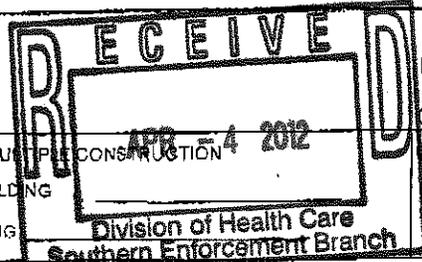


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 03/20/2012
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 03/06/2012
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NAME OF PROVIDER OR SUPPLIER HILLCREST HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREETINGS RD, P O BOX 556 CORBIN, KY 40702
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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>An abbreviated standard survey (KY17926) was conducted on 03/06/12. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "D" level.</p> <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 interview, record review, and review of the facility investigation it was determined facility staff failed to provide services in accordance with each resident's written plan of care for three of three sampled residents (Residents #1, #2, and #3). A review of care plans revealed Residents #1, #2, and #3 required the use of a smoking apron during smoke breaks. However, based on documentation, on 02/22/12, facility staff failed to provide smoking aprons to the residents during a smoke break and the clothing of one of the residents was burned.</p> <p>The findings include: A review of the facility investigation revealed on 02/22/12, the Activities Director found Resident #1 in the hallway outside the smoke break room. The Activities Director observed ashes on the resident's clothes and noted the ashes had burned through the resident's pants and onto a brief worn by the resident. The investigation</p>	F 282	<p><u>F282</u></p> <p>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.</p> <p>1) Resident #1 was immediately assessed and found to be free of injury. Resident's #2 and 3 were also assessed and found to be free of any injury or negative affects from this incident. The nurse aide involved was immediately removed from duty at the time of incident and employment ultimately terminated. Resident #1's MD and RP were notified. The medical director was also notified of this incident.</p> <p>2) All other residents present for this smoke break were assessed and found to be free of injury.</p> <p>3) All staff were re-educated on the use of smoking aprons and resident safety while smoking. Staff and residents were interviewed. All staff verbalized their understanding of protocol for use of aprons while smoking and confirmed they had been consistently using. Residents confirmed that smoking aprons were being used. Resident care</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maed M. H. Jones</i>	TITLE Administrator	(X6) DATE 3-26-12
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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.

Received Time Apr. 4. 2012 11:40AM No. 6569

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F 282	<p>Continued From page 1</p> <p>further revealed nine residents, which included Residents #1, #2, and #3, had been in the smoke room smoking during the 4:30 PM smoke break on 02/22/12, and State Registered Nurse Aide (SRNA) #1 failed to put a smoking apron on any of these residents. A skin assessment of Resident #1 was performed by the Administrator and the Director of Nursing (DON) on 02/22/12, at 5:00 PM, and the resident was assessed to have no evidence of burns and/or blisters on the skin. In addition, according to the investigation report, although the ashes had burned through Resident #1's pants the ashes had not burned through the resident's brief.</p> <p>A review of Resident #1's Comprehensive Care Plan (CCP) dated 01/17/11, Resident #2's CCP dated 11/17/11, and Resident #3's CCP dated 02/06/12, revealed the resident had the "potential for safety hazard, injury" related to smoking. Continued review of the care plans revealed staff was to provide the residents with a flame-proof smoking apron when they smoked.</p> <p>Observation of Resident #1 on 03/06/12, at 9:08 AM, and Resident #3 at 1:20 PM, in the smoking area revealed the residents were smoking and were wearing smoking aprons.</p> <p>Interview with SRNA #1 on 03/06/12, at 10:35 AM, revealed she had worked on 02/22/12, and was in charge of supervising the residents' 4:30 PM smoke break. The SRNA stated she was aware smoking aprons were available in the smoke room, however, was not aware Residents #1, #2, and #3 were to be provided with smoking aprons during smoke breaks and had failed to provide the residents with smoking aprons.</p>	F 282	<p>plans and kardexes were reviewed to ensure that they reflected resident safety while smoking. No problems were noted. Employees will continue to be educated on smoking policy and resident safety during orientation and annually thereafter and sign a statement that they have been educated on this.</p> <p>4) Facility supervisory staff/charge nurse monitored all smoke breaks for compliance for the first 48 hours following this incident. Monitoring was then initiated to be done daily for two weeks at random times/ different breaks, and then continued to be monitored weekly for one month and on an as needed basis thereafter.</p> <p>5) Completion Date: 3/7/12</p>	

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F 282	Continued From page 2 SRNA #1 further stated during interview that she was not aware Resident #1 had dropped ashes on him/herself. Interview with the Administrator and the DON on 03/06/12, at 4:00 PM, revealed it was a requirement for all residents to have smoking aprons placed on them by facility staff to prevent the residents from burning themselves during smoke breaks. Interview further revealed all staff received in-service training related to the use of the smoke aprons and fire prevention at the time they were hired and on an annual basis.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, a review of the facility's investigation, staff training, and policy, it was determined the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for three of three sampled residents (Residents #1, #2, and #3). Facility staff failed to ensure smoking aprons, made of fire-retardant material, were utilized for Residents #1, #2, and #3 on 02/22/12, during the designated smoking time in	F 323	<u>F323</u> 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's #1, #2, and #3 were assessed and found to be free of injury or negative effects from this incident. SRNA #1 was removed from duty directly following this incident and ultimately terminated. Smoke aprons were available for all residents, however, SRNA #1 failed to use them per facility policy.	

