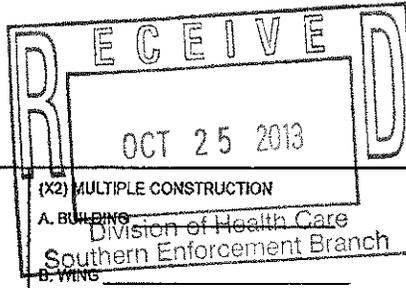


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 10/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING Division of Health Care Southern Enforcement Branch B. WING	(X3) DATE SURVEY COMPLETED  10/03/2013
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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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(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>A standard health survey was conducted on 10/01-03/13. Deficient practice was identified with the highest scope and severity at "D" level.</p> <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 record review and interview it was determined the facility failed to follow the physician's order for one of eleven sampled residents. A physician's order was written on 08/20/13 to discontinue the use of Risperdal (anti-psychotic) for Resident #2. However, review of the September and October 2013 Medication Administration Record (MAR) for Resident #2 revealed the facility continued to administer the Risperdal to the resident from 09/01/13 to 10/03/13.</p> <p>The findings include: Interview with the Director of Nursing (DON) at 1:50 PM on 10/03/13 revealed the facility did not have a policy/procedure regarding following physician's orders. A review of a physician's order dated 08/20/13 revealed the physician discontinued the use of Risperdal for Resident #2. A review of the August 2013 MAR revealed the Risperdal had been discontinued. In addition, a review of nurse's notes dated 08/20/13 in Resident #2's medical</p>	F 281	<p>The resident that was said to be affected by deficient practices doctor was notified of resident continuing to have received the medication after it had been D/C'd. The medication was D/C'd off the MAR. All medication orders dated 8/20/13-10/13/13 were reviewed by the Quality Assurance nurse assuring that all orders were current.</p> <p>All residents have the potential to have been affected by the deficient practice. On 10/6/13 the Quality Assurance nurse finished a complete audit of each resident's MARS/TARS and physician orders to ensure all orders were current. The doctor was notified of any deficient practice.</p> <p>All licensed nurses were in serviced on the correct procedure of transcribing physician orders. One nurse will be responsible for reconciling MARS/TARS monthly.</p> <p>The DON or designees will audit all physician orders comparing them to the MAR to ensure compliance 3X a week for 2 months 1X week for 2 months and randomly thereafter reporting results to the Quality Assurance Committee.</p>	10/15/13

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 2B1	<p>Continued From page 1</p> <p>record revealed Licensed Practical Nurse (LPN) #3 documented the Risperdal had been discontinued. However, a review of the September 2013 and October 2013 MAR revealed facility staff had continued to administer the Risperdal to Resident #2 from 09/01/13 to 10/03/13.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN) #3 at 9:30 AM on 10/03/13. LPN #3 stated she received a physician's order on 08/20/13 to discontinue the use of Risperdal for Resident #2. The LPN stated she discontinued the Risperdal on the MAR and removed the medication from the medication cart. The LPN further stated she documented in the nurse's notes the Risperdal had been discontinued. The LPN stated she faxed a copy of the physician's order to discontinue Risperdal for Resident #2 to the pharmacy on 08/20/13.</p> <p>An interview was conducted with LPN #2 at 9:50 AM on 10/03/13. LPN #2 stated she was responsible to review the physician's order to compare the orders for accuracy near the end of every month. The LPN stated she did not observe a physician's order dated 08/20/13 to discontinue the Risperdal on the August 2013 MAR for Resident #2 and, as a result, failed to remove the Risperdal from the September 2013 MAR. The LPN stated she did not know how she overlooked the discontinued medication on the August 2013 MAR, or the physician's order dated 08/20/13 for Resident #2.</p> <p>Interview with the Director of Nursing (DON) at 1:50 PM on 10/03/13 revealed the pharmacy sends the facility a list with all the names of residents and medications they receive. The</p>	F 2B1		

