DTI. In addition, the interim Care Plan did not address Resident #8's surgical incision site related to a Right Below the Knee Amputation.

Observation of Resident #8's skin assessment was requested, however, denied by the resident on 11/20/14 at 2:00 PM.

Interview on 11/20/14 at 3:00 PM and 4 45 PM with RN #2, who admitted Resident #8 on 11/10/14, revealed on admission, the resident was observed to have a bruised area on the back of his/her heel and it was determined by RN #2 and the RN Manager (this was a DTI). RN #2 stated the DTI measurements should have been documented on the initial skin assessment. Further interview with RN #2 revealed the resident also had an incision site with staples to the right lower extremity amputation site on admission. RN #2 further stated the presence of the incision site from the Right lower extremity amputation should have been documented with the measurements and amount of staples that were present on the initial skin assessment. Continued interview revealed RN #2 had completed the Interim Care Plan for Resident #8 on 11/10/14 on admission, and should have addressed the resident's DTI of the Left Heel and the incision site to the RLE on the Care Plan.

Interview with the RN Manager, on 11/20/14 at 3:24 PM revealed the skin assessments were completed on all residents on admission and weekly and all findings should be documented on

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the skin assessment to include; wounds, DTI, location, measurements, and staging. She further stated any surgical site should also be documented on the skin assessment with a description of the site.

Further interview with the RN Manager, on 11/20/14 at 5 45 PM revealed Interim care plans should be specific related to pressure ulcers, or DTI's and include their location, and staging if applicable and also should address any surgical incision sites.

F 411 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS

The facility must assist residents in obtaining routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident, may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office, and promptly refer residents with lost or damaged dentures to a dentist

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure there was an annual inspection of the residents' oral cavity for signs and symptoms of disease or diagnoses of dental disease for three (3) of ten (10) sampled

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F 411 Continued From page 16 residents (Resident #2, #3, and #9).

Record review revealed there was no documented evidence these residents had been seen by a dentist for routine annual dental services

The findings include:

1. Review of the medical record revealed the facility admitted Resident #2 on 10/04/12, with diagnoses which included Chronic Dementia, Cerebral Vascular Accident (CVA), and Diabetes Mellitus. Review of the Minimum Data Set (MDS) Assessment dated 10/12/14 revealed the facility assessed the resident as having both short and long term memory loss. Further review revealed the facility assessed the resident as having no dental problems.

Review of the Comprehensive Plan of Care dated 10/11/13, revealed Resident #2 had alteration in Activities of Daily Living (ADLs), requiring total care. The interventions included oral care twice a day and as needed as the resident was edentulous

Further review of the medical record, revealed there was no documented evidence a dentist had seen the resident for routine dental care and services since admission to the facility.

2. Review of the medical record revealed the facility admitted Resident #3 on 03/29/12, with diagnoses which included Cerebral Vascular Accident (CVA), Diabetes Mellitus, and Neurogenic Bladder. Review of the Quarterly MDS Assessment dated 08/09/14, revealed the facility assessed the resident as having a Brief

F 411 F411

1. The facility has taken action to correct the deficient practice
 - a. All Long Term Residents or their Responsible Party have been audited if they want the facility to assist with preventative or emergent dental services.
2. The Facility will identify other Residents with the potential to be affected through
 - a. All Residents residing in the facility 6 months, or longer have been offered assistance in establishing preventative and emergent dental and denture services. One Resident's Responsible party requested assistance
 - b. Facility nurses completed an audit identifying any Residents needing emergent dental services and none were found.
3. To ensure the deficient practice does not recur:
 - a. The facility will encourage Residents and Responsible parties to seek preventative dental visits at annual care conference and assist any Resident or their Responsible party in establishing these services.
 - b. The facility Administrator or Registered Nurse Manager have educated staff on preventative and emergent dental and denture requirements and plan of correction.
 - c. New nurses employed by the facility will receive the same plan of correction education during their initial competency assessment.
4. The facility will monitor its performance of plan of correction through:
 - a. The Administrator will track performance of annual care plans and Residents who receive annual preventative dental service visit on the facility Dashboard.

