

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

PRINTED: 04/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2011
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		
(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	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hillcrest Healthcare Center does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure activities were designed to meet the interest and psychosocial needs for one resident (#7), in the selected sample of 24. Resident #7 complained of being bored. Review of activity documentation revealed Resident #7 participated in one activity in a time period of four months. Findings include: A review of the facility's policy for Activity Programs, dated 06/30/06, revealed "A resident's interests and needs were identified and a recreation (Activity) program was designed to appeal to his/her interests and to enhance the resident's highest practicable level of physical, mental and psychosocial well being. Outcomes/responses to recreation program	F 248	 F248 I. How corrective action will be accomplished for those affected: Resident #7 had an individualized activity calendar placed in their room on 4/2/11 with the activities highlighted that they like to attend. Nursing personnel on resident #7's unit were shown this calendar and help requested to ensure resident gets to those activities. Activity aides will ensure resident receives any help needed during an activity and that this is charted. II. How corrective action will be accomplished for those residents having potential to be affected: All residents currently residing in center will have their activities of interest reviewed by the Activity Director to ensure all activity interests are captured by 4/30/11.	5/8/11	



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

TITLE

(X6) DATE

[Handwritten Signature]

ED

4/28/11

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 248	<p>Continued From page 1</p> <p>Interventions were identified in the progress notes of each resident and to assist residents, as needed, to get to and participate in desired activities."</p> <p>Resident #7 was admitted to the facility on 05/13/09, with diagnoses to include Dementia, Osteoarthritis, History of Hip Fracture, History of Wrist fracture and Peripheral Artery Disease.</p> <p>A review of a significant change Minimum Data Set (MDS) assessment, dated 02/02/11, revealed Resident #7 was able to understand and be understood. He/She required extensive assistance of two staff for transfers and was not ambulatory.</p> <p>An observation, on 03/22/11 at 9:30 AM, revealed Resident #7 was in his/her room sitting in a wheelchair. The resident stated he/she was bored and had not attended the activities because he/she required assistance to go to the activities that were provided by the facility. An interview with the resident, on 03/22/11 at 9:30 AM, revealed he/she enjoyed church services when volunteers visited the facility but could not remember when he/she last attended a service. The resident also enjoyed Bingo but his/her vision was impaired and he/she could not participate without the assistance of staff.</p> <p>An interview with the resident's family members, on 03/22/11 at 12:30 PM, revealed Resident #7 enjoyed reading and asked about audio books in the past. The resident also enjoyed listening to the radio, but was not able to operate a radio.</p> <p>An interview with the Activity Director, on 03/24/11 at 8:10 AM, revealed she did not recall that</p>	F 248	<p>Each resident will have an individualized activity calendar posted in their room identifying their activities of interest and what activities they would like to attend by 5/2/11.</p> <p>An in-service will be conducted by the Staff Development Coordinator RN and Activity Director with all nursing staff regarding the posted calendars identifying resident activity preferences and requesting help in ensuring all residents receive adequate help to get them to the activities of their choice to be completed by May 2, 2011.</p> <p>Activity aides will provide appropriate help to all residents who need it while they are leading the groups.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction:</p> <p>Beginning in May, activity calendars not only will be placed in each resident room but they will be individualized by resident so that all staff will be aware of resident activity choices.</p> <p>Each activity employee will check each other's halls at the beginning of each month to ensure the calendars are up timely and individualized.</p>	5/8/11

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F 248	Continued From page 2 Resident #7 attended any specific activity and that family visited frequently. All activities attended by residents were highlighted on the activity calendar and were kept in the residents' charts. An interview with the Activity Assistant, on 03/24/11 at 10:15 AM, revealed she could not recall when she last worked with Resident #7. She stated if she did an "in room" activity with the resident, she would have it documented on the "One to One Activity Sheet." An interview with the Director of Nursing (DON), on 03/24/11 at 10:45 AM, revealed the resident's family members visited often and the DON was not aware Resident #7 complained of being bored. She stated the resident enjoyed talking with people and should be provided an activity. A review of the monthly activity calendars, dated November/December 2010 and January/February 2011, revealed only one activity was highlighted as attended for those months.	F 248	Resident attendance sheets will be checked by the Activity Director or Activity Assistant against the calendar when they are put into charts at the end of each month to ensure residents are attending those events of interest to them. IV. How the facility plans to monitor its performance to make sure that solutions are sustained. The Activity Director will monitor resident attendance and participation in activities of interest on a monthly basis as well as resident satisfaction with activities based on the Resident Council monthly meeting. A report on the findings will be brought to the monthly Performance Improvement Committee (consisting of the Executive Director, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Activity Director, Social Services Director, Medical Director, Environmental Supervisor, and Maintenance Director) for three months or until the committee determines compliance has been sustained.	5/8/11
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure a clean, comfortable environment for one resident (#7), in	F 253	F253 I. How corrective action will be accomplished for those affected: The Maintenance Director pulled the toilet in resident #7's room and replaced the wax ring. The grout was cleaned with an enzyme cleanser to destroy the urine odor. This was done the week of 3/21/11.	5/8/11

