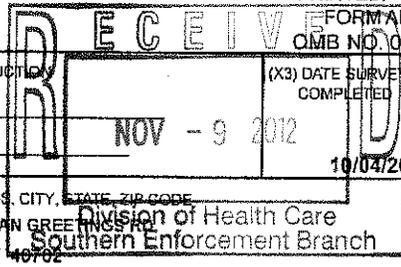


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SOD

PRINTED: 11/02/2012  
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 _____	(X3) DATE SURVEY COMPLETED  10/04/2012
NAME OF PROVIDER OR SUPPLIER  HILLCREST HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREEN INSURANCE CORBIN, KY 40702 Division of Health Care Southern Enforcement Branch	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A standard health survey was conducted 10/02-04/12. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	*See Attached	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *William M. Hayes* TITLE: *Administrator* (X6) DATE: *11-9-12*

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.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policy it was determined the facility failed to notify the physician and the resident's responsible party when there was a need to alter treatment for one of twenty-four sampled residents (Resident #10). Observation during a skin assessment for Resident #10 on 10/02/12, revealed a pressure area to the resident's right buttock, however, staff failed to notify the physician for treatment orders. In addition, staff failed to inform the resident's responsible party of the pressure area. (Refer to F314.)</p> <p>The findings include:</p> <p>A review of facility policies, titled Notification of Change in Resident's Status (not dated) and Skin Ulcers (not dated), revealed facility staff was to immediately notify the physician and the resident's responsible party of any change in the resident's condition. The policy directed staff to notify the physician and responsible party of any falls, bruises, skin tears, abrasions, lesions, rashes, or decubitus. Review of the Skin Ulcers policy revealed staff was to notify the physician of any pressure sore or skin condition.</p> <p>Observation during a skin assessment on 10/02/12 at 3:35 PM, conducted by Licensed Practical Nurse (LPN) #3, revealed Resident #10 had an open area with a red wound bed on the inner aspect of the right buttock. Further observation revealed no treatment or dressing had been applied to the area. During the skin assessment, LPN #3 stated she was not aware of</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>Resident #10 having a pressure area but the resident frequently had skin tears of the arms.</p> <p>Review of the medical record for Resident #10 on 10/03/12 (the day after the skin assessment was conducted), revealed no documented evidence of Resident #10's pressure area of the inner aspect of the right buttock. Further review revealed no documented evidence LPN #3 had contacted the physician for orders to treat the pressure area that was identified during the skin assessment on 10/02/12. The medical record further revealed no documentation the responsible party for Resident #10 was notified of the newly identified pressure area.</p> <p>Review of Resident #10's Care Plan (dated as reviewed on 09/13/12) that addressed skin integrity/pressure areas revealed an intervention for staff to notify the physician and responsible party, as needed, of changes in the resident's skin and/or the development of a pressure area.</p> <p>Interview with LPN #3 on 10/03/12 at 3:10 PM, revealed she was required to report any abnormal skin areas to the physician, resident's responsible party, and the Unit Manager. LPN #3 stated she was required to complete a wound assessment sheet and chart the findings in the medical record if any abnormal skin areas were identified during resident care. LPN #3 stated she failed to report Resident #10's pressure area to the physician, responsible party, and Unit Manager as required. LPN #3 stated she had planned to follow up regarding the pressure area when she returned to work the following day.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 157		

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F 157	Continued From page 3 10/04/12 at 1:25 PM, revealed staff was required to notify the physician and resident's responsible party of any change in a resident's condition. The DON confirmed when an abnormal area (redness, bruise, skin tear, or open area) was identified on a resident's skin, staff was required to contact the physician and notify the resident's responsible party.	F 157			
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 release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164			

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F 164	<p>Continued From page 4</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 ensure personal privacy was provided when staff administered medication via a gastrostomy tube (G-tube) for one of twenty-eight sampled residents and three unsampled residents (Resident B). Observation on 10/02/12 at 12:40 PM, revealed Licensed Practical Nurse (LPN) #1 failed to close the blinds to a window that had a direct view of a covered picnic area (frequently used by staff) and faced a service road, while administering the medications via G-tube.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Resident Dignity (not dated), revealed residents' personal privacy would be protected during care by knocking on the resident's door before entering, closing the resident's door and drawing the privacy curtain, keeping a resident's body covered, and having only the persons providing care in the resident's room during the provision of care. The policy failed to address that complete visual privacy should be maintained by closing the window curtains/blinds.</p> <p>Observation of medication pass for Resident B was conducted on 10/02/12 at 12:40 PM. LPN #1 was observed to prepare two medications for administration via G-tube. LPN #1 was observed to enter Resident B's room and administer the G-tube medications to Resident B. During the G-tube medication administration, LPN #1</p>	F 164			

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F 164	<p>Continued From page 5</p> <p>exposed Resident B's abdominal area, but failed to ensure the window blinds were closed to maintain complete privacy for Resident B. Further observation revealed the window in Resident B's room had a direct view of a covered picnic area where staff was observed during a break. Resident B's window also had the view of a service road and a truck was observed to drive by during the medication administration procedure.</p> <p>Interview on 10/03/12 at 8:45 AM, with LPN #1 revealed she should have closed the blinds to ensure complete privacy before she exposed Resident B's abdomen for the G-tube medication administration. LPN #1 revealed she was nervous and failed to close the window blinds. LPN #1 confirmed the covered picnic area was for staff to take breaks and service trucks frequently use the service road behind the facility.</p> <p>Interview on 10/04/12, at 1:25 PM, with the Director of Nursing (DON) revealed staff was required to provide privacy for residents by closing the door to the resident's room, pulling the privacy curtain around the resident's bed, closing the window blinds, and only exposing the area necessary for the treatment.</p>	F 164		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 281		

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F 281	<p>Continued From page 6</p> <p>Based on observation, interview, record review, and a review of facility policy, the facility failed to ensure services provided met professional standards of quality for two of twenty-four sampled residents (Residents #1 and #9). Both residents had physician's orders for Thrombo Embolic Deterrent (TED) hose to be worn, however, observations on 10/02/12 and 10/03/12 revealed facility staff failed to ensure the TED hose were in use for Residents #1 and #9.</p> <p>The findings include:</p> <p>A review of the facility's policy, no date given, regarding Physician's Orders revealed all physician's orders were to be noted and transcribed to the appropriate place, e.g., MAR (Medication Administration Record), TAR (Treatment Administration Record), etc. The protocol further revealed, "Orders shall be followed accordingly until changed."</p> <p>1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 09/24/12 with diagnoses that included Coronary Artery Disease, Peripheral Vascular Disease, Chronic Left Heel Ulcer, Dementia, Atrial Fibrillation, and Osteoporosis. A review of physician's orders dated 10/01/12 through 10/31/12 revealed the resident was to have "Bilateral Knee High TED Hose on in the AM and off in the PM."</p> <p>Observations of Resident #1 on 10/02/12 at 10:10 AM, 12:40 PM, and 2:10 PM, and on 10/03/12 at 8:25 AM, 9:15 AM, 10:30 AM, and 1:30 PM, revealed TED hose were not in use for this resident.</p>	F 281			