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interview for Mental Status (BIMS) of a thirteen (13) out of fifteen (15). Further review revealed the facility assessed the resident as having no dental problems.

Review of the Comprehensive Plan of Care dated 05/09/14, revealed Resident #3 had a self care deficit, requiring care with ADLs. The interventions included assist with set up to brush teeth.

Further review of the medical record revealed no documented evidence a dentist had seen the resident for routine dental care and services.

3. Review of Resident #9's medical record revealed the facility admitted the resident on 08/20/13, with diagnoses which include Hypertension, Hyperlipidemia, Cerebrovascular Accident, Hemiplegia and Depression. Review of the Annual Minimum Data Set (MDS) Assessment dated 08/11/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of an eight (8) out of fifteen (15) due to failure to recall. Further record review revealed no evidence of dental care consults within one year of admission to the facility.

Interview, on 11/20/14 at 5:30 PM, with the Registered Nurse Manager, revealed the facility did not have a dental contract; however had Ear Nose and Throat specialist on staff who could see the residents as needed. She stated the residents were sent out to see the dentist on an as needed basis.

Interview with the Director of Nursing (DON) on 11/20/14 at 5:59 PM, revealed the facility did not

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b. The administrator will submit the facility dashboard to the Quality Assurance Committee. The Quality Assurance Committee will review and make recommendations as necessary.

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and a History of Urinary Tract Infections (UTIs) Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/09/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a thirteen (13) out of fifteen (15).

Review of the Comprehensive Care Plan dated 05/09/14 revealed the resident had altered urinary elimination with the use of a supra pubic catheter which was placed 05/02/13. Further review revealed a goal stating the resident would have a reduced risk for a UTI through the next review.

Observation on 11/19/14 at 10:30 AM, revealed Resident #3 was in a wheelchair being pushed from the resident's room to the activities room. Further observation revealed the urinary drainage bag was touching the floor.

Interview on 11/29/14 at 10:32 AM with Certified Nursing Assistant (CNA) #2 revealed he was assigned to the resident and had assisted the resident to the wheelchair. He stated he had not positioned the urinary drainage bag correctly under the wheelchair to prevent it from touching the floor.

Interview on 11/20/14 at 6:00 PM with the Infection Control Nurse, revealed urinary drainage bags should not touch the floor due to this could be an infection control issue. She stated the bags should be positioned on the wheelchair in a way to prevent this.

2. Review of facility's policy entitled "Hand Hygiene" dated 08/2012, revealed the facility's practices for properly sanitized hands were for staff to use soap and water or hand sanitizer

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before and after resident contact, between resident contacts, before donning and after removing gloves and after touching patients surroundings.

Interview with the Infection Control Nurse on 11/20/14 at 6:14 PM revealed her expectation for proper hand hygiene was for staff to wash their hands between each patient contact and glove change to prevent the spread of germs and other organisms.

Observation of meal service at lunch in the dining room on 11/19/14 at 12:23 PM, revealed Certified Nursing Assistant (CNA) #2 was observed to pick up Resident #3's cup, rinse it with running water at the sink and hand the cup back to Resident #3. CNA #2 then removed the soiled gloves, and without washing or sanitizing his hands, donned new gloves. CNA #2 then set up a tray for Unsampld Resident A placing a straw in the drink, opening food containers, and cutting up the food. CNA #2 then set up trays for Resident #7 and Unsampld Resident B. CNA #2 changed gloves between resident contacts; however, did not wash or sanitize his hands between contacts.

Interview with CNA #1 on 11/19/14 at 12:30 PM who was also serving food in the diningroom during this meal service revealed the facility's policy for proper hand hygiene was to wash your hands between each glove change. She stated failure to do so would cause possible harm to the resident, such as infection.

Interview with CNA #2 on 11/19/14 at 12:32 PM revealed the facility's policy for proper hand sanitization was to wash your hands between every glove change. He stated failure to do so

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; have a procedure in place to ensure residents received an annual dental exam or consult.

