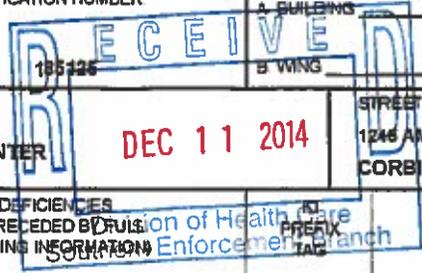


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 C 11/13/2014
NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1246 AMERICAN GREETING ROAD CORBIN, KY 40702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to provide care in accordance with the comprehensive plan of care for one (1) of twenty-four (24) sampled residents (Resident #17). Resident #17's comprehensive care plan contained care plan interventions that included having fall mats at the bedside and a trapeze bar above the resident's bed. However, observations on 11/13/14 revealed no fall mats on the floor and no trapeze bar above the bed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plan Policy and Protocol," with a revision date of August 2012, revealed the comprehensive care plan for each resident would include measurable objectives and timetables to meet a resident's</p>	F 282 F282 See Attached		



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

TITLE

(X6) DATE

Mildred Hobbs Administrator

12/10/14

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 282	<p>Continued From page 1</p> <p>medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment.</p> <p>Review of Resident #17's medical record revealed the facility admitted Resident #17 on 04/29/10 with diagnoses that included Anxiety, Muscle Weakness, Chronic Pain Syndrome, Hyperlipidemia, and Renal Osteodystrophy. Review of the Minimum Data Set (MDS) dated 03/24/14 revealed the resident's Brief Interview for Mental Status (BIMS) score was 9 which indicated the resident to be moderately impaired cognitively. Further review of the MDS revealed Resident #17 needed extensive assistance with transfers.</p> <p>Review of the comprehensive care plan updated 09/02/14 revealed the resident to be at risk for falls with an intervention to have fall mats in place for safety and a trapeze bar to be above the bed to assist the resident with positioning and help to increase independence.</p> <p>Observations of Resident #17 on 11/13/14 at 9:35 AM, 10:55 AM, and 1:25 PM revealed the resident to be in bed without a trapeze bar above the bed and without fall mats placed on the floor.</p> <p>Interview with Unit Manager #1 on 11/13/14 at 2:30 PM revealed the resident had requested that the trapeze bar be taken down and she had forgotten to remove the intervention from the care plan. She further stated she thought the fall mats were there this morning and didn't know why they were gone now.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 11/13/14 at 2:40 PM revealed she</p>	F 282	

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F 282	Continued From page 2 had noticed the fall mats in Resident #17's room a few days ago; however, she noticed they were not there today. According to SRNA #1, she had never seen a trapeze bar on Resident #17's bed or in the room. Interview with the Director of Nursing (DON) on 11/13/14 at 3:30 PM revealed the Unit Supervisor is responsible for updating/revising the care plans and the interventions. The DON said she did chart audits monthly to ensure resident care plans were revised/updated as required and she had not identified any problems.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and review of the Mosby's Nursing Drug Reference, it was determined the facility failed to follow physician's orders for one (1) unsampled resident (Resident A). Facility staff failed to ensure physician orders were followed when administering medication (Phenytoin) to Resident A on 11/11/14. The findings include:	F 309	<u>F309</u> See Attached	

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F 309	Continued From page 3 Interview with the Director of Nursing (DON) on 11/13/14 at 10:30 AM revealed the facility did not have a policy specific to following physician's orders. Review of Mosby's 2015 Nursing Drug Reference, 28th Edition, revealed the recommendation for administering Phenytoin suspension given via G-tube (gastrostomy tube) was to hold tube feedings one hour before and one hour after the dose given. A review of Resident A's physician's orders revealed the resident's G-tube feeding was to be held one hour before and one hour after Phenytoin (medication used to treat seizures) administration. Physician orders further instructed Phenytoin to be given separately from other medications. Observation of medication administration conducted for Resident A on 11/11/14 at 3:35 PM, revealed Licensed Practical Nurse (LPN) #2 failed to follow physician's orders regarding the administration of medications through Resident A's gastrostomy tube (G-tube). LPN #2 was observed to combine Phenytoin 200 mg (milligrams), Ferrous Sulfate Elix. 300 mg, Metformin 500 mg, Ditropan 5 mg, and Liquid Protein 30 cc together in a cup and proceed to enter the resident's room to turn the tube feeding off prior to administering the medications. The surveyor questioned LPN #2 about the physician's orders, and the medications were not given at that time. Interview with LPN #2 on 11/11/14 at 3:40 PM revealed she "forgot" to administer the Phenytoin	F 309			

