

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

PRINTED: 12/30/2015
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 11/19/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE	STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635
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F 000 F 279 SS=D	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 11/17-19/15. Deficient practice was identified with the highest scope and severity at "F" level.</p> <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, and record review, it was determined the facility failed to develop a comprehensive plan of care for one (1) of fifteen (15) sampled residents (Resident #12). Review of Resident #12's plan of care revealed the facility failed to develop a plan of care addressing the grooming or nail care needs of</p>	F 000 F 279	<p>Resident #12 had her toenails trimmed by charge nurse on residents' hall on 11/19/15.</p> <p>DON performed 100% audit of all residents (in facility) nail care on 11/21/15 with no other residents identified as having long nails. All resident care plans were reviewed by MDS nurses and any resident without a care plan addressing nail care had one implemented.</p> <p>MDS nurses were in-serviced by the DON on 11/21/15 regarding the need to ensure that care plans are in place to address grooming needs that include nail care. By 12/2/15 all CNA's were in-serviced by DON or designee to report to nurses the need for nail care if they were unable to complete care themselves to report to nurses the need for nail care if they were unable to complete care themselves. All new hired CNA's will be trained upon hire on the process.</p>	12/2/15

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 279	<p>Continued From page 1 Resident #12.</p> <p>The findings include:</p> <p>Interview with the Director of Nurses (DON) on 11/19/15 at 4:00 PM revealed the facility did not have a policy related to the development of a resident care plan, and had no policy to address resident nail care.</p> <p>Review of the medical record revealed the facility admitted Resident #12 on 09/14/13 with diagnoses of Anxiety, Dementia, Depressive Disorder, and Chronic Obstructive Pulmonary Disease. Review of Resident #12's Annual Minimum Data Set (MDS) dated 05/14/15 revealed the resident required extensive assistance of staff with personal hygiene and total assistance with bathing of two persons.</p> <p>Observation on 11/19/15 at 2:43 PM of Resident #12 revealed the resident's third and fourth toenails on his/her right foot were long and in need of trimming. Interview with Certified Nursing Assistant #7 on 11/19/15 at 2:43 PM, revealed she acknowledged that the resident's toenails were long and in need of trimming but stated that the nurses were responsible for nail care of residents.</p> <p>Review of the Comprehensive Care Plan dated 05/18/15 revealed the plan identified the resident as needing assistance with activities of daily living (ADLs). However, the plan did not include interventions addressing grooming or nail care. Review of the Certified Nurse Aide (CNA) Care Plan and the resident's "Bath Type Detail Report" revealed they also failed to include interventions related to nail care for Resident #12.</p>	F 279	<p>By 12/2/15 all licensed nursing staff was in-serviced by the DON or designee to assess nails during weekly skin assessments and performance as needed to ensure nail care is being done.</p> <p>Grooming needs that include nail care will be discussed for all residents in the weekly care plan meeting to ensure care concerns are addressed.</p> <p>DON or Administrator will round one time a week for 4 weeks then once a month for 3 months comparing care plan to nail care being provided with results being reported to QAPI committee (including but not limited to) Sam Hutchinson, Administrator, Sharon Baird, DON, Milicia Kidd, MDS, Tammy Troxell, QAPI, Donna Stephens, Bookkeeper, Renee Crabtree, Dietary Manager, Gary Duncan, Maintenance, Breanda Butler, Housekeeping, Robin Stephens, Activities, Anna Ross, Medical Records, and Mary Ann Jones, Social Services.</p>	