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F 253	Continued From page 3 the selected sample of 24. Observations on 03/22/11 and 03/23/11 and interviews with family and staff revealed Resident #7's bathroom had a very strong urine odor. Findings include: Observations on 03/22/11 at 9:30 AM, at 2:00 PM and at 4:00 PM and on 03/23/11 at 8:30 AM, at 12:00 PM and at 3:00 PM revealed Resident #7's bathroom had a very strong urine odor. An interview with Resident #7 and his/her family members, on 03/22/11 at 12:30 PM, revealed the bathroom had a strong urine odor "for some time," and another resident used that bathroom and urinated on the floor instead of the toilet. Family members who visited daily stated the strong urine odor was always present and they could not go in the bathroom to use the sink to clean Resident #7's dentures, due to the odor. The odor could be detected from the hall and the family members had complained to the housekeeping staff members, but nothing had changed. An interview with Environmental Services Staff member #1, on 03/24/11 at 10:00 AM, revealed she did not know how many residents used that bathroom, but the urine odor remained even after it was cleaned. An interview with the Environmental Services Supervisor, on 03/24/11 at 10:30 AM, revealed he received complaints about the bathroom and staff cleaned it as often as three times a day in the past; however, he was unaware there was still a problem with the urine odor.	F 253	II. How corrective action will be accomplished for those residents having potential to be affected: The Environmental Services Director, the Maintenance Supervisor or their designee will make weekly rounds of a sample of resident rooms and bathrooms to assure the facility is maintained in a sanitary manner. The Environmental Services Director, the Maintenance Supervisor or their designee will review any findings with the Executive Director and corrective action will be implemented as indicated. III. What measures will be put in place/systemic changes made to ensure correction: The Assistant Housekeeping Supervisor will interview a random sample of residents from at least one room per hall weekly to validate clean and odor free environment. Staff Development Coordinator RN or designee will train all current nursing staff on maintaining a sanitary, orderly, and comfortable interior. In-servicing to be completed by May 2, 2011. The Environmental Services Director will re-train all housekeeping staff on maintaining a sanitary, orderly, and comfortable interior on 4/15/11. This training will also be included in orientation of all new employees.	5/8/11
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	<p>Continued From page 4</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: Based on observations, interviews, and record reviews, it was determined the facility failed to ensure services were provided or arranged to meet professional standards of quality for one resident (#5), in the selected sample of 24 and for one resident (#26), not in the selected sample. On 03/22/11 at 3:56 PM, Certified Medication Aide (CMA) #1 crushed Resident #5's medication (Bisacodyl) and at 4:15 PM, CMA #1 crushed Resident #26's medication, (Ferrous Sulfate) which were labeled on the Medication Administration Records (MAR) as "do not crush." Findings include:</p> <p>A review of the facility's policy entitled, "Medication Administration," dated 10/31/10, revealed "The nursing staff use the medication cart systematically to distribute physician ordered medication to residents. Authorized personnel administered medications, which included medications that needed intravenous administration." Additionally, the policy entitled, "Oral Medication Administration," dated 10/31/10, revealed "Verify physician's orders and resident's identity. If the medication is to be crushed, check the Crush List before the medication is crushed."</p> <p>1. Resident #5 was admitted to the facility on 01/18/09, with diagnoses to include Alzheimer's Disease Complicated with Behaviors, Depression, Anemia and Hypertension.</p> <p>A review of the physician's orders, dated 03/01/11</p>	F 281	<p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The Environmental Supervisor and Maintenance Supervisor will monitor through weekly environmental rounds to assure that the facility is maintained in a sanitary and comfortable manner. A report on the findings will be brought to the monthly Performance Improvement Committee (consisting of the Executive Director, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Activity Director, Social Services Director, Medical Director, Environmental Supervisor, and Maintenance Director) for three months or until the committee determines compliance has been sustained.</p> <p>F281</p> <p>I. How corrective action will be accomplished for those affected:</p> <p>The Certified Medication Aid involved in the medication pass observation was verbally counseled by the Director of Nursing regarding correct procedures on 3/22/11. Order clarifications for both Resident #5 and Resident #26 were received on 3/22/11 by the Licensed Nurse.</p> <p>II. How corrective action will be accomplished for those residents having potential to be affected:</p>	5/8/11