Interview, on 11/20/14 at 6:30 PM, with the Administrator revealed the facility had no dental contract and he did not realize a dental exam was needed yearly.
F 441 483.65 INFECTION CONTROL, PREVENT SS-E 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.

(a) Infection Control Program
; The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident, and
(3) Maintains a record of incidents and corrective actions related to infections.

(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.
(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.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted

F 411 F441
1 The facility has taken action to correct the deficient practice
a Resident #3 catheter bag was noted to be touching the floor, it was repositioned at time.
b. A new catheter bag cover is in place allowing for attachment at the wheelchair in a position to prevent it from touching the ground.
c The SRNA setting up trays in the activity dining room was in-serviced on 11/19/14 by the Registered Nurse Manager and is no longer employed with the facility.
2 The Facility will identify other Residents with the potential to be affected through.
a Other Residents with catheter bags have the potential to be affected Catheter bag covers allowing for a different attachment point to the wheelchair have been utilized and are in place for those Residents who have a catheter and ambulate with a wheelchair
b. Residents eating in the activity dining room have the potential to be affected
c. Staff serving meals in the activity room were provided education for proper infection control practices including glove donning and removal during the survey period to prevent recurrence by the Administrator of Registered Nurse Manager
3. To ensure the deficient practice does not recur
a. Catheter bag covers allowing for catheter bags and tubing to be stored inside are being used for those Residents who have catheters and ambulate via wheelchair The bag covers allow for a higher attachment point, prevent

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/20/2014
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NAME OF PROVIDER OR SUPPLIER CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 175 HOSPITAL DRIVE WINCHESTER, KY 40391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441 Continued From page 19
professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease for two (2) sampled residents (Residents #3 and #7) out of a total sample of ten (10) residents and two (2) unsampled residents (Unsampled Resident A and Unsampled Resident B).

Resident #3's urinary drainage bag was observed to be touching the floor while the resident was being wheeled to the activities room while sitting in a wheelchair.

In addition, poor hand hygiene was observed during meal service by staff for Resident #3, Resident #7, Unsampled Resident A, and Unsampled Resident B.

1. A policy related to the use and care of Urinary Drainage Bags was requested; however, not received.

Review of Resident #3's medical record revealed diagnoses which included Cerebral Vascular Accident, Neurogenic Cerebrovascular Bladder,

F 441

unhooking from the wheelchair and prevent catheter bags from touching the ground

b. Facility Nurses and SRNA's have received education from the Registered Nurse Manager on catheter bag care and placement, infection control practices, hand washing, glove donning and removal.

c. Facility staff serving meals in the activity dining room have received education on hand-washing, glove donning and removal, catheter bag handling and general infection control techniques by the facility's Infection Control Nurse, Administrator or Registered Nurse Manager

d. New employees employed by the facility will receive the same plan of correction education during their initial competency assessment

e. The facility will complete hand washing audits and catheter bag audits

4. The facility will monitor its performance of plan of correction through.

a. The facility Administrator will track performance of audits on the facility Dashboard.

b. The administrator will submit the facility dashboard to the Quality Assurance Committee. The Quality Assurance Committee will review and make recommendations as necessary

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 175 HOSPITAL DRIVE WINCHESTER, KY 40391
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F 441 Continued From page 22
would spread germs to other residents. CNA #2 further stated he did not follow facility policy with regard to hand sanitization.

Interview with the Registered Nurse (RN) Manager on 11/20/14 at 5:39 PM revealed her expectation for proper hand hygiene was for staff to wash their hands between patient contact in the dining room. She stated failure to do so could cause transmission of germs to other residents.