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F 281	Continued From page 2 DON confirmed LPN #2 had the responsibility to review resident charts to compare the physician's orders with the medications listed on the pharmacy's list. The DON also stated the LPN was to make notations of changes to send to the pharmacy before the MARs and monthly physician's orders are printed. According to the DON, she reviews medical records selected at random to ensure accuracy and had not identified any concerns related to medications.	F 281			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's procedure checklist, it was determined the facility failed to ensure appropriate treatment and services were provided to prevent an infection of the urinary tract for one of fifteen sampled residents (Resident #8). Facility staff failed to properly clean and rinse the resident's perineal area while providing catheter care.  The findings include:	F 315	Resident #8 who was said to be affected by the deficient practice was observed from 10/5/13 to 10/9/13 on each shift by a licensed nurse with no signs or symptoms of infection noted.  All residents that have indwelling Foley catheters have the potential to be affected by the deficient practice. Each resident was observed X5 days to ensure no signs or symptoms of infection occurred. If signs or symptoms noted residents were treated.  All CNA's (including CNA #4) were in serviced on the correct techniques for Foley catheter care. Each CNA will be in serviced 1X a month for 3 months.  The DON or designs will observe CNA's performing catheter care on all residents with a Foley catheter 1X a week for 8 weeks and then randomly thereafter. The results will be reported to the Quality Assurance Committee.	10/15/13	

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F 315	<p>Continued From page 3</p> <p>Review of the procedure checklist for Catheter Care (no date) revealed facility staff was required to apply soap and water to a clean, wet washcloth, then cleanse the catheter from the insertion of the catheter down about four inches, and repeat as necessary with a clean area of the washcloth. According to the policy, after cleansing the catheter, facility staff should rinse the catheter with a clean washcloth.</p> <p>Review of the medical record revealed the facility admitted Resident #8 on 07/19/13 with diagnoses including Urinary Retention, Altered Mental Status, and Anxiety. Review of the Minimum Data Set (MDS) dated 08/29/13 revealed the facility assessed Resident #8 to require an indwelling catheter. Further review of the MDS revealed Resident #8 was assessed to always be incontinent of bowel.</p> <p>Certified Nursing Assistant (CNA) #4 was observed to provide Foley catheter care for Resident #8 on 10/02/13 at 11:03 AM. Observation revealed the CNA placed equipment on the bedside table to provide catheter care as follows: a basin with clean warm water with two washcloths placed in water, a bottle of spray soap, and a clean dry towel. CNA #4 washed her hands, put on gloves, and removed the resident's incontinence brief. The CNA was observed to cleanse Resident #8's perineal/urethral area with a clean, wet soapy washcloth and then place the contaminated soapy washcloth back into the water basin with the clean rinse washcloth. CNA #4 then removed a washcloth from the water basin and proceeded to rinse the resident's perineal/urethral area with the washcloth. After rinsing the area, the CNA placed the washcloth</p>	F 315			

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F 315	Continued From page 4 back into the water basin. CNA #4 proceed to clean the catheter with the same soapy washcloth that was placed back into the water basin and rinsed the catheter with the same washcloth that she had used to rinse the perineal/urethral area. CNA #4 then removed the soiled gloves and washed her hands.  Interview conducted with CNA #4 on 10/02/13, at 2:17 PM revealed the CNA had been trained to provide Foley catheter care every shift and on an "as needed" basis. CNA #4 stated she had been trained to use warm water, soap, and washcloths to clean the resident's perineal/urethral area, discard the soiled washcloth, rinse the area with a clean washcloth, discard the soiled washcloth used for rinsing, and use two additional clean washcloths to clean and rinse the catheter. CNA #4 stated, "I should have had four washcloths, two for cleaning and rinsing the perineal/urethral area, and two for cleaning and rinsing the catheter." CNA #4 said she thought she was just going to clean the resident's catheter and, after observing Resident #8's perineal/urethral area for catheter care, got nervous and didn't think about getting more washcloths.  The Director of Nursing (DON) confirmed in an interview conducted on 10/02/13, at 2:36 PM, the CNA should have cleaned and rinsed the resident's perineal/urethral area and catheter with clean washcloths. The DON stated routine in-service training was provided to the CNAs at least annually. The DON stated the floor nurses observe and check CNAs for competency and had not reported any problems related to the staff's performance of incontinence care.	F 315		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	<p>Continued From page 5 <b>UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the facility's policy, interview, and record review, it was determined the facility failed to ensure one of fifteen sampled residents was free of unnecessary drugs. Resident #2 had a physician's telephone order dated 08/20/13 to discontinue the use of Risperdal (antipsychotic). However, the facility continued to administer the Risperdal to Resident #2 from 09/01/13 to 10/03/13.</p>	F 329	<p>Resident #2 was said to be affected by the deficient practice. The MD was called on 10/3/13 to inform that resident had continued to receive medication after the D/C order was received. Resident was observed for 7 days for any negative side effects with none noted.</p> <p>All residents have the potential to be affected by the deficient practice. All residents MARS/TARS for October were audited to ensure current physician orders were in place.</p> <p>All licensed nurses were in serviced on the correct procedure of transcribing physician orders. One nurse will be responsible for reconciling MARS/TARS monthly.</p> <p>The DON or designees will audit all physician orders comparing them to the MAR to ensure compliance 3X a week for 2 months 1X week for 2 months and randomly thereafter reporting results to the Quality Assurance Committee.</p>	10/15/13