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F 279	<p>Continued From page 2</p> <p>Interview with the DON on 11/19/15 at 4:00 PM revealed Certified Nurse Aides were to follow the standard of practice regarding activities of daily living which included nail care, but nail care was not included on residents' individualized care plans.</p> <p>Interview with MDS Coordinators #1, #2, and #3, and the Assistant Director of Nursing (ADON) on 11/19/15 at 3:32 PM revealed MDS Coordinators #1, #2, #3, and the ADON were responsible for formulating and updating the care plans, and to ensure care plan interventions were being followed. However, the MDS Coordinators and the ADON stated they had failed to develop a care plan related to Resident #12's individualized nail care needs.</p> <p>Interview with the Director of Nursing on 11/19/15 at 3:46 PM revealed the facility conducted care plan meetings weekly to review and verify that all identified resident concerns had been addressed in the resident's plan of care. However, the DON stated that the omission of nail care guidelines for Resident #12 had not been identified by the facility.</p> <p>Interview with the Administrator on 11/19/15 at 5:00 PM also revealed the facility had weekly care plan meetings, and performed random audits to ensure care was being performed as specified in each resident's plan of care. However, the Administrator stated he was not aware that nail care had not been addressed on Resident #12's plan of care.</p>	F 279		
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	<p>Continued From page 3</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, and record review it was determined the facility failed to provide care in accordance with the Comprehensive Plan of Care for one (1) of fifteen (15) sampled residents (Resident #4). Resident #4's Comprehensive Care Plan contained interventions that included having palm protectors and finger separators in hands bilaterally at all times; however, observations on 11/17/15 and on 11/18/15 revealed Resident #4 to be without palm protectors and finger separators.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 11/19/15 at 4:17 PM revealed the facility did not have a policy related to following the care plan.</p> <p>Review of Resident #4's medical record revealed the facility admitted Resident #4 on 12/19/02 with diagnoses that include Persistent Vegetative State, Aphasia, Dysphasia, Epilepsy, Hypertension, Thrombocytopenia, Pancytopenia, Ascites, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Review of the quarterly Minimum Data Set (MDS) assessment dated 11/03/15 revealed the facility had not been able to interview Resident #4 for a Brief Interview for Mental Status (BIMS) score due to the resident's cognitive status. Additional</p>	F 282	<p>Resident #4 was said to be affected by deficient practice had palm protectors placed in hands as indicated by care plan. The resident was assessed by OT on 11/20/15 to insure that no negative outcome came from not following the plan of care. No issues were found.</p> <p>DON or designee made rounds on 11/20/15 and 11/23/15 to audit care plans of current residents to ensure residents requiring devices to increase ROM and or prevent further risk of decreased ROM were being followed. For those 6 residents no deficient practices were found.</p> <p>By 12/02/15 all licensed nurses and CNA's were in-serviced by the DON or designee on the need to ensure plan of care is being followed. A review of care concerns will be addressed weekly in the care plan meeting to ensure all needs of residents are being addressed.</p>	12/2/15	

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F 282	<p>Continued From page 4</p> <p>review of the MDS revealed the facility assessed Resident #4 to have functional limitation in range of motion and to have impairment on both sides of the upper and lower extremities. Review of Resident #4's Comprehensive Care Plan dated 08/06/15 revealed an intervention for Resident #4 to have palm protectors and finger separators in hands at all times.</p> <p>Observations of Resident #4 on 11/17/15 at 11:08 AM, 11:20 AM, 2:18 PM, and 3:20 PM (during a skin assessment), and on 11/18/15 at 12:39 PM and 2:47 PM revealed no palm protectors and finger separators were present and applied to Resident #4's hands.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 11/18/15 at 3:28 PM revealed she did not know why the palm protectors and finger separators were not on Resident #4's hands on 11/17/15 and 11/18/15. Further interview revealed SRNA #1 had come in to work on 11/17/15 at 12:00 PM and the palm protector and finger separators were not on Resident #4 as required.</p> <p>Interview with SRNA #2 on 11/18/15 at 3:38 PM revealed Resident #4 did not have the palm protector and finger separator on when she came in to work. Further interview with SRNA #2 revealed the care plan said palm protectors and finger separators were to be worn at all times, and that she or the direct care staff should have put the palm protectors and finger separators back on after staff bathed Resident #4.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 11/19/15 at 4:56 PM revealed she made rounds every two hours to ensure residents were</p>	F 282	<p>DON or designee will audit residents requiring devices to increase ROM and or prevent further risk of decreased ROM daily for one week then once a week for 4 weeks.</p> <p>Results will be reported to QAPI committee monthly.</p>		

