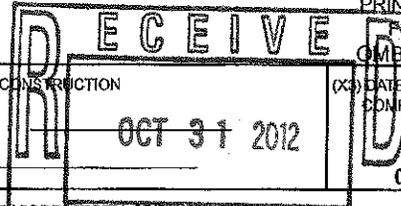


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION	STREET ADDRESS Division of Health Care 68 CALLEBORN Enforcement Branch PINE KNOT, KY 42635
--	---

(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 A standard health survey was conducted on 09/04-06/12. Deficient practice was identified with the highest scope and severity at 'E' level. An abbreviated standard survey (KY18989) was also conducted at this time. The complaint was substantiated with deficient practice identified.	F 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it required by Federal and State law.	
F 225 SS-D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	Allegations from resident #13 were called to Adult Protective Services on 8/27/12 by the Administrator and investigated by the survey team on 9/06/12. It was determined by the Administrator after interviewing involved staff that no other resident was adversely affected by CNA #5 working on 8/26/12. The director of Social Services spoke with all interviewable residents to determine if any incidents of abuse had occurred. All non interviewable residents received a skin assessment to identify any potential abuse. DON reviewed 24 hour report for past 3 months prior to alleged incident in attempt to identify any behavior that would signify potential abuse or any complaints voiced. The 5 day report was filed on 8/30/12 by the Administrator.	11/4/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 10/31/12
---	----------------------------	---------------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the 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: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure alleged violations involving mistreatment and abuse were immediately reported to the Administrator of the facility for one of fifteen sampled residents (Resident #13). In addition, the facility failed to ensure further potential abuse did not occur during the investigation process. Interviews revealed the facility allowed an alleged perpetrator to continue to provide direct resident care after the facility had received an allegation of abuse and prior to the completion of the investigation.</p> <p>The findings include:</p> <p>A review of the facility policy/procedure titled "Abuse Prohibition," dated August 2010, revealed the Administrator and the Director of Nursing were to be notified immediately by the charge person who initially received a report of abuse. Further review of the policy revealed any individual suspected of causing abuse would be removed from direct patient care and reassigned non-patient care duties or suspended from duty</p>	F 225	<p>Administrator/DON reviewed all abuse allegations for past 6 months to ensure all components of abuse policy had been followed.</p> <p>In services were provided on 8/28/12 and 8/29/12, and again on 10/31/12 and 11/01/12 to staff by the Administrator/DON/Department Heads on the facility abuse policy, including the definition of abuse, what constitutes an allegation of abuse, how and to whom to report an allegation of abuse, and the investigation process with an allegation of abuse. Staff were also re-educated on the 24 hour report and the use of the report to document any incidents occurring during the shift. The in-service will be repeated monthly for 3 months then no less than annually. All newly hired employees will be in-serviced during the orientation process by the DON.</p> <p>RN #2 was re-educated on her responsibilities by the DON including the need to immediately notify Administrator/DON of allegations of abuse.</p> <p>All allegations will be investigated by the Administrator/DON</p>		

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635
--	--

(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 225	<p>Continued From page 2</p> <p>until an investigation was completed and an administrative decision was made by the Administrator. According to the policy, events that should be reported and that would be investigated included any act of mistreatment, witnessed verbally or physically abusive incidents, and verbal reports/complaints by residents.</p> <p>A record review conducted for Resident #13 revealed the resident was assessed by the facility to be alert and oriented. A review of the most recent Minimum Data Set (MDS) assessment for Resident #13, dated 08/20/12, revealed the facility assessed Resident #13's interviewable status as "13-15" on the Brief Interview for Mental Status (BIMS), a tool to assess a resident's cognition/interview status. Based on the BIMS report, the resident had been identified as interviewable.</p> <p>An interview conducted with Resident #13 on 09/06/12 at 10:15 AM, revealed the resident had reported to Registered Nurse (RN) #2 that Certified Nurse Aide (CNA) #5 had been "mean" to him/her when the CNA assisted the resident with a shower on 08/25/12. According to Resident #3, CNA #5 was rough with the resident while bathing him/her and when the CNA used a hair dryer to dry the resident's hair she held the hair dryer in one place too long.</p> <p>An interview conducted with CNA #5 on 09/06/12 at 12:55 PM, confirmed the CNA had bathed Resident #13 on 08/25/12. According to CNA #5, Resident #13 had complained about the water being too hot, the CNA adjusted the water, and then the resident complained the water was too cold. According to CNA #5, Resident #13 had</p>	F 225	<p>Upon receiving initial complaint Vice President of Clinical Services or corporate clinical consultant will be contacted to ensure compliance.</p> <p>An Allegation/Abuse Log will be maintained in the Administrators office where a copy of the completed form will be logged.</p> <p>Beginning 11/1/12 and ending 11/3/12 DON/Administrator/Department Heads will interview all staff to determine their understanding of the Abuse Policy, the definition of Abuse, what constitutes an allegation of abuse, how and to whom to report an allegation of abuse, and the investigation process related to an allegation of abuse. Any misunderstanding of the policy will be clarified during the interview process. Beginning 11/1/12 the Director of Social Services will include in her quarterly interviews with all residents/responsible party a question as to if there have been any incidents or complaints voiced by the resident to the staff related to abuse or neglect and if the response is affirmative this will be reported to the Administrator for follow up which will include a review of the Allegation/Abuse Log to ensure all allegations were reported and investigated as per facility policy. Director of Social of Services will report findings no less than quarterly to the facility QA Committee.</p>	