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F 281	<p>Continued From page 5</p> <p>through 03/31/11, revealed an order for Bisacodyl (do not crush) 5 mg tablet by mouth daily.</p> <p>An observation, on 03/22/11 at 3:56 PM, revealed CMA #1 administered Bisacodyl 5 milligram (mg) tablet (laxative) crushed in applesauce to Resident #5. CMA #1 did not check the "Medications not to be Crushed List" prior to administration of the medication.</p> <p>2. Resident #26 was admitted to the facility on 11/01/05 with diagnoses to include Hemorrhagic Cystitis, Coronary Artery Disease, History of Colon Cancer, Depression and Hypertension.</p> <p>A review of the physician's orders, dated 03/01/11 through 03/31/11, revealed an order for Ferrous Sulfate (do not crush) 325 mg tablet by mouth daily.</p> <p>An observation, on 03/22/11 at 4:15 PM, revealed Resident #26 was administered Aspirin 81 mg tablet, Glyburide 1.25 mg tablet, Plavix 75 mg tablet, Hydralazine Hydrochlorothiazide 25 mg tablet, Caltrate 600 mg tablet, and Ferrous Sulfate 325 mg tablet crushed in applesauce. CMA #1 did not check the "Medications not to be Crushed List" prior to the administration of Ferrous Sulfate to Resident #26.</p> <p>An interview with CMA #1, on 03/23/11 at 3:40 PM, revealed she administered medications to Residents #5 and #26 on 03/22/11. She stated, "I check supplies and medications before I start the medication pass. We have a list in front of the MARs of the medications not to be crushed. If I had a question about crushing a medication, I could look at it. I did not realize Bisacodyl and Ferrous Sulfate were not to be crushed. I always</p>	F 281	<p>The Director of Nursing and/or her designee will conduct an audit of the medications for all residents having their medications crushed. For any medications that are not to be crushed the physicians will be contacted and new orders requested for a new medication or for an alternate form.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction:</p> <p>The Staff Development Coordinator will conduct an in-service with the licensed staff/CMA on meeting professional standards with an emphasis on medications that are not to be crushed (PRO 6210). In-service to be completed by May 2, 2011. The Staff Development Coordinator will include information regarding meeting professional standards of quality and medications that are to be crushed in the orientation of new licensed personnel. The Staff Development Coordinator/designee will complete a medication administration check off with each licensed nurse and CMA annually.</p>	5/8/11

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F 281	Continued From page 6 crushed his/her medication. I will let my nurse know I crushed medications that were not supposed to be crushed." An interview with Licensed Practical Nurse (LPN) #3, on 03/23/11 at 4:00 PM, revealed CMA #1 told her about the error after the Assistant Director of Nursing (ADON) informed her of the medication error which involved CMA #1. The CMAs were expected to review the MARs before they started the medication passes to ensure they had the medications and equipment needed for the administration of the medications. There's a "Do Not Crush" list on the carts for the staff to use. An interview with the Director of Nursing (DON), on 03/24/11 at 11:00 AM, revealed the Ferrous Sulfate was not on the "do not crush list." The computer software company they utilized automatically put "do not crush" on the orders for Ferrous Sulfate. The resident's physician did not write an order to not crush the Ferrous Sulfate; however, he did sign the orders which meant he agreed to that order. The Bisacodyl was not supposed to be crushed and was listed on the "do not crush list." The staff were expected to gather equipment prior to starting the medication passes and look at the MARs and follow the orders.	F 281	IV. How the facility plans to monitor its performance to make sure that solutions are sustained. A sample of 25 medication pass opportunities per month will be conducted by the Director of Nursing, Assistant Director of Nurses and Staff Development Coordinator for three months and reported by the Director of Nursing to the Performance Improvement Committee (consisting of the Executive Director, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Activity Director, Social Services Director, Medical Director, Environmental Supervisor, and Maintenance Director) for three months or until the committee determines compliance has been sustained. F282 I. How corrective action will be accomplished for those affected: The Care Plan and ADL assignment sheet for Resident #12 was compared to ensure both were up to date. Nursing personnel will be in serviced on importance on ensuring Resident #12 had all fall interventions in place. This in servicing will be completed by May 2, 2011 by the Staff Development Coordinator.	5/8/11
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	F 282	II. How corrective action will be accomplished for those residents having potential to be affected:	5/8/11

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F 282	<p>Continued From page 7</p> <p>by: Based on observations, interviews, and record reviews, it was determined the facility failed to ensure one resident (#12), in the selected sample of 24, was provided care according to the care plan. Resident #12 was care planned to have anti-roll backs, a sensor pad and a pull tab alarm to the wheelchair, as well as a sensor pad to the bed and grip tape on the floor beside the bed. Observations of Resident #12 revealed the staff failed to ensure the sensor pad and pull tab alarm to the wheelchair were in place on 03/21/11 and failed to ensure the pull tab alarm was in place on 03/22/11, on 03/23/11 and on 03/24/11. Findings include:</p> <p>A review of the policy, entitled "Care Plans," dated 10/31/09, revealed, "A comprehensive care plan is developed that is consistent with the resident's specific conditions, risks, needs, behaviors, preferences and with standards of practice which include measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in the resident's assessment or as identified in relation to the resident's response to the interventions or changes in the resident's condition."</p> <p>Resident #12 was admitted to the facility on 10/09/04, with diagnoses to include Coronary Artery Disease, Hypertension, History of Cerebral Vascular Accident and Osteoporosis.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 02/28/11, revealed the resident had a Brief Interview for Mental Status (BIMS) score of "12", which indicated the resident was moderately cognitively impaired. The resident was assessed to require supervision with</p>	F 282	<p>An initial audit, with a particular emphasis on fall prevention interventions, will be performed of each Resident's Plan of Care and ADL sheets by the Unit Managers on each unit to insure resident's plan is communicated to direct care nursing staff. This audit will be completed by May 5, 2011.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction:</p> <p>Nurse assistant assignment sheets will include each resident's interventions as identified on the comprehensive plan of care. Unit Managers and/or charge nurses will review assignment sheets daily to ensure care plan changes are noted and nurse assistants are made aware of new interventions. Nursing staff will be in-serviced on Policy 605, Care Plans with emphasis on the importance of following the resident's plan of care. In-servicing to be completed by May 2, 2011.</p>	5/8/11