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F 282	<p>Continued From page 5</p> <p>getting the care required and care plan interventions were being followed. Further interview with LPN #2 revealed the SRNAs have profiles for each resident to be followed. Additional interview revealed Resident #4 should have had palm protectors and finger separators present to both hands.</p> <p>Interview with MDS Coordinators #1, #2, and #3, and the Assistant Director of Nursing (ADON) on 11/19/15 at 3:32 PM revealed MDS Coordinators #1, #2, and #3, and the ADON were responsible for formulating and updating the care plans, and to ensure care plan interventions were being followed. Further interview revealed MDS Coordinators #1, #2, and #3, and the ADON performed random rounds weekly. Additional interview revealed MDS Coordinators #1, #2, and #3, and the ADON reviewed and updated the care plans to make sure they are carried over to the SRNA care plans.</p> <p>Interview with the Director of Nursing on 11/19/15 at 3:46 PM revealed facility staff had care plan meetings weekly to verify all orders and to ensure interventions were added to the care plans. She explained she did random checks daily to ensure staff was following the care plans. She further revealed she had not identified any concerns with staff not following the care plans.</p> <p>Interview with the Administrator on 11/19/15 at 5:00 PM revealed the facility had weekly care plan meetings, audits performed, as well as random checks, and care plans were reviewed quarterly. Further interview with the Administrator revealed he had not identified any problems with care plan interventions being followed.</p>	F 282			

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<p>F 312 F 312 SS=D</p>	<p>Continued From page 6 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide nail care for two (2) of fifteen (15) sampled residents (Residents #1 and #12). The facility had assessed Residents #1 and #12 to require extensive staff assistance with personal hygiene. However, both residents were observed during the survey on 11/18/15 and 11/19/15 to have long toenails.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 11/19/15 at 4:00 PM revealed the facility did not have a policy to address resident nail care. The DON stated the Certified Nurse Aides (CNAs) were required to follow standards of practice regarding routine ADL care for residents which included nail care. The DON said nail care should be provided daily and as needed.</p> <p>1. Review of the medical record revealed the facility admitted Resident #12 on 09/14/13 with diagnoses of Rib Fractures, Immobilization, Hypothyroidism, Atrial Fibrillation, Malnutrition, Gastroesophageal Reflux Disease, Anxiety, Dementia, Depressive Disorder, Chronic</p>	<p>F 312 F 312</p>	<p>Resident #12 and resident #1 had her toenails trimmed by charge nurse on residents' hall on 11/19/15.</p> <p>DON performed 100% audit of all residents (in facility) nail care on 11/21/15 with no other residents identified as having long nails. All resident care plans were reviewed by MDS nurses and any resident without a care plan addressing nail care had one implemented.</p> <p>MDS nurses were in-serviced by the DON on 11/21/15 regarding the need to ensure that care plans are in place to address grooming needs that include nail care. By 12/2/15 all CNA's were in-serviced by DON or designee to report to nurses the need for nail care if they were unable to complete care themselves to report to nurses the need for nail care if they were unable to complete care themselves. All new hired CNA's will be trained upon hire on the process.</p>	<p>12/2/15</p>
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F 312	<p>Continued From page 7</p> <p>Obstructive Pulmonary Disease, Gout, and Iron Deficiency Anemia. Review of the Annual Minimum Data Set (MDS) dated 05/14/15 revealed Resident #12 required extensive assistance from staff with personal hygiene and total assistance with bathing of two persons.</p> <p>Review of the Comprehensive Care Plan dated 05/18/15 revealed the plan identified the resident as needing assistance with activities of daily living (ADLs). However, the plan did not include interventions addressing grooming or nail care. Review of the Certified Nurse Aide (CNA) Care Plan revealed the plan did not include an intervention of nail care in the interventions for hygiene or grooming. Review of the "Bath Type Detail Report" included documentation of resident baths but did not include documentation of nail care.</p> <p>Observation of Resident #12 on 11/19/15 at 2:43 PM revealed the third and fourth toenails on Resident #12's right foot to be long.</p> <p>Interview with Aide #6 on 11/19/15 at 2:45 PM revealed, "Nurses usually take care of toenails."</p> <p>Interview with Aide #5 on 11/19/15 at 4:15 PM revealed she verbally reports to the nurse if nails need to be cut or if there are other issues of concern. Aide #5 stated she did not remember if she had made the nurse aware of Resident #12's nails needing to be cut.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 revealed that nails should be cut weekly during skin assessments completed by the nurses but the Aides are supposed to document in the Kiosk (a computerized tablet on the wall in the hall of</p>	F 312	<p>By 12/2/15 all licensed nursing staff was in-serviced by the DON or designee to assess nails during weekly skin assessments and performance as needed to ensure nail care is being done.</p> <p>Grooming needs that include nail care will be discussed for all residents in the weekly care plan meeting to ensure care concerns are addressed.</p> <p>DON or Administrator will round one time a week for 4 weeks then once a month for 3 months comparing care plan to nail care being provided with results being reported to QAPI committee (including but not limited to) Sam Hutchinson, Administrator, Sharon Baird, DON, Milicia Kidd, MDS, Tammy Troxell, QAPI, Donna Stephens, Bookkeeper, Renee Crabtree, Dietary Manager, Gary Duncan, Maintenance, Breanda Butler, Housekeeping, Robin Stephens, Activities, Anna Ross, Medical Records, and Mary Ann Jones, Social Services.</p>	