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F 281	<p>Continued From page 7</p> <p>2. A review of the medical record for Resident #9 revealed the facility admitted the resident on 08/29/06 with diagnoses that included Diabetes, Hypertension, Coronary Artery Disease, Congestive Heart Failure, and Syncope. A review of physician's orders dated 10/01/12 through 10/31/12 revealed the resident was to have "TED hose on in AM, remove PM."</p> <p>Observations on 10/02/12 at 10:20 AM, 12:10 PM, and 2:10 PM, and on 10/03/12 at 8:20 AM, 9:20 AM, 10:30 AM, and 11:00 AM, revealed TED hose were not in use for this resident.</p> <p>An interview conducted with State Registered Nurse Aide (SRNA) #8 on 10/03/12 at 11:20 AM, revealed the nurse aide Kardex for Residents #1 and #9 did not have the use of TED hose included. SRNA #8 stated the Kardexes were used by the SRNAs to identify each resident's care needs/requirements.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 10/03/12 at 11:10 AM, revealed she was not aware of the physician's order for Residents #1 and #9 to utilize TED hose during the day. LPN #1 further stated the order was not included on the TAR.</p> <p>An interview conducted with the Clinical Coordinator (CC) on 10/03/12 at 11:15 AM, revealed the CC was responsible to ensure all physician's orders were transcribed to the appropriate document. The CC stated she should have included the orders for TED hose on the residents' TARs and Kardexes. The CC further stated she was responsible to check the</p>	F 281			

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F 281	Continued From page 8 monthly order sheets at "changeover" to ensure accuracy. According to the CC, it was an oversight and she just missed it.	F 281		
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, and review of facility policy/procedure it was determined the facility failed to ensure staff provided care to residents in accordance with the written plan of care for one of twenty-four sampled residents (Resident #5). Resident #5 required the assistance of two staff members to complete activities of daily living (ADLs). On 09/19/12, the resident received incontinence care with the assistance of one staff member and sustained a fall from bed.  The findings include:  Review of the facility policy/procedure, "Falls Prevention Program" (no effective date), revealed the goal of the policy was to put in place interventions to limit or eliminate risks for residents who were identified as high risk. Further review of the policy/procedure revealed after a resident had been identified as a high risk for falls interventions would be implemented.	F 282		

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F 282	<p>Continued From page 9</p> <p>Review of the medical record of Resident #5 revealed the facility initially admitted the resident on 04/29/10 and readmitted the resident on 08/31/11 with diagnoses that included hypertension, left below-the-knee amputation, end stage renal disease, cerebellar vascular accident, and diabetes mellitus. Review of the significant change Minimum Data Set (MDS) Assessment dated 07/30/12 for Resident #5 revealed the facility had assessed the resident to require extensive assistance of two staff members for bed mobility, transfers, and toileting. Further review of the assessment revealed the resident was at increased risk for falls due to limited range of motion to the left upper arm, left lower leg due to a below-the-knee amputation, and a partial amputation of the right foot.</p> <p>Review of the care plan for Resident #5 dated 08/01/12 and the current care plan dated 09/28/12 revealed facility staff identified Resident #5 to have a self-care deficit. Interventions on the care plan developed by staff to address the resident's deficit included extensive assistance for bed mobility. Further review of the care plan revealed Resident #5 also experienced incontinence and a potential for falls/injury which required extensive assistance of two staff members. Review of the "Resident Kardex" for Resident #5 also revealed the resident required the assistance of two staff members for toileting and bed mobility.</p> <p>Observation of Resident #5 on 10/02/12 from 10:10 AM to 3:55 PM, and on 10/03/12 at 9:10 AM, revealed the resident sitting in a wheelchair or lying in bed. The resident had a leg</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>immobilizer to the right leg and had a below-the-knee amputation to the left. The resident used a self-releasing safety belt while in the wheelchair.</p> <p>Interview with Resident #5 on 10/03/12 at 9:10 AM, revealed the resident sustained a fall from bed on 09/19/12. According to Resident #5, Certified Nursing Assistant (CNA) #6 was in the room to assist with incontinence care. The resident stated CNA #6 had placed the resident on his/her left side and the resident had "rolled out of bed" while the CNAs were obtaining clothing from the dresser.</p> <p>Interview with CNA #6 on 10/03/12 at 10:15 AM, revealed she was responsible for the care of Resident #5 on 09/19/12. According to CNA #6, on 09/19/12, she entered Resident #5's room and determined the resident needed incontinence care. CNA #6 stated she placed the resident onto the left side and left the bedside to retrieve an article of clothing. The CNA stated when her back was turned the resident fell out of bed and onto the floor. CNA #6 acknowledged Resident #5 required the assistance of two staff members for bed mobility and toileting, but the CNA attempted to provide the care unassisted.</p> <p>Interview with CNA #7 on 10/03/12 at 10:20 AM, revealed the CNA was on duty on 09/19/12. CNA #7 stated that on 09/19/12 she heard the emergency call light go on in Resident #5's room. According to CNA #7, when she entered the room the resident was on the floor. CNA #7 confirmed Resident #7 required the assistance of two staff members for toileting and that CNA #6 had provided incontinence care to the resident without</p>	F 282		

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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 CORBIN, KY 40702</b>		
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F 282	Continued From page 11 another staff member to assist. CNA #7 stated Resident #5 always required assistance of two staff members.  A review of a "Resident Incident Report" dated 09/19/12 at 6:00 AM, revealed Resident #5 had "rolled out of bed" during incontinence care. According to the facility investigation, it was determined the air mattress was not fully inflated, which contributed to the fall, and an intervention was added to the care plan for staff to ensure the mattress was properly inflated. However, based on a review of the incident report, the facility failed to identify that only one staff member had attempted to assist Resident #5 with incontinence care on the day of the incident (09/19/12 at 6:00 AM) instead of two staff members as identified in the plan of care.  Interview with the Director of Nursing (DON) on 10/03/12 at 9:40 AM, revealed the DON was unaware Resident #5 was assisted by only one staff member on 09/19/12. The DON stated she had assumed there were two staff members caring for the resident at the time of the incident.	F 282			
F 314 SS=D	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.	F 314			

