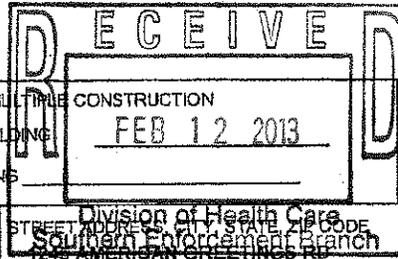


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/05/2013  
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 01/24/2013
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NAME OF PROVIDER OR SUPPLIER  HILLCREST HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREETINGS RD CORBIN, KY 40702
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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
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F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for one of three sampled residents (Resident #2). Resident #2 had physician's orders for a urinalysis with a culture and sensitivity to be obtained on 01/19/13; however, facility staff failed to ensure the urinalysis with culture and sensitivity was obtained as ordered by the physician.</p> <p>The findings include:</p> <p>A review of the facility's policy, "Protocol for Physicians Orders", not dated, revealed any new physician's orders were to be noted and transcribed in the appropriate place and orders were to be followed accordingly.</p> <p>Interview with Resident #2 on 01/24/13 at 9:00 AM, during tour, revealed the resident had experienced burning and throbbing with voiding. Resident #2 stated he/she had informed the physician when the physician made rounds and</p>	F 281	See Attached <i>(initials)</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X8) DATE 2-12-13
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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 281	<p>Continued From page 1</p> <p>thought he was going to do something. Resident #2 stated "but I guess not."</p> <p>A review of the medical record for Resident #2 revealed the facility admitted the resident on 07/13/11, with diagnoses that included Hypertension and Esophageal Reflux. A review of physician's orders dated 01/19/13 revealed an order for facility staff to obtain a urinalysis with a culture and sensitivity. Further review of the medical record revealed no results for the urinalysis with culture and sensitivity.</p> <p>An interview conducted on 01/24/13, at 9:43 AM, with the Clinical Coordinator revealed the urinalysis with culture and sensitivity had not been obtained as per the physician order for Resident #2. The Clinical Coordinator stated on 01/24/13 she spoke with Licensed Practical Nurse (LPN) #4, who worked on 01/19/13 when the physician made rounds, and the LPN had stated to her she must have overlooked the order.</p> <p>Interview on 01/24/13 at 12:19 PM with LPN #4 revealed she had worked on 01/19/13 when the physician made rounds on Resident #2 and had failed to review the physician's order and to obtain a urinalysis with a culture and sensitivity. The LPN stated she reviewed the first page of Resident #2's monthly orders but did not review the other pages which contained the progress note made by the physician and the order for the urinalysis with culture and sensitivity.</p> <p>Interview with the Director of Nursing (DON) on 01/24/13 at 4:00 PM revealed staff were trained and required to review all physician orders. The DON stated she was not aware staff had failed to</p>	F 281	<p>See attached</p> <p><i>(Signature)</i></p>	
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NAME OF PROVIDER OR SUPPLIER  HILLCREST HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREETINGS RD CORBIN, KY 40702		
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F 281	Continued From page 2 review all the pages of the monthly orders therefore missing the order for a urinalysis with culture and sensitivity.	F 281	See attached <u>links</u>		

F281

Submission of this plan of correction does not indicate that a deficiency existed or that a deficiency was cited correctly. This Plan of Correction is being submitted to ensure continuing compliance with State and Federal regulations.

- 1) The physician and RP were contacted regarding the missed order for a urinalysis with culture and sensitivity on resident #2. A new order was given by the physician for a urinalysis with culture and sensitivity and this was obtained on resident #2, and treatment initiated per physician orders.
- 2) The physician orders/lab orders of all other residents were reviewed by the Clinical Coordinator and Director of Nursing to ensure that no physician orders had been missed on any resident. There were no other problems found during this review.
- 3) LPN #4 was counseled regarding the missed urinalysis with culture and sensitivity order on Resident #2. She said that she looked at the initial page where the doctor had signed and did not see any orders, but did not realize there were multiple pages with orders written on the back page. She did voice her understanding of the importance of following all physician orders and reviewing each page of the current orders when a physician makes rounds to make sure all orders are followed through. All nurses were in-serviced regarding protocol for taking off any new orders from the physician and follow-through with these on the Medication Administration Record and/or Treatment Administration Record. The Clinical Coordinator for each unit will review all notes following physician rounds to ensure that physician orders have been taken off and have been accurately followed through with on the Medication Administration Record and/or Treatment Administration Record.
- 4) The nursing secretary and/or Clinical Coordinator will randomly review the physician notes/orders of 3 residents on each unit weekly x 3 months, and then 3 on each unit x 1 month to ensure that there are no further problems with missing any physician orders. Any problems will be immediately reported to the Director of Nursing and physician and the CQI committee for correction.
- 5) Date of Correction : February 11, 2013