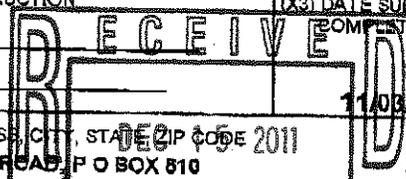


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Received Time: Dec. 15, 2011 7:04AM No. 4123
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2011
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P O BOX 810 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)	
F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility care plan policy, it was determined that the facility failed to develop a comprehensive care plan for two of fifteen sampled residents (Residents #12 and #13). Record review revealed Residents #12 and #13</p>	F 279		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 12/15/11

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.

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

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PRINTED: 12/06/2011
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 _____ B. WING _____	<div style="border: 2px solid black; padding: 5px; text-align: center;"> RECEIVED DEC 12 2011 11/03/2011 Division of Health Care Southern Enforcement Branch </div>		(X3) DEFENSE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P.O. BOX 810 PINE KNOT, KY 42658			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 000	INITIAL COMMENTS	F 000				
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility care plan policy, it was determined that the facility failed to develop a comprehensive care plan for two of fifteen sampled residents (Residents #12 and #13). Record review revealed Residents #12 and #13</p>	F 279				

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

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P O BOX 810 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 279	<p>Continued From page 1</p> <p>had diagnoses of End Stage Renal Disease requiring hemodialysis (a medical procedure performed to remove wastes and toxins from the body when the kidneys fail). However, review of the plan of care showed no evidence that the facility had developed an individualized care plan to address services to be provided to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being related to hemodialysis.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Care Plan Interdisciplinary Team Meetings Policy and Procedures (dated March 2009) revealed that care plans would be read to the interdisciplinary team during the weekly meetings and the team would discuss and/or make changes needed regarding the resident's plan of care at that time. Interview with the Facility Administrator on 11/03/11, at 3:05 PM, confirmed the above policy/procedure was the only policy in place related to care plans.</p> <p>1. Record review revealed the facility admitted Resident #13 on 10/10/11, with diagnoses of End Stage Renal Disease requiring Hemodialysis, Diabetes, and Hypertension. A review of the Admission Minimum Data Set (MDS) assessment dated 10/17/11, revealed the facility assessed the resident to make him/herself understood and has the ability to understand others. Further review of the (MDS) revealed Resident #13 was assessed to require extensive assistance with bed mobility, dressing, and bathing.</p> <p>A review of the care plan dated 10/27/11, for</p>	F 279	<p>The care plans for resident #12 and #13 were reviewed by the IDT and revised or developed as indicated. Included in the care plan as indicated is monitoring the shunt site, monitoring for complications related to dialysis such as hypotension and abnormal bleeding, monitoring weights, watching diet and dietary intake, etc.</p> <p>All comprehensive care plans to be reviewed by IDT by 12/15/11 to ensure that all needs are addressed and that all care plans are current and applicable to the resident. Any updates or revisions will be completed as indicated.</p> <p>Nursing staff including IDT re-educated on the use of the care plan to direct care and the need to include special procedures on the individual care plan. This was completed by the DON on 12/15/11. IDT reviewed the corporate presentation on care planning on 12/12/11; this was confirmed by the DON.</p>	<p>11/7/11</p> <p>12/15/11</p> <p>12/15/11</p>