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F 314	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of facility policy, it was determined the facility failed to ensure one of twenty-four sampled residents received necessary treatment and services to promote healing and prevent the development of new sores. Observation during a skin assessment on 10/02/12 revealed an unidentified pressure sore on Resident #10's right buttock. Staff failed to thoroughly assess and document the area on Resident #10's right buttock and failed to contact the physician for treatment orders for the pressure area. Additionally, staff failed to notify Resident #10's responsible party of the new pressure area. (Refer to F157.)</p> <p>The findings include:</p> <p>Review of the facility's policy titled Skin Ulcers (not dated) revealed staff was to assess residents for risk factors for development of pressure sores by using the Braden Scale Risk Assessment Form. The policy directed staff to perform weekly Skin Integrity Assessments to document all unusual skin conditions such as bruises, skin tears, lacerations, pressure ulcers, venous ulcers, burns, rashes, welted areas, arterial ulcers, or diabetic ulcers. The policy also directed staff to notify the physician of any pressure sores and document the development of any new skin problems identified on residents in the medical record and on the 24-Hour Report Form.</p> <p>Record review revealed the facility readmitted Resident #10 on 07/06/12 with diagnoses of</p>	F 314		

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F 314	<p>Continued From page 13</p> <p>Congestive Heart Failure, Hypertension, and Severe Osteoarthritis. Review of the Significant Change in Condition Assessment and Care Area Assessment dated 09/13/12, revealed the facility had assessed Resident #10 to be at increased risk for pressure ulcers due to decreased mobility, incontinence episodes, use of incontinence products, and a previous history of pressure sores. Review of the assessment to determine residents' risk for pressure sores (Braden Scale for Predicting Pressure Sores Risk) dated 09/13/12 revealed Resident #10 was assessed to be at mild risk to develop pressure areas.</p> <p>Review of the care plan interventions to prevent pressure sores for Resident #10 revealed staff was to assess the resident's skin on a weekly basis, observe skin during care, turn and reposition every two hours, ensure a pressure reduction mattress remained on the resident's bed, encourage the use of a pressure reduction cushion in the resident's chair, and encourage and assist Resident #10 to get out of bed daily. Continued record review revealed the most recent skin assessment conducted for Resident #10 was dated 09/30/12 (2 days prior to the survey) and at that time staff documented Resident #10's skin was warm and dry, with ecchymotic areas of the upper and lower extremities and a skin tear to the left shoulder.</p> <p>Observation during a skin assessment on 10/02/12 at 3:35 PM, conducted by Licensed Practical Nurse (LPN) #3, revealed Resident #10 had an open area with a red wound bed of the inner aspect of the right buttock. Further observation revealed no treatment or dressing</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>had been applied to the area. During the skin assessment, LPN #3 stated she was not aware of Resident #10 having a pressure area, but the resident frequently had skin tears of the arms.</p> <p>Review of the medical record for Resident #10 on 10/03/12 (the day after the skin assessment had been conducted), revealed no documented evidence of Resident #10's newly developed pressure area to the right buttock. Further review revealed no documented evidence LPN #3, or any facility staff member, had contacted the physician for orders to treat the pressure area that had been identified during the skin assessment on 10/02/12. The medical record further revealed no documentation the responsible party for Resident #10 had been notified of the newly identified pressure area.</p> <p>Interview on 10/03/12 at 10:05 AM, with the Clinical Coordinator (CC) of the East Wing revealed skin assessments were conducted once a week. The CC stated showers were provided for residents three times a week. The CC acknowledged staff was to report any skin issues identified during care, however, she had no knowledge of Resident #10 having a pressure area. Observation of a second skin assessment (at surveyor request) conducted by the CC on 10/03/12 at 10:15 AM, revealed a 0.4 centimeter by 0.8 centimeter pressure area of the inner aspect of Resident #10's right buttock. The CC classified the pressure area as a Stage 2 pressure area.</p> <p>Interview on 10/03/12 at 10:25 AM, with CNA #1 and a new employee in orientation working with CNA #1, revealed they had provided a bed bath</p>	F 314			

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F 314	Continued From page 15 for Resident #10 on 10/03/12 and CNA #1 stated she did not notice an open area on Resident #10's buttocks. CNA #1 stated any abnormal areas such as bruises, skin tears, or open areas on the skin were to be reported to the nurse immediately.  Interview with LPN #3 on 10/03/12 at 3:10 PM, revealed she was required to report any abnormal skin areas to the physician, resident's responsible party, and the Unit Manager, complete a wound assessment sheet, and chart the findings in the medical record if any abnormal skin areas were identified during resident care. LPN #3 stated she failed to report Resident #10's pressure area to the physician, responsible party, and Unit Manager but had planned to follow up on the pressure area when she returned to work.  Interview with the Director of Nursing (DON) on 10/04/12 at 1:25 PM, revealed staff was required to conduct weekly head-to-toe skin assessments to detect any skin problems. The DON confirmed when an abnormal area (redness, bruise, skin tear, open area, or pressure area) was identified on a resident's skin, staff was required to contact the physician and notify the resident's responsible party. The DON stated staff was to notify the CC who would take a picture of the area identified and monitor/evaluate the response to treatment.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 16  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the environment remained as free from accident hazards as is possible for one of twenty-four sampled residents (Resident #5). Resident #5 sustained a fall from bed on 09/19/12. The facility determined the root cause of the fall was an improperly inflated air mattress. Resident #5 had been assessed to require two staff members for activities of daily living; however, on the day of the resident's fall, only one staff member had provided incontinence care to the resident.  The findings include:  Review of the facility policy/procedure, "Falls Prevention Program," (no effective date) revealed the goal of the policy was to put in place interventions to limit or eliminate risks for residents who were identified as high risk. Further review of the policy/procedure revealed after a resident had been identified as a high risk for falls interventions would be implemented.  A review of the medical record of Resident #5 revealed the facility admitted the resident on 04/29/10 and readmitted the resident on 08/31/11 with diagnoses that included hypertension, left below-the-knee amputation, end stage renal disease, cerebellar vascular accident, and	F 323			