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MC CREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD PINE KNOT, KY 42635	
(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 225	<p>Continued From page 3</p> <p>complained to the nurses that she had been "mean" to the resident. Additional interview with CNA #5 revealed RN #2 had talked to her about the incident on 08/25/12 and she had been allowed to provide resident care the next day. However, CNA #5 stated she was informed by the facility on 08/29/12 that she could not return to work; four days after the allegation had been reported to the facility by Resident #13.</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 09/06/12 at 10:50 AM, revealed LPN #2 had received a report on the morning of 08/25/12 from CNA #7 that CNA #7 witnessed CNA #5 being hateful to Resident #13. According to LPN #2, she immediately reported this to RN #2.</p> <p>An interview conducted with RN #2 on 09/06/12 at 12:10 PM and 12:23 PM, revealed that she had been made aware of the allegation by LPN #2 on 08/25/12, and went to the resident's room. According to RN #2, Resident #13 was crying and reported that CNA #5 had been verbally mean to the resident by calling the resident a complainer, scrubbing the resident too hard when bathing, and holding the hair dryer in one place while drying the resident's hair. Additional interview revealed the RN had assessed the resident and found no evidence of physical abuse and the resident's head was still wet and had not completely dried with no signs of burns. According to RN #2, she did not consider the report by the resident an allegation of abuse but considered the incident a personality conflict between CNA #5 and Resident #13. RN #2 acknowledged she had not contacted the Administrator or the Director of Nursing (DON) to inform them of the resident's complaint; it was a</p>	F 225	<p>Beginning 11/1/12 the Administrator will discuss the facility Abuse Policy with the Resident Council monthly for 3 months then quarterly for 3 quarters to solicit information regarding any allegations of abuse to determine if any allegations have been reported to staff that were not reported to Administrator as per facility policy. The Administrator will report any findings no less than quarterly to the facility QA Committee.</p> <p>Beginning 11/1/12 DON will review 24 hour reports to identify any incidents reported that may constitute Abuse or Neglect and will review the Allegation/Abuse Log to ensure all allegations had been reported as per the facility policy. These findings will be reported no less than quarterly to the facility QA Committee.</p> <p>DON/Corporate Consultant to review all reports of suspected abuse and injuries of unknown origin monthly to ensure the abuse prohibition is followed, if indicated. Results of these reviews will be presented to the QA Committee no less than quarterly to ensure all complaints of abuse policy are followed including appropriate notifications, protection of residents, investigations and reporting.</p>	

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635	
(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 225	Continued From page 4 Saturday and the DON was not at the facility. RN #2 had left a note under the DON's office door regarding the incident. An interview conducted with the Administrator on 09/06/12 at 1:20 PM, revealed the Administrator was made aware of the allegation by the DON on 08/27/12, two days after the alleged incident. According to the Administrator, an investigation was started, the required state agencies were notified, and CNA #5 was suspended. Additional interview revealed the allegation of abuse could not be substantiated by the facility. However, the Administrator stated CNA #5's behavior was inappropriate with Resident #13 and CNA #5 was terminated on 08/29/12.	F 225		
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.	F 280	Care Plan for resident #3 was updated on 9/5/12 by MDS Coordinator to reflect residents' current intervention 9/10/12 MDS Coordinator/DON reviewed all resident care plans/nurse aide profiles to ensure all appropriate interventions were in place. 9/10/12 MDS Coordinator/DON made rounds to ensure all interventions were being implemented according to the care plan/nurse aide profiles. 9/17/12 DON in-serviced all licensed nurses on updating care plans and monitoring that care plans are implemented.	9/18/12

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635	
(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 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure the comprehensive plan of care for one fifteen sampled residents (Resident #3) had been revised/updated to reflect the resident's needs. Resident #3 had sustained a fall on 08/18/12 with no injuries. A review of the fall investigation for Resident #3 revealed the facility documented a chair alarm would be placed on the chair when the resident was sitting. However, a review of the resident's comprehensive plan of care revealed a chair alarm had not been added to the care plan, and there was no evidence a chair alarm had been placed on the resident's chair. In addition, the resident sustained another fall on 08/19/12 from the wheelchair with no injuries. The findings include: A review of the facility's policy titled "Care Plan Interdisciplinary Team Meetings Policy and Procedures," with a revision date of March 2009, revealed the facility would develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. A review of the facility's policy titled "Falls	F 280	9/17/12 DON/MDS Coordinator will audit each resident care plan IX week for 1 month then IX monthly X3 months to verify that all appropriate interventions are on resident care plans/nurse aide profiles. After 3 months, DON/MDS Coordinator will perform 10 care plans/nurse aide profile audits and resident observations monthly to ensure compliance. These will be presented to the Quality Assurance committee quarterly to ensure sustained compliance.	

