

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

PRINTED: 10/27/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		<div style="border: 2px solid black; padding: 5px; text-align: center;"> <b>R E C E I V E D</b>              NOV - 2 2011              10/19/2011         </div>		(X3) DATE SURVEY COMPLETED  10/19/2011
NAME OF PROVIDER OR SUPPLIER  HILLCREST HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREEN DRIVE CORBIN, KY 40605 <div style="border: 1px solid black; padding: 2px; font-size: small;">             Division of Health Care Southern Enforcement Branch         </div>				
(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 10/11-13/11. Deficient practice was identified with the highest scope and severity at "E" level.  An abbreviated standard survey (KY16641, KY16820, KY17092, KY17149) was also conducted at this time. KY16820 was substantiated with related deficient practice. KY16641, KY17092, and KY17149 were unsubstantiated with no related deficient practice.	F 000					
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	F 164					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *David M. Jones*, TITLE: Administrator, (X6) DATE: 11-2-11

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

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F 164	<p>Continued From page 1</p> <p>release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident health information was maintained in a private and confidential manner during medication administration. Observation of medication pass on 10/11/11, revealed the Medication Administration Record (MAR) was left open and visible on the medication cart in the hallway for three residents (Residents #24, #25, and #26) and as a result the residents' personal health information on the MAR was exposed to the public and other residents.</p> <p>The findings include:</p> <p>A review of the facility's Resident Rights Statement (no issue date) revealed residents had the right to personal privacy and confidentiality of personal and clinical records.</p> <p>Observation during medication pass on 10/11/11, at 3:15 PM, revealed Licensed Practical Nurse (LPN) #2 entered Resident #24's room to administer medications to the resident. Further observation revealed the MAR located on top of the medication cart in the hallway had been left open and the resident's personal and confidential information was exposed and visible to anyone near the cart.</p> <p>Continued observation of the medication pass</p>	F 164	<p><u>F164</u></p> <p>Submission of this plan of correction does not indicate that a deficiency existed or that a deficiency was cited correctly. This plan of correction is being submitted to ensure continuing compliance with State and Federal regulations.</p> <p>1) The MAR Book for residents #24, 25, and 26 have been updated by the Administrator to include additional privacy dividers which make it easier for the nurses to keep both sides of the MAR book covered during med pass to ensure resident confidentiality. The nurse involved in this incident has received 1:1 counseling and education by the Director of Nursing regarding this incident and does understand the necessity of maintaining resident confidentiality.</p> <p>2) The MAR Books for all other residents have been evaluated by the Administrator and Director of Nursing, and additional privacy tabs also added to those books to make it easier for the nursing staff to maintain the privacy and confidentiality of all residents by being able to easily cover both sides of the MAR book with the flip of a tab.</p>	