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F 282	<p>Continued From page 8</p> <p>transfers and had a fall history with no injuries.</p> <p>A review of the comprehensive care plan "Resident at risk for falls," dated 02/09/11, revealed an intervention which included anti-roll backs, sensor pad and a pull tab alarm to the wheelchair, as well as a sensor pad to the bed and grip tape on the floor beside the bed.</p> <p>An observation of the resident, on 03/21/11 at 8:31 PM, revealed he/she was in his/her wheelchair visiting a peer. Further observation revealed there was no sensor pad or pull tab alarm in place on the resident's wheelchair.</p> <p>On 03/22/11 at 9:10 AM, Resident #12 was observed in his/her wheelchair in a group activity with peers. At 11:30 AM, the resident was in his/her wheelchair in his/her room. At 3:25 PM, the resident was in his/her wheelchair on the hallway. During these observations, there was no pull tab alarm in place on the resident's wheelchair.</p> <p>On 03/23/11 at 7:40 AM, the resident was observed in his/her wheelchair awaiting the breakfast meal. At 12:40 PM and 2:30 PM, the resident was in his/her wheelchair in the lobby with peers. At 4:45 PM, the resident was in his/her wheelchair in the bedroom. During these observations, there was no pull tab alarm in place on the resident's wheelchair.</p> <p>On 03/24/11 at 8:30 AM, the resident was observed in his/her wheelchair in his/her room, awake and alert. No pull tab alarm was in place on the resident's wheelchair.</p> <p>An interview with Certified Nurse Aide (CNA) #5,</p>	F 282	<p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Unit Managers/weekend supervisor will make daily rounds to make sure care plan interventions are being implemented. DNS will monitor compliance and report to the monthly Performance Improvement Committee (consisting of the Executive Director, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Activity Director, Social Services Director, Medical Director, Environmental Supervisor, and Maintenance Director) for three months or until the committee determines compliance has been sustained.</p>	5/8/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2011
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 9</p> <p>on 03/24/11 at 9:20 AM, revealed she was assigned to provide care to the resident. She stated the CNAs carry an assignment sheet with them so they know what care to provide for the residents. She assisted the resident with getting dressed, ensured he/she washed well, and set up his/her tray. The resident attempted to go to the bathroom on his/her own. The resident had a sensor pad and pull tab alarm. CNA #5 stated staff members tried to put the alarms out of the reach of the resident; however, at 9:28 AM, CNA #5 revealed Resident #12 was in his/her bedroom in the wheelchair without the pull tab alarm in place. CNA #5 stated the resident did not have the alarm on but was supposed to have the pull tab alarm on while in the bed and wheelchair.</p> <p>An interview with Resident #12, on 03/24/11 at 9:28 AM, revealed, "No, I did not have that alarm clipped to me today. The staff do not want me to take the clip off when they put it on. I guess they were afraid I might fall, but the alarm had not been on in awhile."</p> <p>An interview with CNA #4, on 03/24/11 at 9:30 AM, revealed she was familiar with the resident and was assigned his/her care the previous day. She reported Resident #12 was able to do most of his/her activities of daily living (ADLs) for himself/herself. CNA #4 stated she assisted the resident to get dressed. The resident was supposed to have a sensor pad alarm and a pull tab alarm while in the bed and wheelchair. She stated the resident had a habit of removing the pull tab alarm because he/she felt it was not needed. Whenever staff members assisted the resident to bed or to the wheelchair, the staff member who assisted the resident was responsible to make sure the alarms were in</p>	F 282		5/8/11	

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F 282	Continued From page 10 place and functioned properly. She stated the resident stood up earlier that morning and the sensor alarm sounded but she did not see a pull tab alarm on the resident and did not ensure the alarm was in place. An interview with Licensed Practical Nurse (LPN) #4, on 03/24/11 at 10:41 AM, revealed the resident had a fall history. The resident was supposed to have a pull tab alarm and a sensor pad alarm in bed or while in the wheelchair. The CNAs, who assisted the resident out of bed, were responsible to make sure the resident had all the alarms in place. They also made sure the alarms functioned properly. Resident #12 was known to remove his/her alarm and if an alarm was removed, the staff were expected to put it back on the resident. The CNAs were expected to place the alarms on the residents as indicated in their care plans. As the nurse on the unit, she completed a compliance round at intervals through out the day with no set times. The CNAs signed the aide flow sheet at the end of the day. When they initialed it, this verified the resident's care was completed per the care plan. CNA #5 informed her on 03/24/11 that the resident did not have the pull tab alarm in place, and it needed the batteries replaced.	F 282		5/8/11	
F 323 SS=E	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	F 323	F323 I. How Corrective action will be accomplished for those affected: Resident #1 was evaluated by therapy on March 22, 2011 and they determined the	5/8/11	