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE-KNOT, KY 42635		
(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 6</p> <p>Management," dated 01/01/10, revealed staff was to review the current plan of care and revise or develop a plan of care to reduce the likelihood that the fall will reoccur and/or minimize the risk of injury related to a fall.</p> <p>A review of the medical record for Resident #3 revealed the facility admitted the resident on 08/10/12, with diagnoses that included Left Hip Fracture with Repair, Hypertension, Carotid Artery Disease, and Dementia. A review of the Admission Minimum Data Set (MDS) dated 08/17/12 revealed the facility had assessed the resident to require the extensive assistance of two persons for all transfers.</p> <p>A review of a fall investigation for Resident #3, dated 08/18/12 at 2:00 PM, revealed the resident sustained a fall, without injury, when he/she attempted to transfer from the wheelchair to the bed. The fall investigation revealed a chair and bed alarm would be utilized when the resident was sitting in a chair/wheelchair.</p> <p>A review of a fall investigation for Resident #3, dated 08/19/12 at 8:20 PM, revealed the resident fell from his/her wheelchair while attempting to place trash in the trash container and sustained no injuries. The fall investigation revealed the resident had not been using a bed alarm at the time because the resident was not in bed and a chair alarm had not been checked as being in use.</p> <p>A review of the comprehensive care plan for Resident #3, dated 08/22/12, revealed approaches identified to prevent falls included a bed alarm, keeping the bed in the lowest position,</p>	F 280			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 7</p> <p>non-skid footwear while out of bed, scheduled toileting to assist to the bathroom or bedpan every three hours, and that the resident would use a wheelchair to navigate throughout the facility. Continued review of the care plan revealed no evidence staff had included the use of a chair alarm as an intervention as indicated on the fall investigation completed on 08/18/12 after the resident sustained a fall.</p> <p>Observation of Resident #3 on 09/04/12 at 12:20 PM, 12:50 PM, 1:55 PM, 3:00 PM, 4:10 PM, and 5:15 PM, and on 09/05/12 at 10:30 AM and 12:00 PM, revealed the resident was sitting in a wheelchair and there was no alarm on the resident's wheelchair.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #2 on 09/06/12 at 9:30 PM, revealed she was responsible for Resident #3's care on 08/18/12 when the resident sustained a fall. The LPN stated she was responsible for placing the new interventions on the care plan after the resident had fallen. The LPN stated she had just forgotten to place the chair alarm on the care plan and should have.</p> <p>An interview conducted with the MDS Coordinator on 09/05/12 at 3:45 PM, revealed she had been responsible for completing the comprehensive care plan for Resident #3. According to the MDS Coordinator, when a resident was admitted to the facility the nurse conducting the admission was also required to begin the interim care plan. Continued interview revealed if a resident experienced a change in condition, such as a fall, the nurse providing care for the resident at the time was required to add an intervention to the</p>	F 280			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635	
(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 8 care plan. The MDS Coordinator also stated Resident #3 should have had an intervention for a chair alarm on the care plan and it had just been missed. An interview conducted on 09/06/12 at 12:30 PM, with the Director of Nursing (DON) revealed the DON had reviewed the fall investigation for Resident #3 but failed to ensure the care plan had been revised/updated. An interview conducted on 09/06/12 at 12:30 PM, with the DON revealed the DON had reviewed the fall investigation for Resident #3 but failed to ensure the care plan had been revised/updated.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and a review of manufacturer's guidelines, it was determined the facility failed to ensure services were provided in accordance with the plan of care for two of fifteen sampled residents (Resident #5 and Resident #7). Resident #5 had a care plan intervention to have a bed alarm attached to the resident to alert staff if the resident attempted to rise unassisted in an effort to prevent falls; however, on 09/04/12	F 282		