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F 164	<p>Continued From page 2</p> <p>revealed LPN #2 prepared Resident #25's medications at 3:30 PM, entered the resident's room, and the medication cart remained in the hall. The LPN failed to ensure confidentiality of the resident's health information located in the MAR while she administered medications to Resident #25.</p> <p>Observation revealed two individuals walked past the medication cart with the MAR open/exposed. In addition, two residents in wheelchairs wheeled past the medication cart while the MAR that contained resident health information was open and in view.</p> <p>Further observation of the evening medication pass revealed LPN #2 prepared six oral medications and two different eye drops for Resident #26. LPN #2 left the medication cart in the hallway with the MAR open and failed to ensure the privacy of the resident's personal and confidential information while she administered the medication and eye drops to Resident #26 in the resident's room.</p> <p>Interview conducted on 10/11/11, at 6:15 PM, revealed LPN #2 had been trained to maintain confidentiality of residents' medical information. The LPN stated she was responsible to cover the MAR during medication administration. LPN #2 stated she was nervous and acknowledged she had left the residents' health information exposed.</p> <p>An interview conducted with the Director of Nurses (DON) on 10/13/11, at 3:15 PM, confirmed facility nurses were responsible to cover resident health information/MARs when giving medications to the residents.</p>	F 164	<p>3) All nursing staff were in-serviced by the Director of Nursing on 10/28/11 to ensure they have a good understanding of privacy and confidentiality, as well as the necessity to keep resident MAR's completely covered any time they leave the medication cart. All nursing staff voiced their understanding of the changes put in place to assist them.</p> <p>4) As part of our CQI Process, the Nursing Clinical Coordinators will perform random medication audits weekly for 3 months, and then monthly thereafter to ensure that resident confidentiality is being maintained during medication pass. Any discrepancies will be addressed with nursing staff and corrected immediately and reported to the CQI committee for review.</p> <p>5) Completion Date: 10/28/11.</p>	
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F 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide care for each resident that promoted the resident's dignity and respect. Observation during the 4:00 PM medication pass on 10/11/11, revealed staff entered a resident's room without knocking on the door to obtain consent to enter the resident's room. Additionally, observation of the evening meal on 10/11/11, revealed two staff persons stood at a resident's bedside while feeding the resident.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Resident's Rights (not dated) revealed residents have the right to Quality of Life, including dignity and respect.</p> <p>1. Observation of a medication pass on 10/11/11, at 3:15 PM, revealed Licensed Practical Nurse (LPN) #2 prepared two medications for Resident #25. LPN #2 entered the resident's room to administer the medications without knocking and obtaining the resident's consent to enter the room.</p>	F 241	<p>F241</p> <p>Submission of this plan of correction does not indicate that a deficiency existed or that a deficiency was cited correctly. This Plan of Correction is being submitted to ensure continuing compliance with State and Federal regulations.</p> <p>1) LPN #2 has apologized to resident #25 &amp; #26 for entering their room without knocking. The nurse has assured this resident that she will respect their privacy by always knocking and asking permission before entering the room. A chair is now available for nurse aides to use in rooms 106 and 109 while feeding so that they will always be at eye level when feeding these residents.</p> <p>2) As all other residents had the potential to be affected by this deficiency, this nurse received 1:1 counseling and education on the importance of always knocking on the door and requesting permission to enter before walking into a resident's room. She voiced her understanding of this. As not all rooms have sitting chairs available to staff for feeding residents, the facility has purchased additional</p>	

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F 241	<p>Continued From page 4</p> <p>Further observation revealed LPN #2 obtained two eye drop medications from the medication cart and prepared six oral medications for Resident #26. LPN #2 entered Resident #26's room carrying the two eye drop medications and the six oral medications in a medicine cup. The LPN failed to knock on the resident's door and obtain the resident's consent to enter the room.</p> <p>Interview on 10/11/11, at 6:15 PM, with LPN #2 revealed the LPN should have knocked on each resident's door to obtain consent and should have waited for a response from the resident before she entered the resident's room. The LPN stated she had her hands full with Resident #26's medications but should have placed the medications on the medication cart and positioned the medication cart at the resident's door to enable her to knock and request consent to enter the room.</p> <p>Interview on 10/13/11, at 3:15 PM, with the Director of Nursing (DON) revealed staff should always knock on the resident's door and request consent to enter the room.</p> <p>2. Observation on 10/11/11, at 6:00 PM, of the evening meal service, revealed Certified Nurse Aide (CNA) #1 delivered a meal tray to an unsampled resident in room 109. Further observation revealed CNA #1 stood at the resident's bedside while she fed the resident the evening meal. CNA #1 failed to sit at eye level of the resident while feeding the resident.</p> <p>Continued observation revealed CNA #2 stood at the bedside of an unsampled resident's bed (room 106) and failed to be at the resident's eye</p>	F 241	<p>folding chairs to leave on the units for the employees to use during meal times. This will assist staff members to maintain resident dignity and respect by always being at eye level with them.</p> <p>3) All facility staff have been in-serviced by the Administrator and Director of Nursing on the importance of maintaining the privacy, dignity, and respect of all residents on a continual basis. This includes knocking on doors and awaiting permission to enter before walking in. They have also been educated on the importance of using the additional chairs which have been purchased for them so that they can always feed the residents at eye level.</p> <p>4) As part of the CQI process, the nursing Clinical Coordinators will perform random weekly medication pass and meal pass audits to ensure that all staff are maintaining the privacy, dignity and respect of all residents prior to walking in, and the importance of feeding at eye level. Any discrepancies will be addressed with staff members and corrected immediately and reported to the CQI committee for follow-up.</p> <p>5) 10/28/11</p>		