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F 323	<p>Continued From page 17 diabetes mellitus.</p> <p>Review of the significant change Minimum Data Set (MDS) Assessment dated 07/30/12 for Resident #5 revealed the facility had assessed the resident to require extensive assistance of two staff members for bed mobility, transfers, and toileting. Further review of the assessment revealed the resident was at increased risk for falls due to limited range of motion to the left upper arm, left lower leg due to a below-the-knee amputation, and a partial amputation of the right foot.</p> <p>Review of the care plan for Resident #5, dated 08/01/12 and 09/28/12, revealed staff identified that the resident had incontinence, a potential for falls/injury, and required the extensive assistance of two staff members. A review of the "Resident Kardex" for Resident #5 also revealed the resident required the assistance of two staff members for toileting and bed mobility.</p> <p>Interview with Resident #5 on 10/03/12 at 9:10 AM, revealed on 09/19/12 the resident "rolled out of bed" onto the floor. The resident stated at the time of the incident there had only been one staff member providing the resident with assistance.</p> <p>Interview with CNA #6 on 10/03/12, at 10:15 AM, revealed she was responsible for the care of Resident #5 on 09/19/12. According to CNA #6, she had gone into Resident #5's room to assist the resident out of bed. CNA #6 stated she determined Resident #5 had experienced an incontinence episode and she turned the resident onto the left side to provide assistance in cleansing the resident. The CNA stated she left</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>the resident's bedside to obtain an article of clothing and while her back was turned the resident fell out of bed. CNA #6 acknowledged Resident #5 required the assistance of two staff members for toileting but the staff member who was to assist her had not arrived in the room and she attempted to provide the care alone.</p> <p>Interview with CNA #7 on 10/03/12 at 10:20 AM, revealed she was on duty on 09/19/12 at 6:00 AM. CNA #7 stated she heard an emergency call from Resident #5's room. According to the CNA, when she entered the room Resident #5 was lying on the floor. CNA #7 stated there was only one staff member providing care to the resident at that time. The CNA confirmed the resident required the assistance of two staff members to provide care in an effort to prevent falls/injury.</p> <p>Review of the "Resident Incident Report" dated 09/19/12, at 6:00 AM, revealed Resident #5 sustained a fall from the bed. Further review of the incident report revealed a Certified Nursing Assistant (CNA) had been providing incontinence care to the resident, rolled the resident onto the left side, and the resident rolled out of bed onto the floor. The follow-up of the incident documented the resident's air mattress was noted to be slightly deflated which was determined to be the cause of the resident's fall. There was no evidence the facility determined if the required number of staff had been providing care to the resident.</p> <p>Interview with the Director of Nursing (DON) on 10/03/12 at 9:40 AM, revealed she had reviewed the incident report related to Resident #5. The DON stated the facility investigation determined</p>	F 323			

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F 323	Continued From page 19 the resident's bed was slightly deflated. The DON was unaware there was only one staff member caring for Resident #5 at the time of the resident's fall. According to the DON, she had assumed there were two staff members in the room as the resident required the assistance of two staff members for care needs.	F 323			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by:	F 329			

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F 329	<p>Continued From page 20</p> <p>Based on observation, interview, record review, and review of facility policy/procedure it was determined the facility failed to ensure the drug regimen for two of twenty-four sampled residents was free from unnecessary drugs (Residents #2 and #21). Resident #21 received two antidepressants without documentation of the rationale for the duplicate therapy, two medications for treatment of the symptoms of schizophrenia without a diagnosis of schizophrenia, and received a medication which was documented in the medical record to cause psychosis for the resident. There was no evidence the facility had attempted a gradual dose reduction or elimination of medications for Resident #21. Additionally, Resident #2 received duplicate antidepressant therapy without a documented rationale for duplicate therapy and there was no evidence the facility had attempted a gradual dose reduction of the resident's psychotropic medications.</p> <p>The findings include:</p> <p>Review of the facility policy/procedure, "Protocol for Review and Reduction of Psychoactive Medications," (no effective date) revealed residents that were prescribed antipsychotic medications would be evaluated quarterly during the Resident Assessment Instrument (RAI) process and as indicated to ensure that residents were observed for adverse effects of the medication. According to the policy, the resident's physician would be consulted as indicated. The policy further indicated the Interdisciplinary Team, which included the resident's physician, would make every effort to ensure residents received appropriate</p>	F 329			

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F 329	<p>Continued From page 21</p> <p>medications without significant adverse effects according to their individualized needs. In addition, the policy indicated when feasible, reductions, including discontinuations, would be attempted according to physician's orders.</p> <p>1. Review of the medical record of Resident #21 revealed the facility admitted the resident on 12/13/10 and readmitted the resident from the hospital on 05/19/11 with diagnoses that included anxiety, depression, dementia with behaviors and psychosis due to Seroquel use. Review of the annual comprehensive assessment dated 05/14/12, including the resident's Brief Interview for Mental Status (BIMS) assessment, revealed the resident had a score of 10, which indicated the resident was moderately cognitively impaired.</p> <p>Review of the physician's orders for Resident #21 dated 09/28/12 revealed the resident received the following medications: 10 milligrams (mg) of Aricept (used to treat confusion related to Alzheimer's disease) at bedtime; 20 mg of Lexapro (antidepressant) every day; 15 mg of Remeron (antidepressant) at bedtime; 0.5 mg of Ativan (used to relieve anxiety) twice daily; 10 mg of Namenda (used to treat the symptoms of Alzheimer's disease) twice a day; 5 mg of Zyprexa (used to treat the symptoms of schizophrenia and bi-polar disease) twice a day; and 100 mg of Seroquel (used to treat the symptoms of schizophrenia) twice daily. Further review of the physician's orders in the medical record of Resident #5 revealed the resident had received the Aricept, Lexapro, and Remeron as prescribed since 05/19/11; the Namenda since 10/24/11; the Zyprexa since 12/21/11; the Ativan since 03/28/12; and the Seroquel since 04/16/12.</p>	F 329			

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F 329	<p>Continued From page 22</p> <p>There was no evidence in the medical record that the facility had attempted a gradual dose reduction of the psychotropic medications other than one reduction of the Seroquel on 06/18/12. The resident also received two medications for the treatment of symptoms of schizophrenia (Zyprexa and Seroquel); however, there was no evidence in the medical record the resident had been diagnosed with schizophrenia. Additionally, the resident had a diagnosis of psychosis due to Seroquel use and would be a contraindication for use of the medication.</p> <p>Review of the drug regimen review conducted by the facility's pharmacist from May 2012 to August 2012 revealed a recommendation dated 06/13/12 that the physician consider a dose reduction for the antipsychotic medications or an adjustment in the dosage for Resident #21. Additionally, a review of pharmacy recommendations revealed a Food and Drug Administration (FDA) warning indicating elderly patients with dementia-related psychosis treated with antipsychotic drugs were at increased risk of death. The physician had documented to reduce the Seroquel from three times a day to twice a day. There was no evidence the physician had documented clinical rationale for the benefit of, or the necessity for, the use of multiple medications for depression or the use of medications for schizophrenia in the absence of a diagnosis of schizophrenia.</p> <p>Review of the facility's Psychoactive Medication Quarterly Evaluation for Resident #21 revealed on 05/11/12 and 08/06/12 the facility had evaluated the use of the resident's psychoactive medications. Documentation revealed the use of Ativan had been evaluated for increased anxiety;</p>	F 329			