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the facility on which Aldes document their care by touch screen) if there were any problems, including long nails, that the nurse needed to address.

2. Review of the medical record revealed Resident #1 was admitted to the facility on 06/02/14 with diagnoses including Dementia, Hypertension, Atherosclerosis, Anorexia, Stage IV Sacral Pressure Ulcer, and Dysphagia. Review of the annual MDS assessment dated 09/10/15 revealed the facility assessed Resident #1 to have severe cognitive impairment with a Brief Interview for Mental Status (BiMS) score of 5. Further review of the annual assessment revealed Resident #1 was assessed to require total staff assistance with personal hygiene and bathing needs.

Review of the CNA care plan revealed Resident #1 was to receive a shower on each Thursday and a bed bath daily.

Observations conducted during a skin assessment with facility staff on 11/18/15 at 10:10 AM, revealed the great, second, and third toenails of Resident #1's right foot were long and thick and the great toenail of the resident's left foot was long (extended over the edge of the toe) and jagged. A portion of the nail on the left great toenail appeared to be separated from the nail bed.

Interview conducted with CNA #1 on 11/18/15, at 2:30 PM, revealed she was frequently assigned to care for Resident #1. CNA #1 stated the nurse aides usually trimmed the residents' fingernails but she had never trimmed a resident's toenails and wasn't sure if she was allowed to. The CNA

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F 312	<p>Continued From page 9</p> <p>stated she had observed Resident #1's toenails being long during bathing and believed she had reported this to a nurse but could not recall to whom she reported the issue.</p> <p>Interview conducted with CNA #4 on 11/19/15, at 2:10 PM, revealed she normally worked as part of the bath team responsible for bathing the residents. CNA #4 stated she usually bathed Resident #4 twice a week and washed the resident between his/her toes, but had never noticed the resident's toenails.</p> <p>Registered Nurse (RN) #1 stated in interview on 11/19/15, at 11:10 AM that the CNAs and nurses were responsible to provide toenail care for the residents. RN #1 stated no one had reported a problem with Resident #1's toenails being long/thick to her. The RN further stated the nurses were responsible to monitor the residents to ensure nail care was provided; however, no staff had identified Resident #1 was in need of toenail care.</p> <p>Interview with the DON on 11/19/15, at 3:15 PM, revealed the CNAs or nurses could provide toenail care for residents, but if the CNAs identified the residents' toenails were too long/thick and needed to be trimmed they (CNAs) should report to the nurse. The DON stated the nurses were responsible to provide nail care for diabetic residents and to monitor to ensure toenail and foot care was provided as needed. The DON stated she believed staff had "gotten in a hurry and it had been an oversight."</p>	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE		STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635	