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F 241	Continued From page 5 level while she fed the resident a meal.  Interview on 10/11/11, at 6:10 PM, with CNA #1 revealed staff could stand and feed residents or could sit in a chair to feed the resident.  Interview on 10/11/11, at 6:15 PM, with CNA #2 revealed staff could stand while feeding a resident but should never lean over the resident.  Interview with the DON on 10/13/11, at 3:15 PM, revealed staff should be seated in a chair beside the resident, and at the eye level of the resident, when assisting the resident with meals.	F 241			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of a closed record, it was determined the facility failed to meet professional standards of quality by failing to ensure physician's orders were followed for one of twenty-six residents (Resident #23). Review of the Medication Administration Record (MAR) revealed the facility failed to follow the physician's order to obtain Resident #23's blood pressure and heart rate prior to the administration of an antihypertensive medication (Metoprolol).  The findings include:  Interview with Administrator on 10/12/11, at 11:15 AM, revealed the facility did not have a policy	F 281	F281 Submission of this plan of correction does not indicate that a deficiency existed or that a deficiency was cited correctly. This Plan of Correction is being submitted to ensure continuing compliance with State and Federal Regulations.  1) Resident #23 no longer resides at this facility. Resident #23 suffered no ill-effects from this deficiency.  2) All other resident's MAR's have been reviewed by the Director of Nursing and Nurse Clinical Coordinators to ensure that physician's orders are being followed regarding the administration of their ordered medications.		

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F 281	<p>Continued From page 6</p> <p>specific to following physician's orders when administering medication with parameters.</p> <p>Review of the closed medical record revealed Resident #23 was admitted to the facility on 07/22/11, with diagnoses of Hypertension and Acute Respiratory Failure. A review of the admission physician orders, dated 07/22/11, revealed staff was to administer one tablet of 25 milligrams (mg) Metoprolol (antihypertensive) by mouth (po) twice a day to Resident #23. Additionally, the physician's orders directed staff to withhold the Metoprolol medication if Resident #23's systolic blood pressure was less than or equal to 100 mm/hg or if the resident's heart rate was less than or equal to 70 beats per minute.</p> <p>Review of the MAR dated 07/22/11-07/31/11, revealed staff obtained Resident #23's blood pressure but failed to obtain Resident #23's heart rate prior to the administration of the antihypertensive medication. In addition, a review of the MAR for August 2011 revealed staff had not obtained the resident's heart rate and had only obtained the resident's blood pressure prior to the administration of the antihypertensive medication Metoprolol during the month of August 2011. Further review of the MAR revealed on 08/18/11, staff failed to record a blood pressure or a pulse prior to the administration of the evening dose of Metoprolol. Review of the four days the resident remained in the facility in September revealed staff had not obtained the resident's blood pressure and had only obtained Resident #23's heart rate prior to the administration of the antihypertensive medication twice a day.</p>	F 281	<p>3) All nursing staff were in-serviced by the Director of Nursing on Medication Administration and the importance of following physician's orders regarding medication administration, specifically, checking blood pressure and heart rate if called for if a resident is on any antihypertensive medications.</p> <p>4) As part of the CQI process, the nursing Clinical Coordinators and the Director of Nursing will perform random weekly Medication audits for 3 months and then monthly thereafter to ensure that all medications are being administered per physician orders. Any discrepancies will be addressed with nursing staff and immediately corrected and reported to the CQI team for follow-up.</p> <p>5) Completion Date: 10/28/11.</p>		

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F 281	Continued From page 7 An interview with Licensed Practical Nurse (LPN) #4 on 10/12/11, at 5:10 PM, revealed if a physician's order directed staff to "hold" a medication when the resident's blood pressure and pulse rate were outside the parameters established by the physician, staff was required to obtain/assess the resident's blood pressure and pulse prior to the administration of the medication. LPN #4 stated the results of the resident's blood pressure and pulse rate should be recorded on the MAR each time they were obtained.  An interview on 10/13/11, at 9:50 AM, with the West Wing Unit Coordinator (UC) revealed staff was required to follow physician's orders. The UC confirmed if the physician's order stated to "hold" the medication if the resident's blood pressure or pulse rate was below the parameters established by the physician, then staff would be required to check the blood pressure and obtain the resident's heart rate to determine if the medication should be administered.	F 281			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 334	F334 Submission of this Plan of Correction does not indicate that a deficiency existed or that a deficiency was cited correctly. This Plan of Correction is being submitted to ensure our continuing compliance with State and Federal regulations.  1) Resident #2 has now received the pneumococcal vaccine.		