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD PINE KNOT, KY 42635		
(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 282	<p>Continued From page 9</p> <p>and 09/05/12, the resident was observed to be lying in bed and the bed alarm was not attached to the bed. Resident #7 had a care plan intervention to have fall mats at the resident's bedside when the resident was in bed; however, on 09/04/12 and 09/05/12, Resident #7 was observed in bed and fall mats were not in place at the resident's bedside. Resident #7 also had a care plan intervention to place the resident back in bed after breakfast. However, on 09/04/12 and 09/05/12, the resident was not placed in bed after breakfast.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Falls Management," dated 01/01/10, revealed staff was to complete a falls risk assessment upon admission, readmission, and quarterly, and with any significant change. Upon completion of the assessment, a plan would be developed to address any risk factors identified.</p> <p>A review of the facility's policy titled "Pressure Ulcers," dated 01/01/09, revealed it was the practice of the facility to assess each resident for the risk of developing pressure ulcers, identifying risk factors, and to provide care and services to reduce the risk of developing pressure ulcers.</p> <p>A review of the Personal Sentry Fall Monitoring System's manufacturer's guidelines revealed the monitor was designed to sound an alarm when a resident exceeded his/her safe range of movement from a wheelchair, chair, or bed. The guidelines also revealed the monitor base was to be mounted to either a chair or bed, using the clip on the back of the monitor or using the optional</p>	F 282	<p>9/5/12 resident #5 bed alarm was removed and care plan updated by care plan committee.</p> <p>9/5/12 resident # 7 fall mats were removed and care plan updated by care plan committee.</p> <p>9/10/12 MDS Coordinator/DON reviewed all resident care plans to ensure all appropriate interventions were in place.</p> <p>9/17/12 DON in-serviced all licensed nurses on following care plan process</p> <p>9/17/12 Administrator/DON/designee will round 1X week X30 days then 1X monthly X3 months to ensure appropriate care plan interventions are in place.</p> <p>After 3 months, DON/MDS Coordinator will perform 10 care plans/nurse aide profile audits and resident observations monthly to ensure compliance.</p> <p>These will be presented to the Quality Assurance committee quarterly to ensure sustained compliance.</p>	9/18/12	

