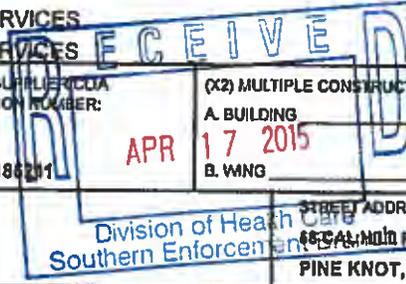


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/26/2015
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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 66 CALMINT ROAD PINE KNOT, KY 42635
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY22999) was conducted on 03/26/15. The complaint was substantiated with deficient practice identified at "D" level.	F 000	Administrator spoke with resident's responsible party at the facility on 3/17/15 at which time no concerns were expressed.	4/13/15
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	Allegations from residents responsible party was investigated by a survey team on 3/26/15. After review of complaint and interview with resident or family member it was determined that no other residents were found to be affected by the deficient practice. Any further allegations will be phoned to the Department of Community Services and Division of Long Term Care in accordance with State and Federal regulations. Facility staff will be in serviced on abuse/neglect policy by Administrator or designee. Any further allegations will be reported to Administrator or Director of Nurses immediately. A copy of the completed final report of allegations being submitted to DCBS and Division of Long Term within 5 working days. An allegation of abuse/complaint log will be maintained in the office where a copy of the completed form will be maintained. All results will be reported to the QA committee.	

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

[Signature]

TITLE

Administrator 4/17/15

(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.

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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD PINE KNOT, KY 42635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy it was determined the facility failed to ensure all alleged violations involving mistreatment, neglect, or abuse were thoroughly investigated and reported immediately to the Administrator and other officials in accordance with state law for one (1) of four (4) sampled residents (Resident #1). An interview with Resident #1's Responsible Party (RP) revealed he requested to file a complaint on 03/15/15 related to Resident #1's "poor care" he/she received while at the facility. The RP stated facility staff told him "no one was there at that time to take a complaint" but he "could call the facility back in the morning." Interviews with staff confirmed the resident's RP requested to speak to someone related to care concerns on 03/15/15, and was instructed to "call back tomorrow" and speak with the Assistant Director of Nursing (ADON). The ADON acknowledged she was made aware of the RP's requests on the morning of 03/16/15 but failed to investigate or report the allegation to the Administrator as required.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Policy and Procedures Abuse Prohibition," last updated August 2010, revealed facility events that should</p>	F 225			

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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
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F 225	<p>Continued From page 2</p> <p>be reported and investigated included suspicious bruising of residents and verbal reports and complaints voiced by residents or their family.</p> <p>A review of Resident #1's medical record revealed the facility admitted the resident on 03/12/15 with diagnoses that included Chronic Respiratory Failure, Hypertension, and Diabetes. A Minimum Data Set (MDS) Assessment had not been completed related to the resident's recent admission.</p> <p>An interview with Resident #1's RP on 03/28/15 at 1:40 PM revealed he had requested to file a complaint related to Resident #1's care and treatment received while at the facility. The RP stated the nurse told him there was no one there to take a complaint, and he was told to call back in the morning. The RP stated no one from the facility had contacted him related to his request to file a care complaint.</p> <p>An interview with Licensed Practical Nurse (LPN) #3 on 03/28/15 at 12:45 PM confirmed Resident #1's RP requested to file a complaint related to the care and treatment Resident #1 received at the facility. The LPN stated she had not notified any administrative staff of the RP's voiced concerns until the next morning (approximately nine and one-half hours later). The LPN stated she had been trained to notify administrative staff immediately; however, since Resident #1 had been transferred to the hospital she waited until the next morning.</p> <p>An interview with the ADON on 03/28/15 at 3:20 PM confirmed she was notified that Resident #1's RP requested to file a complaint related to the resident's care/treatment received while at the</p>	F 225			