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F 329	<p>Continued From page 6</p> <p>The findings include:</p> <p>Review of the facility's Medication Orders policy (no date) revealed medications are reviewed on a monthly basis when the prescriber signs the physician's order. A designated nurse reviews the order summary before giving it to the prescriber to sign.</p> <p>A review conducted on 10/02/13 at 2:15 PM, of physician's orders for Resident #2 revealed the physician discontinued Risperdal for the resident on 08/20/13 and a review of the August 2013 Medication Administration Record (MAR) revealed the Risperdal had been discontinued on the MAR. However, review of the September 2013 and October 2013 MARs revealed the Risperdal remained on the MAR.</p> <p>Observation of the medication cart on 10/02/13 at 4:00PM revealed the medication Risperdal was in the medication drawer designated for Resident #2. Interview with LPN #4 at 1:15 PM on 10/03/13 and LPN #5 at 1:30 PM on 10/03/13 revealed the two LPNs had administered the Risperdal to Resident #2 from 09/01/13 to 10/03/13.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN) #3 at 9:30 AM on 10/03/13. LPN #3 stated she received a physician's order on 08/20/13 to discontinue the use of Risperdal for Resident #2. The LPN stated she discontinued the Risperdal on the MAR for August and removed the medication from the medication cart. The LPN stated she placed the medication in the return box to be returned to the pharmacy, and she faxed a copy of the</p>	F 329		

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F 329	<p>Continued From page 7</p> <p>physician's order to the pharmacy. The LPN further stated, and a review of documentation confirmed, she had documented in the nurse's notes the Risperdal had been discontinued. LPN #3 also stated she had verbally communicated the discontinued medication order to the oncoming nurse on 08/20/13.</p> <p>An interview conducted with LPN #2 at 9:50 AM on 10/03/13 revealed she was responsible to review the physician's pre-printed monthly orders to compare the orders for accuracy near the end of every month. The LPN stated she did not see where the Risperdal had been discontinued for Resident #2 on 08/20/13. The LPN stated she never saw the discontinued medication on the MAR or she would have removed the Risperdal from the September 2013 MAR. The LPN stated it was an oversight on her part and she did not know why/how she overlooked the discontinued medication on the August 2013 MAR, or the physician's order dated 08/20/13 to discontinue the Risperdal for Resident #2.</p> <p>An interview was conducted with the Director of Nursing (DON) at 1:50 PM on 10/03/13. The DON stated the pharmacy sent a "pre-list form" that identified all the residents and medications. The DON confirmed LPN #2 was responsible to go through the resident charts to compare the physician's orders with the pre-list form, document any changes, and send any corrections back to the pharmacy for corrections before the monthly orders and MARs were pre-printed. The DON stated she reviewed medical records selected at random for accuracy, including accuracy of medication orders, and had not identified any problems. The DON further stated the facility had changed pharmacies in August</p>	F 329		

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F 329	Continued From page 8 2013.	F 329			
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy, observation, and interviews, it was determined the facility failed to ensure food was served at a palatable temperature at the noon meal on 10/01/13. A food cart containing eleven resident trays was observed to be on C Hall for thirty-seven minutes before the last tray was removed and intercepted for a palatability test. Based on the palatability test, the meat was cool to taste, the spinach was bland, cold, had a starchy taste, and was not palatable, and the chocolate milk was warm.</p> <p>The findings include:</p>	F 364	<p>Eleven residents were said to be affected by the deficient practice. All residents on C Hall that were interview able were interviewed with no complaints of unpalatable food.</p> <p>All residents receiving food trays on the hallways had the potential to be affected by the deficient practice. All residents that were interview able were interviewed with no complaints of unpalatable food.</p> <p>All Dietary and Nursing staff were in serviced on palatability of food and the importance of passing trays in a timely manner to promote palatability of food.</p> <p>The Administrator or designee will complete a test tray audit 3X a week for 30 days then X1 week for 3 months to ensure the palatability of food. Administrator or designee will address any food complaints with the Resident Council with the results being reported by the Quality Assurance Committee.</p>	10/21/13	