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 282	<p>Continued From page 10</p> <p>universal mounting bracket or chair strap, and attached to the resident's clothing with a string.</p> <p>1. A review of the medical record for Resident #5 revealed the facility admitted the resident on 09/01/09 with diagnoses including Dementia, Hypertension, Delirium, Psychosis, and Depression.</p> <p>A review of the comprehensive care plan for Resident #5 with a review date of 06/27/12 revealed the resident had an intervention for a bed alarm to prevent falls.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment dated 07/13/12 revealed the facility had assessed the resident to require the total assistance of two persons for bed mobility and for all transfers. A review of a fall risk assessment dated 07/13/12 revealed the resident had been assessed by the facility to be at risk for falls.</p> <p>Observation of Resident #5 on 09/04/12 at 11:55 AM, 12:25 PM, and 1:50 PM, and on 09/05/12 at 9:45 AM, revealed the resident to be in bed with a personal alarm attached to the clothing on the resident's left shoulder and the base lying on the bed and not attached to the bed.</p> <p>An interview conducted with State Registered Nursing Assistant (SRNA) #3 on 09/05/12 at 1:30 PM, revealed both she and SRNA #4 were responsible for the care of Resident #5 on 09/04/12 and 09/05/12. The SRNA stated Resident #5 was required to have a bed alarm because the resident was at risk for falls. The SRNA stated she had placed the personal alarm</p>	F 282			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 282	<p>Continued From page 11</p> <p>in bed with the resident because the alarm sounded whenever the resident turned over. The SRNA stated she could not recall attending an in-service on personal alarms and how to properly attach them. The SRNA stated she was required to check the care plan at the beginning of every shift to learn the care needs of the resident.</p> <p>An interview conducted with SRNA #4 on 09/05/12 at 2:10 PM, revealed the SRNA was responsible for the care of Resident #5 along with SRNA #3 on 09/04/12 and 09/05/12. The SRNA also revealed the alarm had been placed in bed with the resident because it would sound if the resident turned over in bed. The SRNA stated she could not recall attending an in-service related to personal alarms and how to properly attach them. The SRNA stated she was required to check the care plan at the beginning of every shift to locate the care needs of the resident.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 09/05/12 at 1:50 PM, revealed she was responsible for the care of Resident #5 on 09/04/12 and 09/05/12, and stated she made rounds every two hours to ensure the residents received the care they required. The LPN stated the staff was required to check the care plan at the beginning of every shift to identify the care needs required by the residents. The LPN stated personal bed alarm bases were to be attached to the bed with a clip. The LPN stated she had not observed that Resident #5's personal alarm base was not attached to the bed and stated it should have been.</p> <p>An interview conducted the Director of Nursing</p>	F 282			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 282	<p>Continued From page 12</p> <p>(DON) on 09/06/12 at 12:30 PM, revealed the DON makes rounds every day to ensure residents are getting the care they require. The DON also revealed nurses were required to make rounds every two hours to monitor the residents' care. The DON stated all personal bed alarms were required to be attached to the bed with the clip. The DON stated she had not identified any issues regarding personal alarms not being attached properly.</p> <p>2. A review of the medical record for Resident #7 revealed the facility admitted the resident on 03/09/06 with diagnoses including Alzheimer's, Senile Dementia, and Cerebral Artery Occlusion. A review of the Significant Change Minimum Data Set (MDS) assessment dated 07/23/12 revealed the resident was assessed by the facility to have severely impaired cognition and to require the total assistance of two persons with bed mobility and all transfers. The MDS also revealed the facility had assessed the resident to be at risk for skin breakdown. A review of a skin assessment for Resident #7 dated 09/03/12 revealed the resident had been assessed to have no skin breakdown.</p> <p>A review of the comprehensive care plan for Resident #7, with a revision date of 08/12/12, revealed the resident had been assessed by the facility to be at risk for falls. The care plan also revealed an intervention for fall mats to be at the resident's bedside. In addition, staff assessed Resident #7 to be at risk for skin breakdown. The care plan revealed an intervention for the resident to return to his/her bed after breakfast.</p> <p>Observation of Resident #7 on 09/04/12 at 10:50</p>	F 282			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNDT, KY 42635		
(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 282	<p>Continued From page 13</p> <p>AM, 12:25 PM, 12:55 PM, and 2:00 PM, revealed the resident to be up in a high-back wheelchair with a waist restraint in place, and at 2:50 PM, 4:00 PM, 4:55 PM, and 5:15 PM, the resident was observed lying in bed but there were no fall mats observed lying by the resident's bed.</p> <p>Additional observations of Resident #7 on 09/05/12 at 9:40 AM and 10:00 AM, revealed the resident to be up in a high-back wheelchair with a waist restraint in place, and at 11:00 AM and 11:55 AM, the resident was observed lying in bed but there were no fall mats beside the resident's bed.</p> <p>Observation of a skin assessment of Resident #7 completed by LPN #1 on 09/05/12 at 10:10 AM, revealed the resident was observed to have a Stage II pressure sore area to the coccyx measuring 1.0 centimeter in length and 0.5 centimeter in width.</p> <p>An interview conducted with SRNA #3 on 09/05/12 at 1:30 PM, revealed both she and SRNA #4 were responsible for the care of Resident #7 on 09/04/12 and 09/05/12. The SRNA stated Resident #7 used to have fall mats but had not had them in a "long" time. The SRNA stated she was required to check the care plan at the beginning of every shift to identify the care needs of the resident. The SRNA also revealed Resident #7 was required to be turned and repositioned by staff every two hours. The SRNA also revealed she was aware the resident was required to return to his/her bed after breakfast. The SRNA stated if there were activities going on they would leave the resident up after breakfast.</p>	F 282			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION).	ID PREFIX TAG	PROMIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 14</p> <p>An interview conducted with SRNA #4 on 09/05/12 at 2:10 PM, revealed the SRNA was responsible for the care of Resident #7 along with SRNA #3 on 09/04/12 and 09/05/12. The SRNA also revealed Resident #7 used to have fall mats but has not had them in quite some time. The SRNA stated she was required to check the care plan at the beginning of every shift to locate the care needs of the resident. The SRNA also stated they got the resident up at around 6:30 AM for breakfast and she realized the resident should have been placed in his/her bed by 9:00 AM. The SRNA stated on 09/04/12 the resident had been up after breakfast because of activities as well.</p> <p>An interview conducted with LPN #1 on 09/05/12 at 1:50 PM, revealed she was responsible for the care of Resident #7 on 09/04/12 and 09/05/12, and she made rounds every two hours to ensure the residents received the care they required. The LPN stated the staff was required to check the care plan at the beginning of every shift to locate the care needs required by the residents. The LPN stated Resident #7 had not had fall mats in a while and was unsure when the fall mats had been removed. The LPN stated she had not been aware fall mats had still been listed as an intervention on Resident #7's care plan. The LPN also stated she had not been aware the SRNAs had not placed the resident back in bed after breakfast on either day. The LPN stated she had been busy and nervous.</p> <p>An interview conducted with the DON on 09/06/12 at 12:30 PM, revealed she made rounds every day to ensure residents received the care they required. The DON also revealed nurses were required to make rounds every two hours to</p>	F 282			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD PINE KNOT, KY 42635		
(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 282	Continued From page 15 monitor the residents' care. The DON stated she reviewed all resident care plans at least every three months during the care plan meeting. The DON also stated Resident #7 should have been placed back in his/her bed after breakfast.	F 282			
F 314 SS=D	An interview with the Administrator on 09/06/12 at 2:00 PM, revealed he had removed the fall mats from Resident #7 "a couple of months" ago during an investigation of an employee fall because he felt the resident did not require the fall mat. The Administrator stated he had failed to notify the DON of the removal of the fall mats. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 a review of facility policy, it was determined the facility failed to ensure one of fifteen sampled residents (Resident #7) received necessary treatment/services to promote healing or to prevent the development of new pressures sores. Resident #7 was assessed to be at risk for the development of pressure sores and had a care plan intervention to be returned to bed after	F 314	Resident # 7 care plan was reviewed and revised by the care plan committee on 9/5/12 to reflect current interventions in place related to resident skin breakdown. On 9/11/12 residents stage II pressure sore was healed with continued use of pressure relieving foam mattress for pressure relieve prevention. Effective 9/10/12, DON/MDS Coordinator reviewed all residents Pressure Ulcer Risk Screens/resident care plans/nurse aide profiles to ensure appropriate pressure relief interventions are in place and being followed for each resident. On 9/17/12, all nursing staff was in-serviced regarding reviewing and following Residents Plan of Care prior to beginning shift by DON.	9/18/12	