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one (1) of twenty-four (24) sampled residents (Resident #17) received adequate supervision and assistive devices (fall mats) to prevent falls and accidents. Resident #17 was assessed to be at risk for falls and the facility had developed a care plan intervention to place fall mats at the resident's bedside. However, observation on 11/13/14 revealed the fall mats were not at the bedside. The findings include: Review of the facility's policy titled "Falls Prevention Program," not dated, revealed interventions for residents who were at high risk for falls would include the use of fall mats. The policy stated interventions would vary based on the individual resident assessment. Review of Resident #17's medical record revealed the facility admitted Resident #17 on 04/29/10 with diagnoses that included Anxiety, Muscle Weakness, Chronic Pain Syndrome, Hyperlipidemia, and Renal Osteodystrophy. Review of the Minimum Data Set (MDS) dated 03/24/14 revealed the resident's Brief Interview for Mental Status (BIMS) score was 9 which indicated the resident to be moderately impaired cognitively. Further review of the MDS assessment revealed Resident #17 to require extensive assistance with transfers. Review of the comprehensive care plan updated 09/02/14 revealed the resident was assessed to	F 323		

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F 323	Continued From page 6 be at high risk for falls. The plan of care included an intervention to place fall mats at the resident's bedside for safety. Observations of Resident #17 on 11/13/14 at 9:35 AM, 10:55 AM, and 1:25 PM revealed the resident to be in bed with no fall mats on the floor. Interview with Unit Manager #1 on 11/13/14 at 2:30 PM revealed she saw the fall mats in Resident #17's room this morning and didn't know why they were gone now. Interview with State Registered Nurse Aide (SRNA) #1 on 11/13/14 at 2:40 PM revealed she had noticed the fall mats in Resident #17's room a few days ago; however, she did notice they were not there today. Interview with the Director of Nursing (DON) on 11/13/14 at 3:30 PM revealed she does chart audits monthly and tries to ensure the care plan interventions are being followed. The DON stated care plan interventions including falls mats should be followed/implemented by staff.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	<u>F371</u> See Attached	

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F 371	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the kitchen equipment in a sanitary manner. The back of the range and confectioner's oven (including the fan) was heavily soiled with grease/debris. In addition, the floor underneath and around the deep fryer was heavily soiled. The findings include: The facility stated they did not have a specific policy regarding the cleaning of the back of the kitchen equipment. Observation of the back/side of the range and the back of the confectioner's oven (including the oven fan) at 5:25 PM on 11/11/14, and another observation at 1:40 PM on 11/13/14 revealed the equipment had a heavily buildup of grease and debris (lint, etc.). In addition, the floor underneath and around the deep fryer was heavily soiled. An interview was conducted with the Registered Dietitian (RD) accompanied by the Dietary Manager (DM) at 1:40 PM on 11/13/14. The RD said she did not know who was responsible for cleaning the back of the kitchen equipment, but it did not appear that the back of the equipment had been cleaned in a while.	F 371		
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	F 441	<u>F441</u> See Attached	

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F 441	<p>Continued From page 8 to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of Infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to ensure staff followed appropriate handwashing</p>	F 441			

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F 441	<p>Continued From page 9</p> <p>procedures to prevent the development and transmission of disease and infection for one (1) unsampled resident (Resident B). On 11/11/14, a State Registered Nurse Aide (SRNA) was observed to pick up a fall mat from the floor and then set up Resident B's evening meal tray without first washing her hands.</p> <p>The findings include:</p> <p>A review of the facility's infection control policy titled "Infection Control Program," undated, revealed the facility would maintain a safe, sanitary, and comfortable environment and help prevent the development and transmission of disease and infection. The Infection Control Program will consist of investigating, controlling, and preventing infections in the facility; deciding what procedures, such as isolation, should be applied to an individual resident; and maintain a record of incidents and corrective actions related to infections.</p> <p>Review of the facility's "Guidelines for Hand Hygiene" policy, undated, revealed hands should be decontaminated after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident.</p> <p>Observation on 11/11/14 at 5:37 PM revealed Resident B sitting up in his/her room. State Registered Nurse Aide (SRNA) #3 was observed to pick up the fall mat from the floor and put it to the side, and then proceeded to set up Resident #B's meal tray without first washing her hands. The SRNA touched the resident's silverware with her unwashed hands.</p> <p>An interview conducted with SRNA #3 on</p>	F 441			