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F 364	<p>Continued From page 9</p> <p>A review of the facility's Meal Service policy (dated 2006) revealed perishable and potentially hazardous foods do not remain at room temperature for more than 30 minutes.</p> <p>Observation of the noon meal on 10/01/13 revealed an enclosed food cart containing 11 trays was transported from the kitchen to C Hall at 12:03 PM. The last tray was intercepted at 12:40 PM (37 minutes later) and food temperatures were obtained with facility staff. The temperature of the pureed meat was 104.3 degrees Fahrenheit, the pureed spinach was 107.8 degrees Fahrenheit, and the chocolate milk was 53.2 degrees Fahrenheit. The meat was cool to taste. The spinach was bland and cold to taste. The spinach also had a starchy taste and was not palatable. The chocolate milk was warm. The test temperatures and palatability of the foods were verified by facility staff.</p> <p>Interview with a facility cook at 1:00 PM on 10/01/13 revealed staff usually passed the trays in less time and she had not received any complaints from the residents about the palatability of food served.</p> <p>Interview with the Dietary Manager (DM) at 6:15 PM on 10/03/13 revealed it should not have taken staff 37 minutes to pass 11 trays, and that the facility had never checked the palatability of the food. According to the DM, staff usually delivers the trays timely and there had not been any complaints voiced by the residents about food palatability.</p> <p>Interview with the Director of Nursing (DON) at 1:50 PM on 10/03/13 revealed she was not aware of how much time it took to pass meal trays.</p>	F 364			

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F 364	Continued From page 10	F 364		
F 371 SS=D	<p>According to the DON, there were two CNAs passing trays on 10/01/13 and it did not usually take them long to pass the trays.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of the facility policy, the facility failed to ensure foods were served to residents under sanitary conditions. Observations of the noon and evening meal on 10/01/13 on A Hall revealed staff served/distributed food to residents with the dessert and bread uncovered.</p> <p>The findings include: Review of the Meal Service; Tray set-up for Meals (no date) revealed only hot foods would be covered if resident trays were placed in a covered cart to maintain better heat retention. The policy noted trays would be delivered from resident room to resident room by rolling the food cart down the hallway.</p> <p>Observations conducted during the noon meal on</p>	F 371	<p>Three residents were identified as having been affected by the deficient practice. None of the 3 residents had food borne illness due to the deficient practice per review of the resident chart.</p> <p>All residents receiving hall trays had the potential to be affected by the deficient practice. All residents were observed and their medical records reviewed with no signs or symptoms of food borne illness noted.</p> <p>All nursing staff was in serviced on the correct procedure for delivering trays that included moving tray cart in front of each room when serving meal trays.</p> <p>Administrator or designed will audit random meals tray pass 3x a week for 30 days then 1X a week for 6 months with the results being reported to the Quality Assurance Committee.</p>	10/21/13

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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		
(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 371	<p>Continued From page 11</p> <p>10/01/13, revealed a closed cart was delivered to A Hall at 12:33 PM. Staff was observed to distribute the trays to resident rooms. At 12:40 PM, facility staff was observed to remove a tray from the food cart and carry the tray to room A-10 (approximately 10 feet away from the food cart); the dessert and bread were noted to be uncovered. At 12:41 PM, another staff person was observed to remove a second tray and carry the tray with the dessert and bread uncovered to room A-12 (approximately 18 feet from the food cart).</p> <p>Additional meal observations conducted on 10/01/13, during the evening meal revealed a closed food cart was delivered to A Hall from the kitchen at 5:17 PM. Facility staff was observed to remove a tray from the food cart containing uncovered dessert and a roll and carried the tray to room A-8 (approximately 14 feet from the food cart) at 5:20 PM. At 5:26 PM, facility staff carried a tray with uncovered dessert and a roll to room A-10 (approximately 12 feet from the food cart). In addition, facility staff was observed to remove another tray at 5:28 PM containing uncovered dessert and a roll from the food cart and carry the tray to room A-12 (approximately 20 feet from the food cart).</p> <p>Interviews conducted with Certified Nurse Aide (CNA) #2 on 10/01/13, at 5:40 PM, revealed she had been trained to deliver/distribute resident meal trays by pushing the food cart from room to room. CNA #2 stated food items were supposed to be covered if not delivered room to room or carried down the hallway. The CNA stated she did not realize the dessert and bread were uncovered during the noon and evening meals on 10/01/13.</p>	F 371			