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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P O BOX 810 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 279	<p>Continued From page 2</p> <p>Resident #13 revealed no evidence the facility had addressed hemodialysis as a care concern for the resident. Further review of the care plan revealed the facility had failed to provide Resident #13 with a plan of care that reflected standards of current professional practices related to hemodialysis.</p> <p>A review of treatment records for Resident #13 for November 2011 revealed no evidence that facility staff was monitoring the resident's hemodialysis vascular access site. An interview with Licensed Practical Nurse (LPN) #2 on 11/03/11, at 2:00 PM, revealed the care plan is what provides the staff direction for providing care for the residents. However, the facility did not identify hemodialysis as a care concern for Resident #13, therefore, no interventions or professional practices related to hemodialysis were available for staff review.</p> <p>An interview with Registered Nurse (RN) #1 on 11/03/11, at 1:45 PM, revealed she had completed the care plan for Resident #13. Further interview confirmed an individualized plan of care related to hemodialysis had not been provided for Resident #13. RN #1 continued to state hemodialysis should have been addressed as a care concern on the care plan for Resident #13.</p> <p>2. Review of the medical record of Resident #12 revealed the facility had admitted the resident on 11/20/07, with diagnoses that included End Stage Renal Disease requiring hemodialysis, Hypertension, and Diabetes Mellitus. A review of the annual comprehensive assessment of Resident #12 with an assessment reference date</p>	F 279	<p>DON to review 25% of care plans each for 4 weeks to ensure all care plans are reviewed a second time within the month to ensure that they are accurate and individualized for each resident., DON will then review a minimum of 25 % care plans each month for 4 months to ensure our procedure for development and review of care plans is implemented. DON will report any issues she finds to the facility QA committee for follow up.</p> <p>Completion date 12/16/11.</p>	12-16-11	

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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 68 CAL HILL ROAD, P O BOX 810 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 279	<p>Continued From page 3</p> <p>of 05/20/11, revealed the resident had been assessed to be able to understand others and to make him/herself understood. Resident #12 was also assessed to have severely impaired vision.</p> <p>Observations of Resident #12 on 11/03/11, at 9:10 AM, revealed the resident was well groomed, sitting in a wheelchair in the resident's room. The resident's vascular access site (vessel in the arm used to place needles for hemodialysis treatments) on the left upper arm was visible. The vascular access site was clean with no problems observed.</p> <p>Interview with Resident #12 on 11/03/11, at 9:10 AM, revealed the resident had no problems with the care he/she received from facility staff.</p> <p>A review of the care plan dated 03/09/09, for Resident #12 revealed the facility had identified a problem area of the resident at risk for infection related to a new shunt site (vascular access for dialysis treatments) to the left upper arm. The interventions were to monitor for signs/symptoms of infection and that the resident received dialysis three times a week. There was no evidence the facility had developed a plan of care for the resident's specific needs related to hemodialysis; for example, bleeding from the vascular access, hypotension after hemodialysis treatment, or shortness of breath (indicating the resident had excess fluid remaining after treatment). Review of Resident #12's treatment record for November 2011 revealed no documentation of monitoring of the resident's shunt or any signs/symptoms of dialysis related problems.</p> <p>Interview with LPN #3 on 11/03/11, at 11:50 AM,</p>	F 279			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2011
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P O BOX 810 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 279	Continued From page 4 revealed LPN #3 was responsible for the care of Resident #12. According to LPN #3, all the resident's care needs should be on the resident's care plan. LPN #3 confirmed the resident's care needs related to hemodialysis were not on the care plan. Interview with LPN #1 on 11/03/11, at 2:15 PM, revealed she was responsible for the development of the care plan for Resident #12. According to LPN #1, the resident's care needs related to hemodialysis should be on the care plan. LPN #1 stated staff was monitoring Resident #12 but the guidance was not on the care plan.	F 279			
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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain the kitchen in a sanitary manner. The confectioner's oven was observed to have an excessive accumulation of grease on the exterior and dust was observed to cover the top of the oven. In addition, the interior of the oven.	F 371			