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F 441	Continued From page 10 11/11/14 at 5:37 PM revealed she should have washed her hands after touching the fall mat. SRNA #3 stated, "Sorry, you caught me." An interview was conducted with the Director of Nursing (DON), who is also the facility's Infection Control Nurse, on 11/12/14 at 4:38 PM. The DON stated, "No, she should not have touched the fall mat, then the silverware, without washing her hands." An interview conducted with the Administrator on 11/13/14 at 2:36 PM revealed SRNA #3 should have washed her hands after touching Resident B's fall mat. The Administrator further stated the facility monitors handwashing techniques throughout the building by making random rounds. Rounds are conducted every two hours by the Minimum Data Set (MDS) Nurses, Unit Managers, DON, and Administrator. The Administrator further revealed the facility has not identified any concerns. According to the Administrator, handwashing in-service training is provided frequently for staff and the facility supplies personnel with hand sanitizer.	F 441		
F 514 SS=D	483.75(1)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	<u>FS14</u> See Attached	

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F 514	<p>Continued From page 11</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure an accurate clinical record was maintained for one (1) of twenty-four (24) sampled residents (Resident #20). The facility failed to ensure Resident #20's drug allergies were accurately documented in the resident's medical record.</p> <p>The findings include:</p> <p>Review of the medical record revealed the facility admitted Resident #20 on 11/06/14 from an acute care hospital. Review of the History and Physical received from the transferring facility revealed the resident's allergy was documented as No Known Drug Allergies (NKDA). Further review of the Medication Reconciliation from the transferring facility revealed the resident allergy was documented as No Known Drug Intolerances, Codeine. Review of the physician's orders for November 2014 revealed the resident to have NKA (No Known Allergy). Review of the resident's record revealed the allergy sticker on the resident's condition alert (the allergy sticker on the front page of the medical record) documented the allergy as Codeine. Further record review revealed Codeine was documented as an allergy on the resident's Kardex.</p> <p>Interview with Resident #20's family member on</p>	F 514		

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F 514	<p>Continued From page 13</p> <p>did not process and ensured the information documented was correct.</p> <p>Interview with the Director of Nursing (DON) on 11/13/14 at 2:00 PM revealed the facility ensured correct documentation in the resident's record by ensuring supervisory staff reviewed all resident admissions on the day after admission. The DON and the Administrator do chart audits monthly on new admissions and other residents. The Pharmacy receives a copy of written orders and orders from the hospital and is expected to inform the facility of any discrepancies.</p> <p>Interview with the Administrator on 11/13/14 at 2:00 PM, revealed the facility monitors the resident's records after admission through random chart audits to identify any incorrect documentation. The Administrator further stated the admission nurse should review the History and Physical and medication orders upon admission and clarify any discrepancies. The Administrator stated the Pharmacy is sent medication orders and should notify the facility of any need for clarifications. The Administrator stated any discrepancies identified in the resident's documented allergies would be clarified by the resident's primary care physician.</p>	F 514			

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) Resident # 17's Care Plan was updated by the unit supervisor to reflect the discontinued use of the trapeze bar per Resident #17's request. The fall mat's were replaced.
- 2) The DON, Unit Supervisors, and MDS Nurses reviewed all care plans and made rounds to ensure that all interventions were in place as needed for each resident, with no discrepancies identified.
- 3) The Unit Supervisors were in-serviced on 12/3/14 by the DON and Administrator on the importance of promptly and accurately updating care plans to reflect care needs/intervention changes; they were also in-serviced on the importance of checking for interventions such as fall mats and equipment during their daily rounds to ensure these interventions are in place as needed. All nurses, nurse aides and housekeeping staff were inserviced on 12/3 and 12/4/14, by their unit and department supervisors on the importance of reviewing resident care plans and being aware of interventions, such as fall mats, and ensuring that they are in place as ordered, and if they notice discrepancies, to correct these immediately and make their unit supervisor aware for follow up.
- 4) The MDS Coordinators will randomly check 5 Care Plan's monthly and ensure noted interventions are in place and care plans are accurate. The unit supervisors, or designated nurse in their absence, will perform thorough rounds daily to ensure that all interventions are in place to meet each resident's care needs. Any discrepancies will be corrected immediately and reported to the CQI Committee for follow up.
- 5) Date of Correction: 12/5/14