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F 371	Continued From page 12  Interview with CNA #1 on 10/01/13, at 5:45 PM, revealed she had also been trained to distribute resident meal trays by pushing the food cart from room to room. CNA #1 stated all food items should be covered if the tray was carried down the hallway. CNA #1 stated she did not realize the foods were uncovered when she passed the trays during the noon and evening meal on 10/01/13.  Interview conducted with the Dietary Manager (DM) on 10/03/13, at 6:15 PM, revealed nursing staff should push the food cart door to door when distributing the resident trays to resident rooms. The DM confirmed food items should be covered if the tray is carried away from the food cart.  Interview with the Director of Nurses (DON) on 10/03/13, at 6:25 PM, also confirmed all food items should be covered during tray delivery. The DON stated nursing staff was trained to push the food cart from door to door to deliver resident trays.	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 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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F 441	<p>Continued From page 13</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 facility policy review, the facility failed to maintain effective infection control technique when handling resident soiled linen in a manner to prevent the development and transmission of disease and infection for residents on A Hall.</p> <p>The findings include:</p> <p>Review of the policy/procedure related to bed making (no date) revealed these instructions</p>	F 441	<p>Two residents were identified as being affected by the deficient practice. Through observation and review of their medical charts no infections were noted due to the deficient practice.</p> <p>All residents had the potential to have been affected by the deficient practice. Through observation and review of the resident's medical charts no infections were noted to have occurred due to the deficient practice.</p> <p>All nursing staff was in serviced on the appropriate soiled linens and infection control process.</p> <p>The DON or designee will complete daily rounds X30 days monitoring infection control procedures including the handling of soiled linens with random rounds completed thereafter. All results will be reported to the Quality Assurance Committee.</p>	10/15/13

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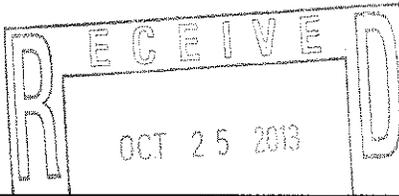
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F 441	<p>Continued From page 14</p> <p>regarding handling linen: do not place soiled linens on the floor, do not hold soiled linens against your clothing, and do not shake or fan the linens.</p> <p>Observations conducted on 10/02/13, at 8:48 AM, revealed soiled linen was observed on the floor near the foot of the bed in room A-9, bed 1. At 8:58 AM, facility staff was observed to roll the dirty linen container to the hallway outside of room A-9. The staff picked up the soiled linen from the floor and carried the linen to the dirty linen container while holding the linen next to her clothing.</p> <p>Additional observation on 10/02/13, at 10:00 AM, revealed soiled linen was also observed lying directly on the resident's bathroom floor in room A-10, bed 2. Follow-up observations conducted at 10:50 AM, revealed the linen had been removed from the resident's bathroom floor.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #2 on 10/02/13, at 4:25 PM, revealed CNA #1 had placed the soiled linen on the floor in room A-9. CNA #2 stated she had gone to get the dirty linen container used for soiled linen. CNA #2 confirmed she picked up the soiled linen and held it against her clothing while transporting the soiled linen to the linen container. The CNA stated she had been trained to dispose of soiled linen immediately into the dirty linen container and to carry the linen away from clothing. In addition, CNA #2 stated she believed the linen had been placed on the bathroom floor of room A-10 after the resident had received a shower by the shower aide.</p> <p>CNA #1 stated in interview conducted on</p>	F 441		