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F 323	Continued From page 11 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to ensure the resident's environment was as free of accident hazards as is possible and the residents receive adequate supervision and assistance devices to prevent accidents for three residents (#1, #12, and #13), in the selected sample of 24. Resident #1 was observed to be transferred with a draw sheet; however, the care plan revealed he/she was supposed to be transferred with a mechanical lift. Resident #12 was care planned to have a sensor pad alarm and a pull tab alarm to the wheelchair and bed. Observations of Resident #12 revealed the staff failed to ensure the sensor pad and pull tab alarm to the wheelchair were in place on 03/21/11 and failed to ensure the pull tab alarm was in place on 03/22/11, on 03/23/11 and on 03/24/11. Resident #13 was ordered a pureed diet related to being diagnosed with an esophageal stricture. Observations revealed he/she was served a piece of cornbread on his/her supper tray. Findings include: 1. Resident #12 was admitted to the facility on 10/09/04 with diagnoses to include Coronary Artery Disease, Hypertension, History of Cerebral Vascular Accident and Osteoporosis. A review of the quarterly Minimum Data Set (MDS), dated 02/28/11, revealed the resident had a Brief Interview for Mental Status (BIMS) score	F 323	safest mode of transfer was with a mechanical sling lift. We began using a mechanical lift for transfers and resident #1's care plan and nurse aide assignment sheet was updated to reflect this on March 22, 2011 after therapy evaluation. This was done by the unit manager. Resident #12 was reviewed for their fall interventions by the Residents At Risk Committee consisting of the Assistant Director of Nursing, the Unit Managers and Social Services on April 5, 2011 to include sensor pad with control under seat, anti roll-backs, pull-tab alarm at all times, non-skid shoes and non-skid strips in front of bed with no changes made to their safety devices. On April 19, the At Risk Committee once again reviewed this resident's fall interventions for continued effectiveness. Resident #12 was reviewed again on April 26 by the At Risk Committee with the recommendation to discontinue the personal alarm and continue with all other safety interventions. Resident #13 had the cornbread removed from their plate on March 22, 2011. Resident # 13 continues on a pureed diet and does receive foods only of pureed consistency. Immediate in servicing was done on March 22, 2011 with the dietary staff on duty by the registered dietician.	5/8/11	

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F 323	<p>Continued From page 12</p> <p>of "12" which indicated the resident was moderately cognitively impaired. The resident was assessed to require supervision with transfers and had a fall with no injuries.</p> <p>A review of the comprehensive care plan, "Resident at Risk For Falls," dated 02/09/11, revealed there were interventions in place such as anti-roll backs to the wheelchair, a sensor pad and a pull tab alarm to the wheelchair, as well as a sensor pad to the bed and grip tape on the floor beside the bed.</p> <p>An observation of the resident, on 03/21/11 at 8:31 PM, revealed he/she was in his/her wheelchair visiting a peer. Further observation revealed there was no sensor pad or pull tab alarm in place on the resident's wheelchair.</p> <p>On 03/22/11 at 9:10 AM, Resident #12 was observed in his/her wheelchair in a group activity with peers. At 11:30 AM, the resident was in his/her wheelchair in his/her room. At 3:25 PM, the resident was in his/her wheelchair on the hallway. During these observations, there was no pull tab alarm in place on the resident's wheelchair.</p> <p>On 03/23/11 at 7:40 AM, the resident was observed in his/her wheelchair awaiting the breakfast meal. At 12:40 PM and 2:30 PM, the resident was in his/her wheelchair in the lobby with peers. At 4:45 PM, the resident was in his/her wheelchair in the bedroom. During these observations, there was no pull tab alarm in place on the resident's wheelchair.</p> <p>On 03/24/11 at 8:30 AM, the resident was observed in his/her wheelchair in his/her room,</p>	F 323	<p>The training included following spreadsheets for therapeutic diets. Nursing Staff on duty was in serviced on March 22, 2011 by the staff development coordinator. The training included following therapeutic diets and following tray cards at the time of tray service. In servicing continued with on-coming staff on March 23, 2011 and all education to be completed on May 2, 2011.</p> <p>Resident #13 was re-evaluated by speech therapy on March 29, 2011 to ensure appropriateness of their diet orders and need for assistance with meals. Resident #13's care plan was updated by the Director of Nursing on March 29, 2011 to reflect this evaluation.</p> <p>II. How corrective action will be accomplished for those residents having potential to be affected:</p> <p>An initial audit, with a particular emphasis on diet, transfers, alarms, supervision and assistive devices will be performed of each Resident's Plan of Care and nurse aide assignment sheets by the Unit Managers and administrative nurses on each unit to insure resident's plan is communicated to direct care nursing staff to be completed by May 5, 2011. The unit managers will revise the nurse aide assignment sheets and ensure care plans are updated with changes.</p>	5/8/11