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F 334	<p>Continued From page 8</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that —</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive</p>	F 334	<p>2) The charts of all other residents have been reviewed by the Administrator and Director of Nursing, and vaccines have been received timely.</p> <p>3) The nurse unit managers/clinical coordinators have been in-serviced by the Administrator on the vaccination policy and voice their understanding of adhering to this policy. All nursing staff have also been in-serviced by the Director of Nursing and voice their understanding of adhering to this policy.</p> <p>4) As part of the CQI process, the MDS Coordinators will review the charts of all new admissions for one month and then one admission weekly for two months to ensure that all vaccinations have been administered per facility policy. Any discrepancies will be corrected immediately and reported to the CQI committee for follow-up.</p> <p>5) Completion Date: 10/28/11.</p>	

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F 334	<p>Continued From page 9</p> <p>the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the pneumococcal vaccine was provided for one of twenty-six sampled residents (Resident #2).</p> <p>The findings include:</p> <p>A review of the facility policy titled "Vaccination Policy" (no date) revealed all residents would receive the pneumococcal vaccine upon admission unless they have received vaccination in the last five years.</p> <p>A review of the medical record revealed Resident #2 was admitted to the facility on 08/29/11. A review of the admission physician's orders revealed the physician had prescribed a pneumococcal vaccine upon admission.</p> <p>A review of the immunization record and Medication Administration Records (MARs) for Resident #2 revealed no evidence a pneumococcal vaccine had been administered to</p>	F 334			

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NAME OF PROVIDER OR SUPPLIER  <b>HILLCREST HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1245 AMERICAN GREETINGS RD, P O BOX 556</b> <b>CORBIN, KY 40702</b>		
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F 334	Continued From page 10 the resident. A consent form had been signed by the resident's responsible party on 08/29/11, consenting for the resident receiving the vaccine.  An interview conducted with the Unit Manager (UM) for the East Wing of the facility on 10/13/11, at 9:30 AM, revealed the UM was responsible for administering the pneumococcal vaccine for residents on the East Wing. The UM stated the pneumococcal vaccine should have been administered to Resident #3 and it had "just been missed."  An interview with the Director of Nursing (DON) on 10/13/11, at 3:45 PM, revealed it was the UM's responsibility to ensure the residents receive immunizations timely. The DON stated Resident #3 should have received the pneumococcal immunization upon admission.	F 334			
F 431 SS=D	<b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b>  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	<b>F431</b> Submission of this plan of correction does not indicate that a deficiency existed or that a deficiency was cited correctly. This Plan of Correction is being submitted to ensure continuing compliance with State and Federal regulations.  1) The vial of influenza vaccine was immediately dated after brought to the attention of nursing staff. No residents were negatively affected by this deficiency.		

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F 431	<p>Continued From page 11</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined the facility failed to ensure all drugs and biologicals were labeled in accordance with currently accepted professional principles. Observation on 10/13/11, of the West Wing medication room revealed an opened vial of Influenza Virus Vaccine had not been dated when opened.</p> <p>The findings include:</p> <p>On 10/13/11, a policy was requested related to labeling/dating of multi-dose vials. The DON stated the facility did not have a written policy that guided staff regarding the labeling/dating of multi-dose vials.</p> <p>Observations of the medication refrigerator on the</p>	F 431	<p>2) No other residents were negatively affected by this deficiency. The medication carts were checked by the Nurse Clinical Coordinators, and all other medications were dated appropriately.</p> <p>3) All nursing staff have been in-serviced by the Director of Nursing on Medication Administration, including properly dating multi-dose vials of medication when initially opened.</p> <p>4) As part of the CQI process, the nursing Clinical Coordinators will check all multi-dose vials on the medication carts weekly for one month and then monthly for 2 months to ensure they are properly dated. Any discrepancies will be corrected immediately and reported to the CQI committee for follow-up.</p> <p>5) Completion Date: 10/28/11.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>HILLCREST HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1245 AMERICAN GREETINGS RD, P O BOX 556 CORBIN, KY 40702</b>		
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F 431	Continued From page 12 West Wing on 10/13/11, at 5:05 PM, revealed a vial of Influenza Virus Vaccine available for use. The vial had been opened but there was no date to indicate when the vial had been opened.  Interview with Licensed Practical Nurse (LPN) #2 on 10/13/11, at 5:05 PM, revealed staff was required to date all vials when they were opened to ensure the medication would be discontinued after 30 days. LPN #2 confirmed the vial should have been dated when it was opened.  Interview on 10/13/11, at 5:20 PM, with the DON revealed in accordance with facility practice staff was required to write the date on all multi-dose vials of medications with the date the medication had been opened.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT 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	F 441	F441 Submission of this plan of correction does not indicate that a deficiency existed or that a deficiency was cited correctly. This Plan of Correction is being submitted to ensure continuing compliance with State and Federal regulations.  1) Residents #'s 5, 10 & 25 have suffered no ill-effects from this deficiency.  2) All residents on the West Wing had the potential to be affected by this deficiency. LPN's #1 and #2 have received 1:1 counseling and		