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F 323	<p>Continued From page 3</p> <p>accordance with facility policy and Resident #1 dropped ashes on his/her clothes. Although the ashes burned through the resident's pants, documentation revealed Resident #1 did not suffer any burns to the body as a result of the ashes.</p> <p>The findings include:</p> <p>A review of the facility smoking policy, revised 01/25/11, revealed smoking aprons were to be provided to all residents during smoke break times.</p> <p>A review of facility training revealed staff was trained at the time of their employment related to the facility's smoking policy and the requirement that residents were to utilize smoking aprons while smoking. Interview with the Administrator and the Director of Nursing (DON) on 03/06/12, at 4:00 PM, confirmed that as part of all employees' orientation upon hire they are trained on the smoking policy.</p> <p>A review of the facility's investigation revealed on 02/22/12, during the 4:30 PM smoke break, State Registered Nurse Aide (SRNA) #1 failed to utilize smoking aprons for nine residents. The investigation revealed the Activities Director found Resident #1 in the hallway outside of the smoke room with ashes on his/her pants which had melted through the pants onto the brief. The investigation further revealed the Activities Director poured water on the resident's pants and the resident was taken to his/her room. Continued review of the investigation revealed the Administrator and the DON performed a skin assessment of Resident #1 and there were no</p>	F 323	<p>2) All other residents present for this smoke break were assessed and found to be free of injury.</p> <p>3) All staff were re-educated on the use of smoking aprons and resident safety while smoking. Staff and residents were interviewed. All staff verbalized their understanding of protocol for use of aprons while smoking and confirmed they had been consistently using. Residents confirmed that smoking aprons were being used. Resident care plans and kardexes were reviewed to ensure that they reflected resident safety while smoking. No problems were noted. Employees will continue to be educated on smoking policy and resident safety during orientation and annually thereafter and sign a statement that they have been educated on this.</p> <p>4) Facility supervisory staff/charge nurse monitored all smoke breaks for compliance for the first 48 hours following this incident. Monitoring was then initiated to be done daily for two weeks at random times/ different breaks, and then continues to be monitored weekly for one month and on an as needed basis thereafter.</p> <p>5) Completion Date: 3/7/12</p>		

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F 323	<p>Continued From page 4</p> <p>burns or blisters observed on the resident's skin as a result of the ashes.</p> <p>An interview was attempted with Resident #1 on 03/06/12, at 9:05 AM, however, the resident was non-interviewable per the roster matrix. Facility staff was requested to perform a skin assessment of Resident #1 at 2:30 PM on 03/06/12. Observation during the skin assessment revealed no evidence of burns and/or blisters to the resident's skin.</p> <p>Interview with Resident #2 on 03/06/12, at 8:53 AM, revealed the resident was in the smoke room on 02/22/12, the day the incident with Resident #1 occurred. Resident #2 stated no one was wearing smoking aprons that day during the smoke break. The resident further stated the smoke break was really "rushed" that day and she/he guessed SRNA #1 forgot to put the aprons on the residents. Resident #2 further stated facility staff usually provides them with the aprons prior to smoking.</p> <p>Interview with Resident #3 on 03/06/12, at 9:37 AM, revealed the resident was not aware any resident had burned themselves and/or their clothing while smoking. Resident #3 stated smoking aprons were always provided and he/she did not remember that smoking aprons had not been provided on 02/22/12.</p> <p>An interview with SRNA #1 on 03/06/12, at 10:35 AM, revealed she did not remember the facility in-servicing or training her on the facility smoking policy. The SRNA stated on 02/22/12, at the 4:30 PM smoke break time she was in a hurry because that was not her regular time to</p>	F 323		

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F 323	<p>Continued From page 5</p> <p>supervise the smoke break and she had only been asked to supervise the break a few minutes prior to the break time. SRNA #1 stated she was aware the smoking aprons were on the back of the door; however, she was in a "hurry" on 02/22/12. Interview further revealed the SRNA was not aware Resident #1 dropped ashes on him/herself on 02/22/12, during the 4:30 PM smoke break.</p> <p>A review of SRNA #1's employee record revealed she had been trained at the time of her employment on 11/12/11 (approximately three months prior to the incident), on the facility's smoking regulations.</p> <p>Interview with the Administrator and the DON on 03/06/12, at 4:00 PM, revealed all facility staff was required to place smoking aprons on each resident prior to the resident smoking. Interview further revealed they conducted observations of staff at random and had never observed residents in the designated smoke area without smoking aprons on. Further interview confirmed the DON and the Administrator performed a skin assessment on Resident #1 on 02/22/12, and revealed although the ashes had burned through Resident #1's pants, there were no bum marks on the resident.</p>	F 323		