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F 329	<p>Continued From page 23</p> <p>however, a review of the behavior documentation for June 2012 through September 2012 revealed no documentation the resident had behavioral symptoms or increased anxiety. The use of Zyprexa had been evaluated as used for schizophrenia on 05/11/12 and for psychosis on 08/06/12. The use of Remeron and Lexapro had been evaluated as needed for depression; however, the comprehensive assessment dated 05/14/12 revealed facility staff assessed the resident to have minimal symptoms of depression. The use of Seroquel had been evaluated on 08/06/12 for the resident's psychosis; however, a review of the comprehensive assessment revealed no symptoms of psychosis. There was no evidence the use of Namenda had been evaluated, and the resident had no diagnosis of Alzheimer's disease which was an indication to support the use of Namenda.</p> <p>Interview with the consultant pharmacist on 10/04/12 at 10:48 AM, revealed the pharmacist reviewed each resident's drug regimen monthly. According to the pharmacist, a notification was sent to the physician every three months for reduction or discontinuation of psychotropic medications. The pharmacist stated they were lucky to get a response from the physician and stated the physician usually documented "no changes" on the recommendation and rarely documented a rationale for the continued use of the medications.</p> <p>Interview with the physician for Resident #21 on 10/04/12, at 10:25 AM, revealed if the medications had not been decreased for a while they probably should be. The physician was</p>	F 329			

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F 329	<p>Continued From page 24</p> <p>unaware the medications had not been decreased since they had been ordered. The physician was unaware of the resident's diagnosis of psychosis due to Seroquel use. According to the physician, he tries to look at one drug each month to evaluate the need for reduction. The physician confirmed the resident "probably" did not require two antidepressants. The physician confirmed he was also the Medical Director for the facility. The physician stated the facility's Quality Assurance activity only reviews psychoactive medications for residents with the most behaviors and the medications are not routinely part of the quality management activities.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 10/04/12 at 9:15 AM, revealed the MDS staff was responsible for evaluating the use of psychotropic medications when conducting resident assessments. According to the MDS Coordinator, she documented the medications the resident received and if any reductions had been attempted. The MDS Coordinator confirmed she did not review the medications for duplicate therapies or to ensure the resident had a diagnosis to support use of the medication. The MDS Coordinator stated she did not review the behavior documentation when she evaluated the use of Ativan for Resident #21.</p> <p>Interview with the Director of Nursing (DON) on 10/04/12 at 9:30 AM, revealed the consultant pharmacist delivered the recommendations for residents to her and she faxed the recommendations to the resident's physician. When she received the return fax from the physician she delivered any orders to the nursing</p>	F 329			

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F 329	<p>Continued From page 25</p> <p>staff and filed the recommendation. The DON stated she did not review the pharmacy recommendations. According to the DON, if the physician did not make changes then no changes would be made.</p> <p>2. A review of the medical record for Resident #2 revealed the facility admitted the resident on 07/13/11 with diagnoses including insomnia and depression. A review of the resident's admission Minimum Data Set (MDS) assessment dated 07/25/11, annual MDS dated 06/14/12, and the most recent quarterly MDS dated 09/10/12, revealed the resident had no indicators of mood or depression and the resident was care planned for potential decline related to the use of psychotropic medication.</p> <p>A review of the physician's orders revealed Resident #2 was ordered to receive 25 mg of Zoloft daily in the AM, and 25 mg of Elavil daily at bedtime, both to be administered for depression.</p> <p>A review of the facility's pharmacist recommendations provided to Resident #2's attending physician revealed the pharmacist had requested a dose reduction for the Zoloft and Elavil on 12/08/11, however, the resident's attending physician declined the request and provided no rationale for the continued use of the duplicate therapy. Additional review of pharmacy recommendations for Resident #2 revealed the facility pharmacist recommended a dose reduction again on 06/13/12 which was declined by the resident's attending physician with no rationale documented for the continued use of the duplicate therapy.</p>	F 329			

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F 329	Continued From page 26 An interview conducted with the facility's pharmacist on 10/04/12 at 9:50 AM, revealed the pharmacist had made the recommendations to Resident #2's physician, had reviewed the physician's response, and was aware the physician provided no rationale for the duplicate therapy. Further interview with the pharmacist revealed she had not discussed the concern with the resident's physician or with the Medical Director of the facility.  An interview conducted with Resident #2's attending physician on 10/04/12 at 10:10 AM, revealed the physician had wanted the resident to receive Zoloft in the morning and Elavil at night in an effort to reduce the resident's drowsiness during the daytime and allow the resident to sleep better at night. Further interview with the attending physician revealed the physician had not agreed with the reductions in medications for Resident #2 because of concerns the resident may not tolerate the reduction and become agitated, and acknowledged he had not documented the rationale for the continued use of the medications in the medical record.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  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	F 431		

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F 431	<p>Continued From page 27</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</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 observation, interview, record review, and a review of facility policies, the facility failed to ensure a system of records for the disposition of controlled substances was sufficient to maintain an accurate reconciliation. One milligram or 0.5 milliliters of Ativan (a controlled substance used to treat anxiety) injectable for unsampled Resident A was missing and not accounted for.</p> <p>The findings include:</p>	F 431			

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F 431	<p>Continued From page 28</p> <p>A review of the facility policy titled Protocol for Narcotic Count (undated) revealed the controlled drugs were to be counted every shift by the nurse leaving and the nurse coming on duty. Further review of the policy revealed the Director of Nursing (DON) was required to be notified immediately if controlled substances were missing.</p> <p>A review of the controlled substance log for Resident A revealed 7.5 milliliters of injectable Ativan should have been available for use. Observation of the medications available for Resident A revealed there were 6 vials of Ativan that were unopened and each vial contained 1 milliliter of Ativan. However, continued observation revealed there were 2 vials of injectable Ativan that had been opened and 0.5 ml of the contents had been removed from each vial. Based on the observation, even though the narcotic log revealed there should have been 7.5 milliliters of the injectable Ativan available for use, observation revealed there were only 7 milliliters of the medication available for use.</p> <p>A review of Resident A's Medication Administration Record (MAR) revealed the resident had not received an injection of Ativan on 10/04/12, the day of the observation.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #5 on 10/04/12 at 1:50 PM, revealed the LPN had counted the Ativan that was available for Resident A's use with the nurse that had worked the previous shift and had not noticed 1 mg (or 0.5 ml) of the Ativan was not accounted for.</p>	F 431		

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F 431	Continued From page 29 An interview with the Director of Nursing (DON) conducted on 10/04/12 at 3:00 PM, revealed the DON was not aware the medication count of the Ativan available for Resident A's use was not accurate and could not be accounted for.	F 431			
F 441 SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441			

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F 441	<p>Continued From page 30</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, Food and Drug Administration (FDA) recommendations, and the State Operations Manual, it was determined the facility failed to maintain an effective Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for residents. Observation of the noon meal on 10/02/12 revealed staff handled residents' hamburger buns with bare hands. Observation on 10/02/12 revealed staff failed to wear gloves during the beginning of a skin assessment for Resident #4. Staff was observed to don gloves during the skin assessment, but when the skin assessment was completed staff was observed to remove the soiled gloves and place the soiled gloves in the pocket of her uniform. Observation of ice pass for residents on 10/03/12 revealed the ice scoop handle was left in contact with the ice in the ice chest. Additionally, observation on 10/03/12 and 10/04/12 revealed staff placed soiled linens on the floor in residents' rooms.</p> <p>The findings include:</p> <p>Review of the facility policy titled Meal Pass (not dated) failed to address the handling of residents' food. However, review of the FDA Food Code</p>	F 441			