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F 441	<p>Continued From page 13</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy it was determined the facility failed to provide a safe, sanitary environment to help prevent the development and transmission of disease and infections for two of twenty-six residents (Residents #5 and #10). During observation of medication pass on 10/11/11, Licensed Practical Nurse (LPN) #1 administered medications by subcutaneous injections to Residents #5 and #10 and failed to wear gloves as required by the facility's policy and accepted standard precautions. Further observation revealed LPN #2 failed to wash/sanitize her hands after the administration of medications to Resident #25.</p>	F 441	<p>education by the Director of Nursing on handwashing, glove use, and general infection control procedures.</p> <p>3) All nursing staff have been in-serviced by the Director of Nursing regarding handwashing, glove use, and the facility Infection Control Program.</p> <p>4) As part of the CQI process, the Nursing Clinical Coordinators will perform random medication pass audits weekly for 3 months, and then monthly thereafter to ensure that facility staff are following infection control protocols in order to maintain a safe, sanitary environment for all residents during medication pass. Any discrepancies will be addressed with nursing staff, corrected immediately and reported to the CQI committee for review.</p> <p>5) Completion Date: 10/28/11</p>	

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F 441	<p>Continued From page 14</p> <p>The findings include:</p> <p>A review of the facility policy titled Insulin Administration Procedure (not dated) revealed facility staff was required to wash hands and wear gloves with the administration of subcutaneous injections. Review of the facility policy titled Standard Precautions (no date given) revealed staff was required to wash hands between resident contact.</p> <p>1. During observation of a medication pass on 10/11/11, at 11:40 AM, Licensed Practical Nurse (LPN) #1 administered Novolin R insulin subcutaneously in the right arm of Resident #10. LPN #1 was observed to wash her hands prior to and after the administration of the insulin. However, the LPN failed to wear gloves when she administered the subcutaneous injections as mandated by facility policy and by the recommended basic standard/transmission precautions.</p> <p>Further observation revealed LPN #1 prepared Novolog 70/30 insulin for administration of the medication by injection into the subcutaneous tissue of Resident #5's right mid-abdomen. LPN #1 failed to wear gloves with the administration of the medication by subcutaneous injection.</p> <p>During an interview on 10/11/11, at 11:35 AM, LPN #1 stated wearing gloves during insulin administration was the nurse's discretion. LPN #1 stated she did not wear gloves during the administration of subcutaneous injections but would wear gloves if the medication was ordered to be administered intramuscularly.</p>	F 441			

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F 441	<p>Continued From page 15</p> <p>2. Observation on 10/11/11, of the evening medication pass revealed LPN #2 entered Resident #25's room to administer five medications. LPN #2 was observed to take the resident's pulse by placing her fingers on the resident's wrist. LPN #2 then assisted Resident #25 with taking the oral medications. Further observation revealed LPN #2 exited Resident #25's room, returned to the medication cart, failed to wash/sanitize her hands, and then prepared the next resident's medications.</p> <p>Interview on 10/11/11, at 6:15 PM, with LPN #2 revealed hands should be washed/sanitized after resident contact. LPN #2 stated she used hand sanitizer after giving any oral medications but if administering injections or giving medications thru a tube she would wash her hands at the resident's sink. LPN #2 stated she just failed to sanitize her hands after administering medications to Resident #25.</p> <p>Interview with the Director (DON) on 10/13/11, at 3:45 PM, revealed staff was required to wash/sanitize hands prior to preparing the medications for the resident and after the medications were administered to the resident.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>HILLCREST HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1245 AMERICAN GREETINGS RD, P O BOX 556 CORBIN, KY 40702</b>		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Eight (8).</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (WET SYSTEM)</p> <p>EMERGENCY POWER: Type II natural gas generator.</p> <p>A life safety code survey was initiated and concluded on 10/12 /11, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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