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F 323	<p>Continued From page 13</p> <p>awake and alert. No pull tab alarm was in place on the resident's wheelchair.</p> <p>An interview with Certified Nurse Aide (CNA) #5, on 03/24/11 at 9:20 AM, revealed she provided care to the resident. The resident was supposed to have a sensor pad and pull tab alarm in place. An interview at 9:28 AM revealed she observed Resident #12 in his/her bedroom in the wheelchair without the pull tab alarm in place. CNA #5 stated the resident did not have the alarm on but was supposed to have the pull tab alarm on while in the bed and while in the wheelchair.</p> <p>An interview with Resident #12, on 03/24/11 at 9:28 AM, revealed, "No, I did not have that alarm clipped to me today. The staff did not want me to take the clip off when they put it on. I guess they were afraid I might fall, but the alarm has not been on in awhile."</p> <p>An interview with CNA #4, on 03/24/11 at 9:30 AM, revealed she was familiar with the resident and was assigned to his/her care the previous day. The resident was supposed to have a sensor pad alarm and a pull tab alarm while in the bed and wheelchair. She stated the resident had a habit of removing the pull tab alarm because he/she felt it was not needed. She stated the resident stood up earlier that morning and the sensor alarm sounded, but she did not see a pull tab alarm on the resident and did not ensure the alarm was in place.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 03/24/11 at 10:41 AM, revealed the resident had a fall history, (recently on 03/18/11). The resident had a pull tab alarm and a sensor</p>	F 323	<p>III. What measures will be put in place/systemic changes made to ensure correction:</p> <p>SDC/designee will in service all staff on importance of following Plan of Care (POL 605) correctly for each resident with emphasis on Fall interventions, transfers and dietary restrictions. Nursing staff will also be in-serviced on Resident Mobility Safety (POL 513), Mechanical Sling Lift (PRO 51010), and Dining Skills (PRO 61007-02) with emphasis on monitoring trays for appropriateness and matching of meal to tray card. In-servicing to be completed by May 2, 2011.</p> <p>Therapy will evaluate/screen all residents who have been identified to use mechanical lifts for safe transfers and use of mechanical lifts.</p> <p>All care plans and nurse aide assignment sheets have been updated to reflect the use of mechanical lift and sling size recommended for each resident.</p> <p>Therapy will evaluate residents prior to using mechanical lifts for transfers except in emergency situations outlined in Emergency Blanket Transfers PRO 53000-01 such as a Fire or total evacuation of a facility.</p> <p>Diet orders for all residents were reviewed by the District Director of Clinical Operations on March 22, 2011 and compared to the tray cards to ensure correctness. The unit managers are comparing diet orders with the nurse aide</p>	5/8/11

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F 323	<p>Continued From page 14</p> <p>pad alarm while in bed or in the wheelchair. When the CNAs assisted the resident, they were to ensure all alarms were in place and functioned properly. The CNAs were expected to place the alarms on the residents as indicated in the care plans. She was not aware the resident did not have the pull tab alarm on until the CNA informed her. The alarms were in place to alert the staff whenever the resident attempted to get up unassisted and the staff knew to go to the area when they heard the alarm.</p> <p>An interview with Registered Nurse (RN) #1, on 03/24/11 at 10:52 AM, revealed she was the Unit Manager where the resident resided. She stated the staff were expected to complete care according to the resident's care plan and tried to allow him/her to remain as independent as possible. She also stated Resident #12 had falls in the past; however, the staff did not ensure both alarms were in place according to the care plan.</p> <p>An interview with the Director of Nursing (DON), on 03/24/11 at 11:00 AM, revealed the staff members were expected to provide care according to the resident's care plan. The staff members needed to ensure Resident #12 had both of his/her alarms in place.</p> <p>2. A review of the policy, "Dining Skills Level", dated 03/05/08, revealed verbal cues on proper intake of food should be given to individuals who required supervision and limited assistance with dining. Trays would be monitored by food appropriateness and the meal matched to the tray card.</p> <p>A lunch observation, on 03/22/11 at 12:20 PM, revealed Resident #13 received a lunch tray at</p>	F 323	<p>assignment sheets to be completed by May 5, 2011.</p> <p>Dietary staff received specific education by the registered dietician on following the spreadsheet for therapeutic diets on 4/11. The tray line was reviewed by the Administrator, Nutritional Services Supervisor and the registered dietician to identify opportunities to improve the process on 3/24/11. Job duties were realigned to assign one staff member to address special requests during lunch to minimize interruptions during the tray line.</p> <p>Unit Managers/weekend supervisor will make daily rounds to make sure care plan interventions are being implemented</p> <p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained;</p> <p>The Unit Manager's daily round sheets will be turned in to the DNS for review and findings reported at the monthly Performance Improvement Committee (consisting of the Executive Director, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Activity Director, Social Services Director, Medical Director, Environmental Supervisor, and Maintenance Director) for three months or until the committee determines compliance has been sustained.</p> <p>Please refer to F364 for dietary monitoring plan.</p>	5/8/11

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F 323	<p>Continued From page 15</p> <p>12:40 PM. Certified Nurse Aide (CNA) #1 set up the tray in the resident's room. The diet card specified a pureed standard tray, with no "lumps" in the food. The pureed meat and corn had visible "lumps", and a piece of cornbread was on the resident's tray. From 12:40 PM to 1:10 PM, the resident received no assistance with lunch. LPN #1 was informed by the surveyor about the cornbread at 1:10 PM, and the item was removed from the resident's tray.</p> <p>A record review revealed Resident #13 was admitted to the facility on 09/05/10 with a diagnosis to include Esophageal Stricture. A review of the quarterly Minimum Data Set (MDS), dated 02/03/11, revealed the facility identified the resident to be cognitively intact with setup and supervision required for eating. The MDS revealed the resident had difficulty or pain with swallowing.</p> <p>A review of the "Medical Nutrition Therapy Assessment", dated 09/05/10, revealed Resident #13 had a diagnosis of Esophageal Stricture with difficulty swallowing and was disoriented and confused at times. A review of the "Dysphagia Discharge Summary", dated 10/18/10, revealed recommendations included a pureed diet with a bite/sip size of one-half teaspoon.</p> <p>A review of the physician's orders, dated 02/11/11, revealed an order for a regular pureed, "baby food" diet with a specified feeding order of small bites (three to five) milliliters (ML), and small sips (five to eight) ML. The order was to provide assistance with all meals.</p> <p>A review of the Comprehensive Care Plan, dated 02/13/11, revealed the resident should be</p>	F 323		5/8/11