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F 441	<p>Continued From page 31</p> <p>recommendations revealed bare hand contact with foods such as sandwiches and salads can result in contamination of food and contribute to foodborne illness outbreaks. Additionally, according to the State Operations Manual bare hand contact with foods is prohibited.</p> <p>Review of the facility's policy titled Using Gloves (not dated) directed staff to wear gloves to prevent contamination of the employee's hand when providing treatment or services to residents. The policy directed staff to discard used gloves in the waste receptacle.</p> <p>Interview with the Director of Nursing (DON) on 10/04/12 at 3:27 PM, revealed the facility did not have a policy regarding the proper storage of the ice scoop. The DON stated the standard of practice at the facility was for staff to use the storage caddy located on the ice cart when the scoop was not in use.</p> <p>Review of the facility policy titled Laundry/Linen (not dated) revealed all soiled linen must be placed directly in a plastic bag and then taken to a laundry hamper. The policy directed staff to handle all soiled linen as though it was potentially infectious.</p> <p>1. Observation of the dining room noon meal on 10/02/12 revealed residents were served a chicken filet patty on a hamburger bun. Further observation revealed small bowls that contained lettuce, tomato, and onion for the sandwich on the resident's tray. Continued observation revealed as CNA #4 delivered meal trays to Residents #2 and #16 and unsampled Residents A and C in the main dining room, the CNA lifted</p>	F 441			

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F 441	<p>Continued From page 32</p> <p>the top of the hamburger bun with her bare hands and asked the resident if they wanted lettuce, tomato, and onion on the sandwich. CNA #4 was observed to apply the lettuce, tomato, and onion to the sandwiches, replace the top of the hamburger bun, and then place the palm of her bare hand on the sandwich to compress the sandwich. Additionally, Resident A received spice cake that was covered with plastic covering. CNA #4 was observed to remove the plastic covering but the cake had adhered to the plastic. CNA #4 handled the cake with her bare hands and placed it on Resident A's plate.</p> <p>Interview with CNA #4 on 10/02/12 at 12:15 PM, revealed the CNA was unsure if she was permitted to handle residents' food with her hands. CNA #4 concluded handling food with bare hands would be acceptable since she had used hand sanitizer.</p> <p>Interview on 10/03/12 at 1:25 PM, with the Registered Dietitian (RD) revealed staff in the kitchen was not allowed to handle residents' food with their bare hands. The RD stated she was not sure if the handling of residents' food with bare hands during tray delivery was acceptable.</p> <p>Interview with the DON on 10/04/12 at 1:25 PM, revealed the issue regarding handling residents' food with bare hands had been discussed after the residents were served lunch and staff inquired about the practice. The DON stated staff has been instructed to use hand sanitizer but added that she would need to look at the policy to ensure what additional measures were required for meal delivery.</p>	F 441			

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F 441	<p>Continued From page 33</p> <p>2. Observation of a skin assessment for Resident #4 on 10/02/12 at 3:00 PM, revealed LPN #3 started the skin assessment at the resident's feet. LPN #3 was observed to remove the resident's socks with her bare hands. LPN #3 handled Resident #4's feet and legs with her bare hands. Further observation revealed a dressing was dry and intact to the resident's left heel and was scheduled to be changed on 10/04/12. As LPN #3 continued the skin assessment, she donned gloves to expose the resident's perineal area. LPN #3 continued to wear the gloves to complete the skin assessment. Following the skin assessment, LPN #3 was observed to remove the soiled gloves and place the soiled gloves in her uniform pocket. LPN #3 also retrieved a note pad and pen she had placed on the resident's bed and put the items in her pocket with the soiled gloves. Prior to leaving the resident's room, LPN #3 was observed to remove the gloves from her uniform pocket and discard them in the waste receptacle in the resident's room.</p> <p>Interview with LPN #3 on 10/03/12 at 3:10 PM, revealed she realized she had failed to don gloves to perform the skin assessment for Resident #4. LPN #3 stated gloves should be worn with any resident contact. LPN #3 stated she was nervous but should not have put the soiled gloves in her uniform pocket.</p> <p>Interview on 10/04/12 at 1:25 PM, with the DON revealed staff was required to wear gloves for any resident care.</p> <p>3. Observation on 10/03/12 at 8:50 AM, revealed an ice cart positioned in the hallway between</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 CORBIN, KY 40702</b>		
(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 441	<p>Continued From page 34</p> <p>resident rooms 121 and 123. Further observation revealed the ice scoop had been left in the ice chest with the handle in contact with the ice. Continued observation revealed CNA #11 exited resident room 123, opened the ice chest, removed the ice scoop from the ice, filled the resident's ice pitcher with ice, and then placed the ice scoop in the caddy on the ice cart.</p> <p>Interview with CNA #11 on 10/03/12 at 1:10 PM, revealed she did not remember the ice scoop being left in the ice chest. CNA #11 was knowledgeable of the requirement to store the ice scoop in the caddy on the ice cart. CNA #11 stated if the scoop was found in the ice cooler, staff was to take the cooler and scoop to the kitchen to be cleaned.</p> <p>Interview on 10/04/12 at 1:25 PM, with the DON revealed staff was required to store the ice scoop in the caddy on the ice cart when not in use.</p> <p>4. Observation during incontinence care for Resident #17 on 10/03/12 at 4:00 PM, revealed CNA #9 placed a soiled sheet and a soiled incontinence pad on the floor beside Resident #17's bed. CNA #9 was observed to obtain a trash bag and place the soiled items in the trash bag.</p> <p>Additional observation on 10/04/12 at 11:15 AM, revealed CNA #1 was in resident room 209. CNA #1 was observed to be making the bed for Resident #15. Further observation revealed CNA #1 had placed three pillows with the pillowcases on the floor beside Resident #15's bed. Further observation revealed two blankets were lying on top of the pillows. CNA #1 was observed to</p>	F 441			

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

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F 441	<p>Continued From page 35</p> <p>remove the blankets and pillows with the same pillowcases from the floor and place the items on Resident #15's bed.</p> <p>Interview conducted on 10/03/12 at 4:00 PM, with CNA #9 revealed the CNA was knowledgeable of the requirement to place soiled linens in a trash bag. CNA #9 confirmed that placing the soiled linens on the floor could spread germs.</p> <p>Interview with CNA #1 on 10/04/12 at 11:15 AM, revealed linen should never be placed on the floor. The CNA acknowledged the floor was considered dirty and even though she knew not to place residents' linens on the floor, she had rushed to get the resident's bed made.</p> <p>Interview with the Director of Nurses (DON) on 08/23/12 at 2:45 PM, revealed staff had been trained to never place soiled items on the floor to prevent transmission of germs, and confirmed staff should never place soiled linens on a resident's bed.</p>	F 441		