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F 318	<p>Continued From page 10</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure one (1) of fifteen (15) sampled residents (Resident #4) who had limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further risk of injury and/or decrease in range of motion. The facility had assessed Resident #4 to have a decrease in range of motion to the upper extremities and had care planned an intervention to have palm protectors and finger separators in hands at all times. However, observations of Resident #4 on 11/17/15 and 11/18/15 revealed Resident #4 to be lying in bed without palm protectors and finger separators in place.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON) on 11/19/15 at 4:17 PM revealed the facility did not have a specific policy for range of motion or application of devices to control and prevent contractures.</p> <p>Review of Resident #4's medical record revealed the facility admitted Resident #4 on 12/19/02 with diagnoses that include Persistent Vegetative State, Aphasia, Dysphasia, Epilepsy,</p>	F 318	<p>Resident #4 was said to be affected by deficient practice had palm protectors placed in hands as indicated by care plan. The resident was assessed by OT on 11/20/15 to insure that no negative outcome came from not following the plan of care. No issues were found.</p> <p>DON or designee made rounds on 11/20/15 and 11/23/15 to audit care plans of current residents to ensure residents requiring devices to increase ROM and or prevent further risk of decreased ROM were being followed. For those 6 residents no deficient practices were found.</p> <p>By 12/02/15 all licensed nurses and CNA's were in-serviced by the DON or designee on the need to ensure plan of care is being followed. A review of care concerns will be addressed weekly in the care plan meeting to ensure all needs of residents are being addressed.</p>	12/2/15

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F 318	<p>Continued From page 11</p> <p>Hypertension, Thrombocytopenia, Pancytopenia, Ascites, Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Review of the quarterly Minimum Data Set (MDS) assessment dated 11/03/15 revealed the facility assessed Resident #4 to have functional limitation in range of motion and to have impairment on both sides of the upper and lower extremities. Additional review of the MDS revealed the facility had not been able to interview Resident #4 for a Brief Interview for Mental Status (BIMS) score due to the resident's cognitive status. A review of the care plan dated 08/08/15 for restorative nursing program revealed the facility assessed Resident #4 to have decreased mobility. Review of Resident #4's Comprehensive Care Plan dated 08/08/15 revealed an intervention for Resident #4 to have palm protectors and finger separators in hands at all times.</p> <p>Observations of Resident #4 on 11/17/15 at 11:08 AM, 11:20 AM, 2:18 PM, and 3:20 PM during a skin assessment, and on 11/18/15 at 12:39 PM and 2:47 PM revealed Resident #4 had bilateral contractures to the hands and no palm protectors and finger separators were applied to Resident #4's hands.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 11/18/15 at 3:28 PM revealed she did not know why the palm protectors and finger separators were not on Resident #4 on 11/17/15 and 11/18/15. Further interview with SRNA #1 revealed she had come in to work on 11/17/15 at 12:00 PM and the palm protectors and finger separators were not on Resident #4 as required.</p> <p>Interview with SRNA #2 on 11/18/15 at 3:38 PM</p>	F 318	<p>DON or designee will audit residents requiring devices to increase ROM and or prevent further risk of decreased ROM daily for one week then once a week for 4 weeks.</p> <p>Results will be reported to QAPI committee monthly.</p>	

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F 318	<p>Continued From page 12</p> <p>revealed Resident #4 did not have the palm protectors and finger separators on when she came in to work, however, Resident #4's plan of care required the devices to be in place at all times. SRNA #2 stated that she should have ensured that Resident #4 had the palm protectors and finger separators in place.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 11/19/15 at 4:58 PM revealed she made rounds every two hours to ensure residents were getting the care required and care plan interventions were being followed. Further interview with LPN #2 revealed the SRNAs have profiles for each resident to be followed, and Resident #4 should have had palm protectors and finger separators present to both hands.</p> <p>Interview with MDS Coordinators #1, #2, and #3 and the Assistant Director of Nursing (ADON) on 11/19/15 at 3:32 PM revealed they were responsible for formulating and updating the care plans and ensuring interventions were followed. Further interview revealed MDS Coordinators #1, #2, and #3 and the ADON performed random rounds weekly, and were responsible to review and update the care plans to make sure they were included on the SRNA care plans.</p> <p>Interview with the Director of Nursing (DON) on 11/19/15 at 3:46 PM revealed the facility had care plan meetings weekly, that all care plans were reviewed quarterly, and nursing audits were done randomly to ensure care plan interventions were being followed. Further interview with the DON revealed she had not identified any problems with the care plan interventions not being followed.</p> <p>Interview with the Administrator on 11/19/15 at</p>	F 318		
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F 318	Continued From page 13 5:00 PM revealed he had not identified any problems with care plan interventions being followed.	F 318			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy it was determined the facility failed to ensure the medication error rate was five (5) percent or less. During medication administration observation on 11/17/15 and 11/18/15, thirty-one (31) opportunities were observed and two (2) errors were observed, resulting in a medication error rate of six (6) percent. The findings include: Review of the facility's Medication Administration policy dated 12/18/12 revealed medications would be administered in accordance with written orders of the attending physician. The policy directed that medications would be administered within 60 minutes of the scheduled time, except before or after meal orders, which would be administered based on the meal times. In addition, the policy noted consideration would be given for medications that were required to be administered with regard to food intake. Observation of medication administration on	F 332			