F309

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 did not receive the Phenytoin 200 and therefore was not affected by this incident. The attending physician was notified regarding this incident and new orders received.**
- 2) The labs for each resident receiving Phenytoin were reviewed, with no concerns noted. LPN #2 did receive one on one counseling by the DON on 11/17/14 regarding medication administration, specifically regarding administration of Phenytoin and the facility policy to give it separately and to hold the tube feeding one hour before and one hour after administration.**
- 3) All nurses were re-educated on 12/3 and 12/4/14, regarding the proper procedures and administration of Phenytoin by the unit supervisors.**
- 4) The unit supervisors will observe the medication passes of 2 different nurses weekly x 1 month, with a special emphasis on the administration of Phenytoin, and then 2 monthly thereafter. Any discrepancies will be addressed immediately and reported to the CQI committee for follow up.**
- 5) Date of Correction: 12/5/14**

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 fall mats for resident #17 were replaced to the bedside. This resident was not affected by this deficiency.
- 2) The DON, Unit Supervisors, and MDS Nurses reviewed all care plans and then made rounds to ensure that all interventions were in place as needed for each resident, with no other discrepancies identified.
- 3) All nurses, nurse aides and housekeeping staff were inserviced on 12/3 and 12/4/14, by their unit and department supervisors on the importance of ensuring that all fall interventions, such as fall mats, are in place as ordered, and if they notice discrepancies, to correct these immediately and make their unit supervisor aware for follow up. The Unit Supervisors were in-serviced on 12/3/14 by the DON and Administrator on the importance of checking for interventions, such as fall mats, during their daily rounds to ensure these interventions are in place as needed.
- 4) The unit supervisors, or designated nurse in their absence, will review all residents with fall risks and their interventions 1 x weekly to ensure these are in place to meet each resident's care needs. Any discrepancies will be corrected immediately and reported to the CQI Committee for follow up.
- 5) Date of Correction: 12/5/14

F371

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) No residents were affected by this deficiency.
- 2) All residents had the potential to be affected by this deficiency.
- 3) The Dietary Manager, with the assistance of the Maintenance Supervisor, cleaned the back of the range and confectioner's oven, including the fan, and the floor around the deep fryer. The cleaning of the back's of these areas was added to the weekly cleaning schedule and all dietary staff were inserviced on 12/3 and 12/4/14, on this updated cleaning schedule, as well as the cleaning process for these areas, by the Dietary Manager and Maintenance Supervisor. The Registered Dietitian and Dietary Manager completed a thorough sanitation review of the entire kitchen, with no other areas of concern noted.
- 4) The dietary manager, or dietitian in her absence, will complete weekly sanitation reviews x 1 month and then monthly thereafter, to ensure that all areas of the kitchen are clean and sanitary. Any discrepancies will be corrected immediately and reported to the CQI Committee for follow up.
- 5) Date of Correction: 12/5/14

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 B was not affected by this deficiency.
- 2) All residents had the potential to be affected by this deficiency.
- 3) All staff members were in-serviced on 12/3 and 12/4/14 on infection control by their unit supervisor/department manager, specifically addressing appropriate handwashing procedures to prevent the development and transmission of disease and infection, with return demonstration; and with the example of not handling medical equipment and other objects without decontaminating hands. All department heads and unit supervisors were in-serviced on 12/3/14, by the administrator on the importance of continuing to randomly monitor infection control practices, specifically handwashing, of all staff members. One on one counseling was completed with SRNA #3 by the Director of nursing to ensure she understood her infection control violation and what the correct procedure was for decontaminating hands to maintain a safe and sanitary environment.
- 4) Each department head and unit supervisor will be completing observations of 5 staff members weekly x 1 month, and then 2 weekly thereafter to ensure that they are using the proper infection control/handwashing practices, with return demonstration of staff members, in order to maintain a safe and sanitary environment for our residents. Any discrepancies will be immediately corrected and then reported to the CQI Committee for follow-up.
- 5) Date of Correction: 12/5/14

F514

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 medical record for resident #20 has been updated following interviews with family and the attending physician to confirm that there is no allergy to codeine. This resident was not affected by this deficiency.
- 2) The Director of Nursing and Unit Supervisors reviewed the medical records of all admissions for the past month to ensure that all records were accurate, and all allergies were correctly documented and flagged on their charts, with no problems identified.
- 3) Unit Supervisors and floor nurses were in-serviced on 12/3 and 12/4/14 by the Director of Nursing on the importance of thoroughly reviewing all documentation prior to admission and interviewing families, specifically regarding allergies, and clarifying any discrepancies prior to the resident entering the facility.
- 4) Unit Supervisors will review the medical records of all new admissions on the opposite unit weekly x 1 month, and then 2 admissions monthly thereafter to ensure that all medical records are accurate, and that allergies are accurately flagged on the chart, with no discrepancies. If any discrepancies are found upon review, these will be corrected immediately and reported to the CQI committee for follow up.
- 5) Date of Correction: 12/5/14