### F157

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) A head to toe assessment was completed on resident #10. The physician was contacted regarding findings and treatment initiated as ordered. The family was notified of the change in status. Resident #10's care plan was updated to reflect the change in status.
- 2) The Director of Nursing and Nursing Supervisors completed head to toe skin assessments on all residents to ensure that treatments were in place for any areas of skin breakdown and MD/RP notification had been completed per facility policy.
- 3) LPN #3 was counseled regarding skin assessment policy/procedures and notification of change. All nursing staff was in-serviced by the Director of Nursing and Administrator regarding skin assessment and treatment and notification of change.
- 4) The Nursing Clinical Coordinators on both units will complete 2 random head to toe assessments on each hallway weekly x 1 month; then 1 per hallway weekly thereafter to ensure that all skin assessments are being completed per policy, with treatments initiated per protocol, and that the MD and RP are being notified timely with any changes in status. Any discrepancies will be corrected immediately and reported to the CQI committee for follow up.
- 5) Date of Correction: 10/26/12

### F164

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 nurse involved in this incident, LPN #1, was counseled regarding her failure to provide privacy to resident B. Resident B was unaffected by this deficient practice as he was unaware that the blind was left open.
- 2) All residents had the potential to be affected by this deficient practice.
- 3) All nursing staff was in-serviced on the importance of maintaining resident privacy when providing personal care, including medication administration. They were specifically reminded of the necessity to always close the window blinds so that others could not see into the room from outside the window. All supervisory staff was in-serviced on the importance of randomly observing staff members from each department to ensure that they are observing all residents' rights to privacy.

- 4) Each nursing supervisor will complete 5 random staff observations weekly x 1 month and then 2 per week thereafter. Any problems will be addressed immediately with the employee and reported to the CQI Committee for follow up.
- 5) Date of Correction: 10/26/12

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) The Treatment Administration Records and Kardex's for Resident #1 and #9 were updated immediately to include the orders for TED hose to be applied. The TED hose were immediately applied as ordered for residents #1 and #9.
- 2) The Director of Nursing and Clinical Coordinators reviewed all resident physician orders of all residents to ensure that all other resident physician orders, including those for TED hose were placed on the Treatment Administration Records, Medication Administration Records, Care Plans and Kardex's and orders carried through as they should be, with no other problems noted for any residents.
- 3) The Clinical Coordinator was counseled regarding proper follow through with all physician orders to ensure that all services are provided to meet the professional standards of quality and making sure that all orders are transferred to the Medication Administration Record, Treatment Administration Record, Kardex and Care Plan. All nursing administrative staff and staff nurses were in-serviced on the importance of following through with all physician orders to make sure that services are provided to meet the professional standards of quality and making sure that all orders are transferred to the Medication Administration Record, Treatment Administration Record, Kardex and Care Plan.
- 4) The Director of Nursing and Clinical Coordinator will randomly check the Physician Orders, Treatment Administration Records, Medication Administration Records, Care Plans, and Kardex's of 5 residents a month to ensure that all orders have been placed on these and carried through per protocol to meet the professional standards of quality for all residents. Any discrepancies will be corrected immediately and reported to the CQI Committee for follow up.
- 5) Date of Correction: 11/9/12

F282

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 air mattress for resident #5 was replaced with a new one and completely inflated at the time of the incident. She was also provided halo rings to aid her in positioning and feelings of safety during ADL care. She has been re-assessed by nursing staff to ensure that her Kardex accurately reflects the amount of assistance needed for ADL's with no discrepancies noted. CNA #6 was counseled regarding the need to follow each resident's Kardex when providing ADL's, specifically, the appropriate number of staff to provide care.
- 2) All air mattresses were checked for proper inflation and functioning to ensure no other residents would be affected. In addition to this, all rooms and equipment throughout the facility were checked to ensure that they were in proper working order to ensure that the residents' environment remained as free from accident hazards as possible. The DON, Clinical Coordinators and MDS Nurses reviewed each resident assessment, Medication Administration Records, Treatment Administration Records, Care Plans and Kardex's to ensure that they accurately reflect each resident's care needs, including the amount of assistance needed for ADL's with no further problems identified.
- 3) All nursing staff have been inserviced by the DON and Administrator regarding the importance of following each resident's care plan/Kardex for all care needs, including the appropriate number of staff is being used, as assessed, to provide care, and to make sure all equipment is safe and in proper working order when in use. Staff Nurses and Clinical Coordinators have been inserviced by the DON and Administrator on how to complete a thorough investigation of incidents/accidents and documentation of these.
- 4) The Director of Nursing and Administrator will closely review each incident report for completeness and immediately investigate any discrepancies, making interventions as necessary. The MDS Coordinators will randomly check 5 Kardex's, Care Plans, Medication Administration Records, and Treatment Administration Records monthly for accuracy. Clinical Coordinators will observe 5 CNA's weekly x 1 month, and then 2 weekly throughout all 3 shifts, thereafter, to ensure that they are following the Care Plan/Kardex for all care needs, including the correct number of staff to provide ADL Care. The housekeeping supervisor will randomly check 5 resident rooms weekly to ensure that the rooms are safe and all equipment is in working order. Any discrepancies will be addressed immediately and reported to the CQI committee for follow up.
- 5) Date of Correction: 11/9/12

### F314

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 physician and responsible party for resident #10 were notified regarding the findings of the skin assessment completed by LPN #3 on 10/2/12. Orders were obtained and a treatment initiated. LPN #3 was counseled by the DON regarding facility policy for skin assessment and treatment and MD/RP notification of change.
- 2) The Director of Nursing and Nursing Supervisors completed head to toe skin assessments on all residents to ensure that treatments were in place for any areas of skin breakdown and that MD/RP notification had been completed per facility policy.
- 3) All nursing staff was in-serviced by the DON and Administrator regarding skin assessment and treatment and notification of change.
- 4) The Clinical Coordinators on both units will complete 2 random head to toe assessments on each hallway weekly x 1 month; then 1 per hall weekly thereafter to ensure that all skin assessments are being completed per policy, with treatments initiated per protocol, and that the MD and RP are being notified timely with any changes in status. Any discrepancies will be corrected immediately and reported to the CQI committee for follow up.
- 5) Date of Correction: 10/26/12

### F323

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 air mattress for resident #5 was replaced with a new one and completely inflated at the time of the incident. She was also provided halo rings to her bed to aide her in positioning and feelings of safety during ADL care. CAN #6 was counseled regarding the importance of always going by what is listed on the Kardex for appropriate number of staff to perform ADL care.
- 2) All air mattresses were checked for proper inflation and functioning to ensure no other residents would be affected. In addition to this, all rooms and equipment throughout the facility were checked to ensure that they were in proper working order to ensure that the residents' environment remained as free from accident hazards as possible. The DON, Clinical Coordinators and MDS Nurses reviewed each resident assessment, Medication Administration Records, Treatment Administration Records, Care Plan and

Kardex's to ensure that they accurately reflect each resident's care needs, including the amount of assistance needed for ADL's with no further problems identified.