F 492 483.75(b) COMPLY WITH
SS=C FEDERAL/STATE/LOCAL LAWS/PROF STD

The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the Kentucky Revised Statute (KRS), it was determined the facility failed to comply with all Federal, State, and local laws, regulations and codes. Information about Human Immunodeficiency Virus (HIV) and Auto Immune Deficiency Syndrome (AIDS) provided by the facility did not meet the statutory requirements of KRS 214.620 (4) which states information on the HIV infection shall be presented to any person who receives treatment in a skilled nursing facility. The information shall include, but not be limited to methods of transmission, methods of prevention, and appropriate attitudes and

F 441 F492 12/29/14

1. The facility has taken action to correct the deficient practice
 - a. All Residents or their Responsible Parties have been presented with updated HIV & AIDS Awareness and Prevention Information
2. The Facility will identify other Residents with the potential to be affected through:
 - a. All Residents admitting to the facility have the potential to be affected.
 - b. All Residents or their Responsible Party have been presented with HIV & AIDS Awareness and Prevention Information.
3. To ensure the deficient practice does not recur:
 - a. The Facility has updated information for HIV Awareness and Prevention presented in the admission packet presented to Residents or their Responsible Parties when they admit to the facility.
 - b. The Administrator has educated nurses on HIV and AIDS awareness and prevention admission information.
 - c. New nurses employed by the facility will receive the same plan of correction education during their initial competency assessment.
4. The facility will monitor its performance of plan of correction through:
 - a. The facility Administrator will track compliance of new admission information on the facility Dashboard
 - b. The administrator will submit the facility dashboard to the Quality Assurance Committee. The Quality Assurance Committee will review and make recommendations as necessary.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185428	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/20/2014
NAME OF PROVIDER OR SUPPLIER CLARK REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY STATE, ZIP CODE 175 HOSPITAL DRIVE WINCHESTER, KY 40391		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 492	Continued From page 23 behaviors ensuring the facility provides quality services to all patients, regardless of HIV status. The findings include. Review of the Checklist for Compliance with KRS 214.620 (4) HIV/AIDS Patient Information revealed information provided by each facility must include methods of transmission, methods of prevention, and appropriate attitudes and behaviors to ensure the facility provides quality services to all patients, regardless of HIV status Review of the facility's information provided to the residents on admission, "HIV: Know the Risks, Get the Facts", Administration on Aging, undated, addressed methods of transmission; however, there was no documented evidence the information contained methods of transmission to include; the infected mother may pass HIV to the unborn child, receiving contaminated blood or blood products organ/tissue transplants, and artificial insemination. In addition, the facility's information included methods of prevention, however, there was no documented evidence the information contained methods of prevention to include, no sexual intercourse except with a monogamous partner who was not infected, and should be tested for HIV if pregnant or plan to be pregnant. Also, the facility's information did not address appropriate attitudes and behaviors to ensure the facility provides quality services to all patients, regardless of HIV status. Interview with the Administrator on 11/20/14 at 1:30 PM, revealed the HIV information which was	F 492			

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NAME OF PROVIDER OR SUPPLIER CLARK REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 175 HOSPITAL DRIVE WINCHESTER, KY 40391
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F 492	Continued From page 24 included in the admissions packet needed to be updated to include all methods of transmission and prevention and needed to address appropriate attitudes and behaviors regardless of HIV status	F 482		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185428	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - CLARK REGIONAL MED CENTER NF B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2014
NAME OF PROVIDER OR SUPPLIER CLARK REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 175 HOSPITAL DRIVE WINCHESTER, KY 40391	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR §483.70
Building: 01

Survey under: NFPA 101 (2000 Edition) New Health Care

Plan approval: 01/17/2011

Facility type: Hospital

Smoke Compartments: Eight (8)

Type of structure: One (1) story Type II (222)

Fire Alarm: Complete Fire Alarm installed new

Sprinkler System: Complete sprinkler system (wet) installed new.

Generator: Two (Type 1) Diesel

A Life Safety Code Survey was conducted on 11/18/14. The facility was found to meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70. The census the day of the survey was twenty-two (22). The facility is licensed for twenty-five (25) beds

DEC 18 2014

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

[Signature]
C. M. NEMAS

TITLE

ADMINISTRATOR

(X6) DATE

12/18/14

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.