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F 225	Continued From page 3 facility. The ADON stated she spoke with the Director of Nursing (DON) related to the request to make a complaint regarding care but had not notified the Administrator. The ADON stated she had not contacted the RP to follow up on the request to file a complaint because the resident was no longer in the facility. An interview with the DON on 03/26/15 at 2:40 PM revealed she had been notified of the RP's request to file a complaint approximately three days after the request was made. She stated she had not investigated or followed up with the RP to obtain information and/or investigate the RP's concerns. The DON further stated she should have contacted the RP regarding the concerns. An interview with the Administrator on 03/26/15 at 4:00 PM revealed he had not been made aware of Resident #1's RP's request to file a complaint related to the resident's care/treatment. The Administrator stated staff should have notified him of the complaint so he could have "looked into the complaint."	F 225			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441			

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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD PINE KNOT, KY 42835		
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F 441	<p>Continued From page 4</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain a safe and sanitary environment to help prevent the development and transmission of infection. Observations of treatments on 03/26/15 revealed staff failed to maintain a sterile field during sterile procedure for one (1) of two (2) treatments observed.</p>	F 441	<p>One resident was identified as being affected by the deficient practice. Through patient observation and medical chart review no infections were noted due to the deficient practice.</p> <p>Two other residents with trachs had the potential to have been affected by the deficient practice. Through patient observation and medical chart review no infections were noted to have occurred due to the deficient practice.</p> <p>Nursing staff was in serviced on appropriate techniques to maintain a sterile field during trach care by D.O.N.</p> <p>The Director of Nurses or designee will complete daily rounds 3 time a week X2 weeks then weekly X4 weeks monitoring trach care procedures including maintaining a sterile field. All nurses will perform a return demonstration annually.</p> <p>All results will be reported to QA committee.</p>	4/13/15	

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F 441	<p>Continued From page 5</p> <p>The findings include:</p> <p>Request for the facility policy was made regarding infection control and facility staff provided copies from a skills manual titled "Preparing a Sterile Field." Review of the procedure revealed instructions on how to maintain a sterile field.</p> <p>Review of the record for Resident #3 revealed the resident was admitted to the facility on 03/18/15 with diagnoses that included Chronic Respiratory Failure, Morbid Obesity, and Dysphagia. The resident was admitted to the facility with a tracheostomy. Review of the Medication Administration Record revealed tracheostomy care was to be performed daily.</p> <p>Observations of tracheostomy care performed for Resident #3 on 03/28/15 at 12:45 PM revealed Licensed Practical Nurse (LPN) #1 prepared the sterile field. After removing soiled gloves and donning new sterile gloves, LPN #1 was observed to reach over the sterile field several times causing contamination. Gloves were removed and LPN #1 donned new sterile gloves. Upon reaching for the inner cannula, LPN #1 bent over and her hair swept over and contaminated the sterile field. LPN #1 continued with tracheostomy care without recognition of contamination or setting up a new sterile field.</p> <p>Interview with LPN #1 on 03/28/15 at 2:00 PM revealed that she was unaware that she contaminated the sterile field during tracheostomy care. LPN #1 stated, "I did not recognize my hair went into the sterile field or that I reached over anything. I should have stopped and started over and pulled my hair up."</p>	F 441			

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F 441	<p>Continued From page 6</p> <p>Interview with LPN #5 on 03/28/15 at 2:10 PM revealed she was the Quality Assurance nurse but the DON assists in the Quality Assurance process. LPN #5 stated the facility has a book at the nurses' station on procedures and the Director of Nursing (DON) helps with the training process. LPN #5 stated new staff is trained with a nurse and the time varies as to how long they are trained. Interview with LPN #5 further revealed the DON completes the training with a skills check-off.</p> <p>Interview with the Director of Nursing (DON) on 03/28/15 at 2:40 PM revealed staff was told to pull their hair back during sterile technique and LPN #1 normally has her hair pulled back. When sterile field is set up, staff was instructed not to reach over any sterile field or supplies and LPN #1 should not have reached over the sterile field. The DON stated the guide manual is reviewed with staff and skills are observed annually. The DON stated she does "spot checks" and any concerns are identified and addressed through the process.</p>	F 441			