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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P O BOX 810 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	Continued From page 5 contained burned food particles/debris and was in need of a thorough cleaning. The findings include: The facility had no specific policy/procedure related to cleaning of the confectioner's oven. During the initial tour of the kitchen at 9:10 AM on 11/01/11, the oven was observed to have dark areas covering the exterior, and the entire top of the oven was observed to be covered with dust. An additional sanitation tour of the kitchen was conducted on 11/03/11, at 3:05 PM, with the facility's Administrator. The exterior of the oven was observed to have an excessive accumulation of grease and the top of the oven was covered with dust that was easily wiped off by hand.	F 371	No residents were identified. The oven was cleaned on 11/4/11 by Dietary Manager. The dietary manager inspected all equipment in the kitchen on 11/4/11. Any equipment that needed cleaning was cleaned at that time. The dietary manager reviewed the cleaning schedule for the dietary department and in-serviced all dietary staff on the schedule on 11/11/11. She will repeat this in-service monthly for 3 months. All newly hired dietary employees will be in-serviced during orientation. Beginning 11/14/11 the administrator and dietary manager or cook will inspect the equipment and kitchen area each Friday for one month then every two weeks for one month then monthly for 3 months to ensure sustained compliance with the cleaning schedule. The dietary consultant will inspect the kitchen for cleanliness no less than monthly beginning November 2011. The dietary consultant will present a written report of her monthly sanitation review to the facility QA committee for review. The administrator will report on the dietary audits to the facility QA committee for no less than quarterly.	11/4/11 11/4/11 12/17/11
F 492 SS=D	The Administrator stated in interview at 3:05 PM on 11/03/11, that he also thought the buildup of darkened areas on the exterior of the confectioner's oven was an excessive accumulation of grease. An interview with the cook on duty at 3:08 PM on 11/03/11, revealed the interior of the confectioner's oven was to be cleaned on a weekly basis. The cook further stated when staff cleaned the interior of the oven they were to also to clean/wipe off the front of the oven. Review of the cleaning schedule revealed staff had documented the oven had been cleaned on 10/23-29/11, the week prior to the observation.	F 492	Completion date 12/17/11.	12/17/11
483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/03/2011
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P O BOX 810 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 492	<p>Continued From page 6</p> <p>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, personnel record reviews, and a review of facility policies/procedures, it was determined the facility failed to ensure one (1) of three (3) State Registered Nursing Assistants (SRNAs) had a current state certification as required. The SRNA's certification had expired on 08/27/11.</p> <p>The findings include:</p> <p>Review of the facility policy/procedure Abuse Prohibition (dated as approved on 04/28/05) revealed the Board of Nursing would be contacted to verify an active license and a good standing status of any Licensed Nurse applicant, Certified Nursing Assistant (CNA), or Nursing Assistant.</p> <p>Review of the personnel record of SRNA #5 revealed the SRNA (formerly referred to as CNA) had a hire date of 07/01/11. Review of the Online Validation Results obtained by the facility's Office Manager revealed SRNA #5's certification had lapsed effective 08/27/11, 57 days after employment and 65 days prior to the observation. SRNA #5 had worked a regular, full-time schedule after expiration of her certification and</p>	F 492			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P O BOX 810 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 492	Continued From page 7 was observed working on 11/01/11. Interview on 11/03/11, at 4:10 PM, with the Director of Nursing (DON) revealed she was unaware SRNA #5's certification had expired. The DON stated she checked the status of newly hired SRNAs but not again after hire. Interview with the facility Office Manager on 11/03/11, at 4:50 PM, revealed the Office Manager was responsible for ensuring all staff had current certification and/or license. The Office Manager stated she was unaware SRNA #5's certification had expired. According to the Office Manager, she checked the status of all licensed/certified staff by online validation through the Board of Nursing upon hire and at the first of each year. According to the Office Manager, she would be unaware of any license/certification expirations after the employee's hire date until the first of each year.	F 492	Verification of employment on SRNA #5 faxed to the KY Board of Nursing on 11/03/11 by Office Manger and SRNA received active status on 11/04/11. All employment records were audited on 11/4/11 by DON. The records were checked to ensure that all SRNA'S were active. No other staff were identified. Office Manger was re-educated by Director of Nursing on 11/4/11 regarding the review of certification for SRNA. Office Manager will be responsible to check the certification status of all SRNAs upon hire and monthly and notify the Director of Nursing if any SRNAs let their certification expire. Any SRNA who is not active will be removed from the schedule until active status is obtained. All SRNAs were re-educated as to their responsibility to maintain active certification on 12/12/11 by DON. Office Manager will report her findings regarding the certification status on SRNA to the facility QA committee for monitoring. Completion date 12/12/11	11/4/11 11/4/11 12/12/11 12/12/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185211	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2011
NAME OF PROVIDER OR SUPPLIER MCCREARY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD, P O BOX 810 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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Three</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 11/02/11, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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