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 314	<p>Continued From page 16</p> <p>breakfast; however, staff failed to place the resident back in his/her bed after breakfast on 09/04/12 and 09/05/12, in accordance with the resident's comprehensive plan of care in an effort to prevent the development of pressure sores. A skin assessment conducted on 09/05/12 at 10:10 AM, revealed the resident had a Stage II pressure sore to the coccyx.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Pressure Ulcers," dated 01/01/09, revealed it was the practice of the facility to assess each resident for the risk of developing pressure ulcers, identifying risk factors, and to provide care and services to reduce the risk of developing pressure ulcers.</p> <p>A review of the medical record for Resident #7 revealed the facility admitted the resident on 03/09/06 with diagnoses including Alzheimer's, Senile Dementia, and Cerebral Artery Occlusion. A review of a Significant Change Minimum Data Set (MDS) assessment dated 07/23/12 revealed the resident was assessed by the facility to have severely impaired cognition and required the total assistance of two persons with bed mobility and all transfers. The MDS also revealed the facility had assessed the resident to be at risk for skin breakdown.</p> <p>A review of the comprehensive care plan for Resident #7, with a revision date of 08/12/12, revealed the facility assessed the resident to be at risk for skin breakdown. The care plan revealed an intervention for staff to assist the resident to his/her bed after breakfast.</p>	F 314	<p>DON/MDS Coordinator/Designee will round X30 days and then weekly X3 months to ensure residents at risk by Pressure Ulcer Risk Screens are being treated per plan developed from screen forming.</p> <p>After 3 months, DON/MDS Coordinator will perform 10 care plans/nurse aide profile audits and resident observations monthly to ensure compliance.</p> <p>These will be presented to the Quality Assurance committee quarterly to ensure sustained compliance.</p>		

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD PINE KNOT, KY 42635		
(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 314	<p>Continued From page 17</p> <p>Continued review of the medical record revealed staff conducted a skin assessment of Resident #7 dated 09/03/12 and noted the resident had no skin breakdown.</p> <p>Observation of Resident #7 on 09/04/12 at 10:50 AM, 12:25 PM, 12:55 PM, and 2:00 PM, and on 09/05/12 at 9:40 AM and 10:00 AM, revealed the resident was sitting in a high-back wheelchair with a waist restraint in place.</p> <p>Observation of a skin assessment of Resident #7 completed by LPN #1 on 09/05/12 at 10:10 AM, revealed the resident had a Stage II pressure sore to the coccyx. Staff was observed to measure Resident #7's Stage II pressure sore and noted the area measured 1.0 centimeter in length and 0.5 centimeter in width.</p> <p>An interview conducted with SRNA #3 on 09/05/12 at 1:30 PM, revealed both she and SRNA #4 were responsible for the care of Resident #7 on 09/04/12 and 09/05/12. The SRNA stated she was required to check the care plan at the beginning of every shift to locate the care needs of the resident. The SRNA revealed Resident #7 was required to be turned and repositioned by staff every two hours, and that staff was required to return the resident to his/her bed after breakfast. The SRNA stated if there were activities going on they would leave the resident up after breakfast. The SRNA stated she had not observed any skin breakdown when she had gotten the resident out of bed on 09/05/12 and revealed if she had she would have reported it to the nurse.</p> <p>An interview conducted with SRNA #4 on</p>	F 314			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 314	<p>Continued From page 18</p> <p>09/05/12 at 2:10 PM, revealed the SRNA was responsible for the care of Resident #7 along with SRNA #3 on 09/04/12 and 09/05/12. The SRNA stated she was required to check the care plan at the beginning of every shift to locate the care needs of the resident. The SRNA stated they got the resident up at around 6:30 AM for breakfast and she realized the resident should have been placed in his/her bed by 9:00 AM. The SRNA stated on 09/04/12 the resident had been up after breakfast because of activities as well. The SRNA revealed she had not observed any skin breakdown on Resident #7 when she assisted the resident out of bed and revealed if she had she would have notified the nurse.</p> <p>An interview conducted with LPN #1 on 09/05/12 at 1:50 PM, revealed she was responsible for the care of Resident #7 on 09/04/12 and 09/05/12, and that she made rounds every two hours to ensure the residents received the care they required. The LPN stated the staff was required to check the care plan at the beginning of every shift to locate the care needs required by the residents. The LPN stated she had not been aware the SRNAs had not placed the resident back in bed after breakfast on either day. The LPN stated she had been busy and nervous. The LPN stated she had not been notified of Resident #7 having any skin breakdown.</p> <p>An interview conducted with the DON on 09/06/12 at 12:30 PM, revealed she made rounds every day to ensure residents received the care they required. The DON also revealed nurses were required to make rounds every two hours to monitor each resident's care. The DON stated Resident #7 should have been placed back in</p>	F 314			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 314 F 323 SS=D	Continued From page 19 his/her bed after breakfast. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards 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, record review, facility policy/procedure review, and a review of the manufacturer's guidelines, it was determined the facility failed to ensure one of fifteen sampled residents (Resident #3) received appropriate assistive devices to prevent accidents. The facility failed to follow manufacturer's guidelines related to applying a bed alarm for Resident #3. Resident #3 had a care plan intervention for a bed alarm to prevent falls, however, observations conducted on 09/04/12 and 09/05/12 revealed the bed alarm pull string was clipped to the resident's clothing but the bed alarm base was unattached and lying on the resident's bed. A review of the manufacturer's guidelines revealed the alarm was to be attached to the bed. The findings include: A review of the facility's policy titled "Falls Management," dated 01/01/10, revealed staff was to complete a falls risk assessment upon	F 314 F 323	Resident #3 assessed on 9/07/12 by care plan committee to determine continued need for bed alarm. Bed alarm was discharged. On 9/10/12, DON/MDS Coordinator reviewed all residents having been assessed and needing personal safety alarms. All residents that were assessed for having needed alarm were reviewed to ensure manufacture guidelines for personal safety alarms were followed. On 9/17/12, all staff was in-serviced to ensure knowledge of manufacture guidelines and personal safety alarms. Administrator/DON will round 1X week for 1 month and then 1X a month for 3 months to ensure manufacture guidelines for personal safety alarms are followed. After 3 months, DON/MDS Coordinator will perform 5 care plans/nurse aide profile audits and resident observations monthly to ensure compliance. These will be presented to the Quality Assurance committee quarterly to ensure sustained compliance.	9/18/12	