- 3) All nursing staff have been inserviced by the DON and Administrator regarding the importance of following each resident's care plan/Kardex for all care needs, including the appropriate number of staff is being used, as assessed, to provide care, and to make sure all equipment is safe and in proper working order when in use. Staff Nurses and Clinical Coordinators have been inserviced by the DON and Administrator on how to complete a thorough investigation of incidents/accidents and documentation of these.
- 4) The Director of Nursing and Administrator will closely review each incident report for completeness and immediately investigate any discrepancies, making interventions as necessary. The MDS Coordinators will randomly check 5 Kardex's, Care Plans, Medication Administration Records, and Treatment Administration Records monthly for accuracy. Clinical Coordinators will observe 5 CNA's weekly x 1 month, and then 2 weekly throughout all 3 shifts, thereafter, to ensure that they are following the Care Plan/Kardex for all care needs, including the correct number of staff to provide ADL Care. The housekeeping supervisor will randomly check 5 resident rooms weekly to ensure that the rooms are safe and all equipment is in working order. Any discrepancies will be addressed immediately and reported to the CQI committee for follow up.
- 5) Date of Correction: 11/9/12

### F329

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 drug regimens of residents #2 and #21 have been reviewed by the attending physicians and reductions made accordingly. The order for resident #21 was incorrectly written as "psychosis due to Seroquel," and has been clarified as, "Seroquel due to psychosis," as it was meant to be.
- 2) The Director of Nursing, with the nursing supervisors, have reviewed the anti-psychotics being utilized for each resident and has worked with each staff physician on reductions of each of these medications as resident appropriate. The consultant pharmacist has also completed a review of all resident drug regimens and new recommendations have

been sent to the physicians, along with updated guidance on their review and completion of these.

- 3) An in-service was conducted with all nursing staff, by the Administrator & DON, to ensure their understanding of their role in ensuring that residents were free of unnecessary drugs. The in-service included: educational information regarding the Black Box Warning and the use of psychotropic medications, the need to observe for duplicate therapy for same diagnoses, observing for adverse effects of medications, and ensuring that physicians are aware if residents have indicators for use of a medication, or possible adverse effects of a medication. The nurses were also advised of the importance of communicating with the physician the resident's diagnoses, behaviors, alternatives to medication usage that have been attempted to reduce or eliminate behaviors. The in-service also reviewed specific conditions that must be present prior to antipsychotic drug therapy being initiated and if done that gradual dose reductions should be attempted unless contraindicated by the physician. The physicians were also reminded of the Regulatory standard and were given a listing of all of their residents, their medications, and their diagnosis for each medication.

The CQI Committee has formed an Unnecessary Medication Reduction Program in which the ID Team, including the physician & pharmacist, are reviewing medications & diagnoses, attempting gradual dose reductions, if not contraindicated, ensuring that rationale for duplicate therapy or explanation as to why physician would not agree to a dosage reduction are documented in the medical record. As a part of this program, a review will also be completed of behavioral interventions for each of the residents as indicated.

The MDS Coordinators were also in-serviced on the importance of reviewing the medications with correlating diagnosis, behaviors, any alternatives attempted, dosage reductions, and duplicate therapy when they complete the RAI process and notifying the Director of Nursing if concerns are noted.

- 4) The CQI Committee designee will review 4 charts per unit on a weekly basis for one month then monthly for one quarter to ensure that medications have appropriate diagnoses, duplicate therapy has been addressed per physician, consultant pharmacists' recommendations are being addressed by physicians timely with rationale to support their decision being documented in the medical record. The audit will also consist of a review of Psychoactive Medication Review assessment that is completed during the RAI process to ensure that it has been completed thoroughly, addressing medication, indications/lack of indications for use, diagnoses, attempted dosage reductions &

alternatives attempted for behaviors if indicated. Any irregularities will be reported to the CQI Committee for further review and follow-up.

5) Date of Correction: 11/9/12

#### F431

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 A was not negatively affected by this deficiency. The Director of Nursing, consulting pharmacist, and Administrator conducted an investigation into the missing .5ml of Ativan, which was a total missing from 2 bottles opened, and the issue was resolved.
- 2) A review of all controlled substances was completed by the consulting pharmacist and Director of Nursing with no other discrepancies noted.
- 3) All nursing staff was in-serviced on med-pass and the reconciliation of controlled substances by the Director of Nursing and Administrator. Pharmacy staff will complete random monthly audits to ensure that controlled substances are being stored and reconciled per facility policy and state and federal guidelines.
- 4) The Clinical Coordinators on each unit will perform narcotic reviews on all controlled substances weekly x 1 month and then monthly thereafter to ensure that these medications are being reconciled appropriately. Any discrepancies will be investigated and reported immediately per facility policy, and reported to the CQI committee for follow up.

5) Date of Correction: 10/26/12

#### 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) Resident's #2, #16, #4, #17 and unsampled residents A and C were not negatively affected by this deficiency. Resident #15's bed linens and pillows were changed as soon as supervisory staff became aware of this deficient practice. One-on-One counseling was completed by the Director of Nursing with CNA's #4, #9, and #1, as well as LPN #3 to make sure they understood their infection control violations and what the correct

procedures were for handling these incidents to maintain a safe and sanitary environment.

- 2) All other residents had the potential to be affected by this deficient practice.
- 3) All staff members were in-serviced on infection control, specifically going over food handling and no bare-hands contact with food; glove use during skin assessments and treatments and proper disposal of gloves; and handling of clean and soiled linens. The facility meal pass policy has been updated to include specific guidance regarding no bare-handed handling of foods. All staff members have been inserviced on this policy update and the procedure for assisting residents with their meals. All department heads and unit supervisors have been in-serviced by the Registered Dietitian and Administrator on the importance of randomly monitoring the infection control practices of all staff members.
- 4) Each department head and unit supervisor will be completing weekly observations of 5 staff members weekly x 1 month, and then 2 weekly thereafter to ensure that they are using the proper infection control practices in order to maintain a safe and sanitary environment for our residents. Any discrepancies will be immediately corrected and reported to the CQI committee for follow up.
- 5) Date of Correction: 10/26/12

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

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K 000	<p>INITIAL COMMENTS</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: 8</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (WET SYSTEM)</p> <p>EMERGENCY POWER: Type II natural gas generator.</p> <p>A life safety code survey was initiated and concluded on 10/02/12, 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.