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F 441	<p>Continued From page 15</p> <p>10/02/13, at 4:30 PM, she had left the linen on the resident's floor in room A-9 after spilling the resident's coffee during the breakfast meal. CNA #1 stated she got "side tracked" when she went to get the dirty linen container and had not placed the linen in the appropriate container immediately. CNA #1 stated the linen had been placed on the bathroom floor in room A-10 by the shower aide. CNA #1 stated she had also been trained to dispose of linen in the appropriate container and she was not supposed to place soiled linen on the floor.</p> <p>Interview with the shower aide (CNA #3) on 10/03/13, 1:10 PM, revealed she had given the resident in room A-10 a shower on 10/02/13; however, she denied placing the soiled linen on the resident's bathroom floor. CNA #3 stated she had been trained to place soiled linen in the dirty linen container immediately and not on the resident's floor.</p> <p>Interview conducted with the Director of Nurses (DON) on 10/03/13, at 8:25 PM, revealed staff had been trained to place soiled linen immediately into the designated soiled linen containers. The DON stated she conducted random rounds throughout the facility to observe/monitor for appropriate infection control procedures. The DON stated she had identified problems with soiled linen being placed on the resident's floor "last week" and had conducted re-education for staff regarding appropriate linen handling procedures.</p>	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 42636
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K 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)  BUILDING: 01  PLAN APPROVAL: 1985  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V (111)  SMOKE COMPARTMENTS: 3  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)  EMERGENCY POWER: Type II diesel generator  A life safety code survey was initiated and concluded on 10/01/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029		

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

TITLE

(X6) DATE

*[Handwritten Signature]*

*Administrator*

*10/25/13*

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 30 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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K 029	<p>Continued From page 1</p> <p>and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a hazardous area door was held open in an approved manner. This deficient practice affected one of three smoke compartments, staff, and fourteen residents. The facility has the capacity for 60 beds with a census of 58 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 10/01/13 at 10:20 AM, with the Director of Maintenance (DOM), a corridor door to the back stockroom was observed to have a door hold-open device. Hazardous area doors cannot be held open unless connected to the fire alarm system. An interview with the DOM on 03/26/13, at 10:20 AM revealed he was not aware of this requirement.</p> <p>The findings were revealed to the staff member in charge upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.2.2.2.6*</p>	K 029	<p>No residents were found to be affected.</p> <p>Fourteen residents had the potential to be affected. The door hold-open device was removed from identified door on 10/2/13</p> <p>Maintenance, Housekeeping, and all Nursing staff were serviced on 10/10/13 that no hazardous area door will be held open in an unapproved manner.</p> <p>Administrator or designee will complete walking rounds 3X a week for 1 month then 1X a week for 2 months to ensure compliance.</p> <p>Thereafter, random walking rounds will be completed to ensure compliance.</p> <p>The Quality Assurance Committee will review audits to ensure compliance monthly for 12 months.</p>	10/10/13

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K 029	Continued From page 2 Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 029		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. This deficient practice affected one of three smoke compartments, staff, and fourteen residents. The facility has the capacity for 60 beds with a census of 58 on the day of the survey.	K 076	Maintenance and all Nursing staff were in serviced on not storing more than 12 oxygen cylinder tanks at any one storage area. Laminated signs were placed above the racks reminding staff that no more than 12 oxygen cylinders were to be stored in that area.  Administrator or designee will complete walking rounds 3x a week for 1 month then 1x a week for 2 months to ensure compliance.  Thereafter, random walking rounds will be completed to ensure compliance.  The Quality Assurance Committee will review audits to ensure compliance monthly for 12 months.	10/16/13

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K 076	<p>Continued From page 3</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 10/01/13, at 10:18 AM with the Director of Maintenance (DOM), 14 E size oxygen cylinder tanks were observed to be stored in the back stockroom. These tanks were within five feet of combustible storage. Oxygen cylinders while in storage and in quantities greater than 300 cubic feet must be kept five feet from combustibles.</p> <p>An interview with the DOM on 10/01/13, at 10:18 AM revealed he was not aware of oxygen storage requirements.</p> <p>Quantities 300 cubic feet (12 E sized cylinders) and less may follow the requirements of S&amp;C-07-10.</p> <p>The findings were revealed to the staff member in charge upon exit.</p> <p>Reference: S&amp;C-07-10</p> <p>Up to 300 cu ft (12 E sized cylinders) of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse's station or in a corridor of a healthcare facility.</p> <p>This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the</p>	K 076			

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K 076	<p>Continued From page 4</p> <p>use of the corridor. This amount of medical gas is in addition to those cylinders contained in "crash carts" and in use on wheelchairs or gurneys.</p> <p>The term "PRN" means "as needed." An individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) but less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>) (A) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection</p>	K 076		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186211	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  10/01/2013
NAME OF PROVIDER OR SUPPLIER  MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 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	
K 076	Continued From page 5 rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076			