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD PINE KNOT, KY 42635		
(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 20</p> <p>admission, readmission, and quarterly, and with any significant change. Upon completion of the assessment a plan would be developed to address any risk factors identified.</p> <p>A review of the Personal Sentry Fall Monitoring System's manufacturer's guidelines revealed the monitor was designed to sound an alarm when a resident exceeded his/her safe range of movement from a wheelchair, chair, or bed. The guidelines also revealed the monitor was to be mounted to either a chair or bed using the clip on the back of the monitor or using the optional universal mounting bracket or chair strap.</p> <p>A review of the medical record for Resident #5 revealed the facility admitted the resident on 09/01/09 with diagnoses including Dementia, Hypertension, Delirium, Psychosis, and Depression.</p> <p>A review of the comprehensive care plan for Resident #5, with a review date of 06/27/12, revealed the resident had an intervention for a bed alarm to prevent falls.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 07/13/12, revealed the facility had assessed the resident to require the total assistance of two persons for bed mobility and for all transfers. A review of a fall risk assessment, dated 07/13/12, revealed the resident had been assessed by the facility to be at risk for falls.</p> <p>An observation of Resident #5 on 09/04/12 at 11:55 AM, 12:25 PM, and 1:50 PM, revealed the resident lying in bed with a personal alarm</p>	F 323			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 21</p> <p>attached to the clothing on the resident's left shoulder and the monitor base was lying on the bed, beside the resident's pillow, and was not attached to the bed.</p> <p>Additional observation of Resident #5 on 09/05/12 at 9:45 AM, revealed the resident lying in bed with a personal alarm attached to the clothing on the resident's left shoulder; the bed alarm base was observed lying, unattached, on the bed.</p> <p>An interview conducted with SRNA #3 on 09/05/12 at 1:30 PM, revealed both she and SRNA #4 were responsible for the care of Resident #5 on 09/04/12 and 09/05/12. The SRNA stated she was required to check the care plan at the beginning of every shift to locate the care needs of the resident and that staff was required to have a bed alarm on the bed of Resident #5 due to the resident's risk for falls. The SRNA stated she had placed the personal alarm in bed with the resident and stated the alarm sounded whenever the resident repositioned in bed. The SRNA stated she could not recall attending an in-service on personal alarms or how to properly attach them.</p> <p>An interview conducted with SRNA #4 on 09/05/12, at 2:10 PM, revealed the SRNA was responsible for the care for Resident #5 along with SRNA #3 on 09/04/12 and 09/05/12. The SRNA also revealed the alarm had been placed in bed with the resident because it would alarm if the resident turned over in the bed. The SRNA stated she could not recall attending an in-service related to personal alarms and how to properly attach them. The SRNA also stated she was required to check the care plan at the beginning</p>	F 323			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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 22 of every shift to locate the care needs of the resident. An interview conducted with LPN #1 on 09/05/12 at 1:50 PM, revealed she was responsible for the care of Resident #5 on 09/04/12 and 09/05/12, and she made rounds every two hours to ensure the residents received the care they required. The LPN stated the staff was required to check the care plan at the beginning of every shift to locate the care needs required by the residents. The LPN stated personal alarms were to be attached to the bed with a clip. The LPN stated she had not identified that Resident #5's alarm was not attached to the bed and stated it should have been. An interview conducted with the DON on 09/06/12 at 12:30 PM, revealed the DON made rounds every day to ensure residents received the care they required. The DON also revealed nurses were required to make rounds every two hours to monitor each resident's care. The DON stated all personal bed alarms were required to be attached to the bed with the clip. The DON stated she had not identified any issues regarding personal alarms not being attached properly.	F 323			
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 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
(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	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy/procedure it was determined the facility failed to ensure the Dietary Department was maintained to ensure food for resident consumption was prepared under sanitary conditions. The range, deep fryer, and convection oven were observed during the survey to have a buildup of grease and food particles. The findings include: Review of the facility policy/procedure, "Environmental Sanitation/Infection Control," dated 2006, revealed all food service workers would be trained in the proper cleaning schedules and routines. The policy/procedure stated staff was to follow the cleaning schedule forms. Review of the cleaning schedule forms revealed the range hood, deep fat fryer, and ovens were to be cleaned weekly. Observation on 09/04/12 at 4:00 PM, revealed the side of the range adjacent to the deep fat fryer had a buildup of grease down the side with food particles adhered to the surface. The soiled area was approximately two feet long and two feet in width. The side of the deep fat fryer adjacent to the range had a buildup of grease and food particles on the side of the fryer surface. The side of the convection oven adjacent to the deep fat fryer had a buildup of grease and food particles on the side surface of the convection oven.	F 371	No residents were identified. Effective 9/17/12, Administrator/Dietary Manager will round and review the cleaning schedule 1X a week X12 weeks. On 9/14/12 all dietary staff was re-educated by Dietary Manger regarding the cleaning schedule. On 9/07/12 the range, deep fat fryer, and convection oven were cleaned and inspected by the Dietary Manger. On 9/25/12 a Dietary sanitation check list was completed by the Dietary Consultant. The Administrator/Dietary Consultant will audit the cleaning schedule on a weekly basis with the results being reported at Quality Assurance meetings X6 months.		9/26/12