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F 323	<p>Continued From page 16</p> <p>assisted during meals, with feeding instructions of small bites and sips (as specified by the physician's order). A review of the "Assignment Sheet", dated 03/22/11, revealed a regular, pureed "baby food" diet for Resident #13.</p> <p>An interview with CNA #1, on 03/22/11, revealed she set up the resident's lunch tray, but did not see the cornbread on the tray. She revealed the resident required no assistance with eating. If the resident consumed the cornbread, she stated, "The resident could have choked."</p> <p>An interview with LPN #1, on 03/24/11 at 9:45 AM, revealed staff were expected to read the resident's diet card to ensure the correct diet and consistency of the tray. She stated cornbread was not acceptable on a pureed diet. She also revealed the pureed food was not "baby food" consistency.</p> <p>An interview with LPN #2, on 03/23/11 at 4:10 PM, revealed she expected staff to ensure the resident's diet order was followed and Resident #13 required setup assistance with meals.</p> <p>An interview with the Dietary Manager, on 03/23/11 at 4:30 PM, revealed the cornbread was placed on the resident's tray in error. He revealed, "We have been working on a better system." He attempted several times to make the resident's food "less lumpy", but certain foods were difficult to puree. He revealed, "baby food" consistency should have no "lumps."</p> <p>An interview with the DON, on 03/24/11 at 11:10 AM, revealed the specific feeding order for Resident #13 should have been discontinued, as the resident did not need assistance with meals.</p>	F 323		5/8/11

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F 323	<p>Continued From page 17</p> <p>She expected staff to compare the food on a resident's tray to the diet card. Dietary should be made aware when a resident received food inconsistent with their diet order.</p> <p>3. Resident #1 was admitted to the facility on 04/08/08 with diagnoses to include Alzheimer's Dementia, Dysphagia, Chronic Obstructive Pulmonary Disease and Renal Failure. An annual MDS assessment, dated 01/15/11, revealed the facility assessed the resident to require extensive assistance of two staff for transfers.</p> <p>A review of the Comprehensive Care Plan, dated 04/15/08, revealed "transfer bed to chair with mechanical lift and two assist." The intervention was dated 11/18/09.</p> <p>A review of the Nurse Aide Flow Sheet Record, dated 03/01/11 through 03/31/11, revealed "transfer bed to chair with mechanical lift and two assist."</p> <p>An observation, on 03/22/11 at 11:40 AM, revealed Resident #1 was transferred from the bed to a Broda chair. CNA #1 was positioned at the head of the bed and CNA #2 was at the foot of the bed and each CNA held the corners of a draw sheet, which was underneath the resident. They lifted the resident from the bed and positioned him/her over the Broda chair and then lowered the resident onto the Broda chair.</p> <p>Interviews with CNA #1 and CNA #2, on 03/22/11 at 11:45 AM, revealed they always lifted and transferred the resident with a sheet because they thought "they were supposed to." CNA #1 and CNA #2 were not sure what care plan interventions were documented to transfer</p>	F 323		5/8/11	

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F 323	Continued From page 18 Resident #1. An interview with Occupational Therapist (OT) #1, on 03/22/11 at 3:10 PM, revealed he would not make a recommendation to transfer a resident with a sheet because it was not safe. An interview with RN #1, on 03/22/11 at 3:20 PM, revealed she thought "therapy" administered training for staff regarding sheet transfers. An interview with the DON, on 03/22/11 at 5:00 PM, revealed Resident #1 was discussed in the morning meeting, (date unknown) and staff members determined the resident should be lifted and transferred with a sheet. The DON stated she was not aware if the facility completed an assessment for the safe use of a sheet during transfers. The DON stated she thought CNAs were trained in CNA School to transfer with a sheet.	F 323		5/8/11
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to	F 364	F364 I. How Corrective action will be accomplished for those affected: Nutrition Services Manager met with Resident #13 and reviewed food preferences on 3/22/11. Resident #13 had requested more soup so pureed homemade soup has been made available on a daily basis. NSM will ensure that their pureed foods are served in separated dishes so that food will not run together.	5/8/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2011
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303		
(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 364	<p>Continued From page 19</p> <p>ensure residents received food prepared in a manner which retained food quality, taste and appearance. Food was maintained on the steam table, during the noon meal on 03/22/11, for up to two (2) hours and 45 minutes and food was placed on the steam table one (1) hour and 30 minutes prior to the noon meal service. In addition, pureed meals were not served in divided plates and had a lumpy and runny consistency. A review of the Census and Condition Report, dated 03/21/11, revealed the facility census was 145, with 141 of those residents served food from the kitchen.</p> <p>Findings include:</p> <p>1. An observation of the kitchen, on 03/22/11 at 10:30 AM, revealed the steam table was being prepared for serving green chili stew, bean and corn salad, mashed potatoes, rice, alternates for the renal diets, green beans, chicken soup, corn and pureed bread and stew.</p> <p>A review of the "Lunch Dining Schedule," dated 02/01/11, revealed the tray line should start service at 12:00 PM and continue service until approximately 1:10 PM, when the Main Dining Room was scheduled for the second seating to be served.</p> <p>An interview with the Dietary Manager, on 03/22/11 at 10:35 AM, revealed there was no way to cook for and serve 150 residents in 20 minutes from the steam table.</p> <p>An interview with the Dietician, on 03/22/11 at 10:40 AM, revealed he was unaware meals were held on the steam table for one and one-half (1 1/2) hours prior to meal service.</p>	F 364	<p>Nutrition Services Manager educated dietary staff on ensuring the food is placed on the steam table no more than 30 minutes prior to starting the tray line which began with the next meal on March 22, 2011.</p> <p>II. How corrective action will be accomplished for those residents having potential to be affected</p> <p>All residents with pureed diet orders have been reviewed by dietician on April 14, 2011 to ensure food is being served in an attractive manner, according to MD orders, and at proper consistency. Divided plates are now being used with each meal for pureed diets. No food is to be placed on the steam table prior to 1/2 hour before being served according to our PRO 54003.</p> <p>III. What measures will be put in place/systemic changes made to ensure correction:</p> <p>All dietary staff will be trained by NSM and dietician on PRO 54003 and importance of ensuring resident receive food prepared in a manner which retains food quality, taste and appearance. Staff has been in serviced on how to prepare pureed foods to ensure that there is a smooth texture with no lumps for residents on a pureed diet. This training was completed on April 14, 2011.</p>	5/8/11	