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

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/06/2012
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD PINE KNOT, KY 42635		
(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 24</p> <p>Review of the August 2012 cleaning schedule for dietary staff revealed cleaning tasks were documented on the schedule with the day of the week to be completed and an area for staff to initial when the task was completed. Review of the cleaning schedule for the week of August 5th to 11th revealed the oven was scheduled to be cleaned on Thursday; however, there were no staff initials to indicate the task had been completed. For the week of August 26th to September 1st, again there were no staff initials to indicate completion of the task.</p> <p>Interview with the Cook on 09/04/12 at 4:20 PM, revealed she was responsible for ensuring the range, convection oven, and deep fat fryer were cleaned weekly. The Cook stated she was unable to thoroughly clean the appliances because they were too close together and she could not pull them out. According to the cook, she would reach as far as she could to clean the sides of the appliances.</p> <p>Interview with Dietary Aide #6 on 09/06/12 at 9:25 AM, revealed she could not reach to the bottom of the range, deep fat fryer, or convection oven to ensure a thorough cleaning. The Dietary Aide stated the appliances were too close together to reach the bottom and back.</p> <p>Interview with the Dietary Manager on 09/04/12 at 4:00 PM, revealed she was unaware staff had not been cleaning between the range, convection oven, and deep fat fryer. According to the Dietary Manager, those appliances were scheduled to be cleaned on a weekly basis.</p>	F 371			

MCCREARY HEALTH AND REHABILITATION

P.O. BOX 810 U.S. 27 HWY. 592

PINE KNOT, KY. 42635

(606) 354-3155

Fax: (606) 354-3260

Addendum Tag F 225

An Allegation/Abuse log will be maintained by the Administrator and kept in the Administrator's office. The purpose of the log is to maintain a list of all allegations and a timeline for reporting, investigating, and the conclusion of the incident. When an allegation of abuse is made the nurse is responsible for reporting the allegation to the Administrator/DON, upon which the Admin/DON will start an investigation, report the allegation to the appropriate agencies, then complete the investigation. Upon completion the allegation will be logged in the Allegation/Abuse log with dates and outcome noted. This log will be used as a QA tool to check that all allegations are reported investigated and concluded per the facility abuse policy.

SH
NHA, MA CCC-SLP
Sam Hutchinson, NHA, MA, CCC-SLP
Administrator

11/19/12