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F 364	<p>Continued From page 20</p> <p>2. A review of the policy, "Food Preparation and Presentation", dated 10/31/08, revealed food was prepared according to standardized, adjusted recipes for pureed foods in order to produce an appetizing and palatable meal. Food was prepared in a form designed to ensure individual needs were met. Pureed foods should be the consistency of pudding or mashed potatoes. Every effort should be made to make pureed foods appetizing and attractive, with an appearance that closely resembled the unprocessed food;</p> <p>An observation of the lunch meal, on 03/22/11 at 12:40 PM, revealed Resident #13 received pureed mashed potatoes, corn and meat. The portions were not separated. The mashed potatoes were runny and ran into the other foods on the plate. The meat and corn had visible "lumps." An observation of the breakfast meal, on 03/23/11 at 7:35 AM, revealed the resident received pureed eggs, meat and bread. All items were covered with white gravy. A runny "yellow substance" covered the bottom of the plate. The meat had visible "lumps." Further observation of the breakfast meal, on 03/24/11 at 7:45 AM, revealed ground sausage with visible "lumps."</p> <p>A record review revealed Resident #13 was admitted to the facility on 09/05/10 with a diagnosis of Esophageal Stricture. A review of the quarterly Minimum Data Set (MDS), dated 02/03/11, revealed the facility identified the resident to be cognitively intact with setup and supervision required for eating. A review of the "Physician's Orders", dated 02/11/11, revealed an order for a regular pureed, "baby food" diet.</p> <p>An interview with Resident #13, on 03/22/11 at</p>	F 364	<p>The Dietary Manager will include information on food palatability, following recipes and delivery of food at the desired temperature, in the orientation of new dietary personnel. These in services were done on 4/11.</p> <p>The Dietary Manager will attend Resident Council monthly to discuss the palatability and temperature of the food and make any changes as appropriate based on resident concerns</p> <p>The Registered Dietician will conduct monthly audits for tray accuracy and food palatability and presentation. Any concerns will be addressed immediately.</p> <p>IV. How the facility plans to monitor its performance to make sure that solutions are sustained: The Dietary Manager will monitor through observation and record review, at least monthly for three months, then at least quarterly, to assure that residents receive palatable food at the desired temperature. The dietician will track and trend data on resident council interviews and monthly tray audits. This will be reported monthly at the Performance Improvement Meeting (consisting of the Executive Director, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Activity Director, Social Services Director, Medical Director, Environmental Supervisor, and Maintenance Director) by the registered dietician for three months or until the committee determines compliance has been sustained.</p>	5/8/11	

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NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303	
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F 364	<p>Continued From page 21</p> <p>12:55 PM, on 03/23/11 at 7:35 AM, and on 03/24/11 at 7:45 AM, revealed the foods prepared by dietary were always mixed together. The food was often unrecognizable, and had "lumps." The resident revealed he/she loved eggs, but could not eat them because they were too "firm", and hard to swallow.</p> <p>An interview with the Dietary Manager, on 03/23/11 at 4:30 PM, revealed "baby food" consistency should not have "lumps." Pureed meats were not going to be "mashed potato" consistency. Resident #13 complained frequently about the consistency of the food, but he stated, "We have never gotten it right." The "yellow substance" on the resident's plate was butter, from the pureed bread. He revealed it was "tough" to make pureed food presentable.</p> <p>An interview with the Registered Dietician, on 03/23/11 at 5:00 PM, revealed it was hard to make pureed foods "look good". He revealed the resident had been unhappy with the food, and stated, "We may have needed to try other options."</p>	F 364	The Administrator is responsible for overall compliance.	5/8/11



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NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303	
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 03/24/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000	5/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *John K... E.D. 4/15/11* 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.