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F 332	<p>Continued From page 14</p> <p>11/17/15 at 3:30 PM, revealed RN #1 administered Rivastigmine (dementia medication) 3 mg (milligrams) to Resident A with water.</p> <p>Review of the November 2015 physician's orders and Medication Administration Record (MAR) revealed the Rivastigmine was to be administered twice daily with food; however, the medication was not administered with food.</p> <p>Continued observation of the medication administration pass on 11/17/15, at 4:10 PM, revealed RN #1 administered Metformin (diabetes medication) 500 mg with water to Resident B.</p> <p>Review of the November 2015 physician's orders and Medication Administration Record (MAR) revealed the Metformin was to be administered twice daily with meals. Review of the Meal Times Schedule provided by the facility revealed dinner was served in the facility dining room at approximately 5:30 PM daily.</p> <p>Interview with RN #1 on 09/19/15 at 11:10 AM revealed she had been trained during orientation to administer medications as ordered by the physician and as directed by the MAR. RN #1 stated she was not aware the Rivastigmine was directed to be given with food and had not noticed the instruction on Resident A's MAR. Further interview with RN #1 revealed Resident B ate dinner in the dining room and she believed giving the medication at 4:10 PM was close enough to the dinner meal to be in accordance with the "give with meals" directive.</p> <p>Interview with the DON on 09/19/15 at 3:15 PM, revealed the nurses should be reading the MAR</p>	F 332	<p>Resident A and B had no negative outcome from the deficient practice as indicated from a review that was performed by the DON on resident's medical records and an assessment of the residents on 11/19/15.</p> <p>DON and designee reviewed MARS for other residents who met same criteria as resident A and resident B (food with meds). All residents identified were assessed with no negative outcomes noted.</p> <p>By 12/2/15 all licensed nurses were inserviced by the DON on the 5 medication rights. A medication pass audit was done with the nurse that made the error on 11/24/15 to ensure that nurse was in compliance. A random medication pass audit was done on 11/24/15 on a licensed nurse to insure compliance.</p> <p>DON or designee will audit medication pass weekly 3X a week for 4 weeks the once monthly for 3 months to ensure compliance. The findings of these audits will be reported to the QAPI committee monthly.</p>	12/2/15

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F 332	Continued From page 15 and doing triple checks to ensure medications are given as directed by the physician's orders and the MAR. The DON stated if the order directed to give with food, a snack such as pudding or crackers should be provided and the meal should not be waited on unless it was readily accessible. The DON further stated the Consultant Pharmacist conducted random medication pass audits and she also "spot checked" the medication pass to ensure medications were being administered correctly and no problems had been identified.	F 332			
F 371 SS=F	483.35(f) 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, interviews, and review of facility policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for fifty-four (54) of fifty-four (54) residents of the facility who received nutrition from the kitchen. Observations in the kitchen on 11/17/15 during the lunch meal tray line revealed the a dietary aide was observed to	F 371			

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F 371	<p>Continued From page 16</p> <p>adjust her pants while the tray line was in process and returned to the tray line without washing/sanitizing her hands. Additionally, on 11/17/15 four (4) of five (5) meal carts were observed to have a dust and grease buildup on top of the meal carts.</p> <p>The findings include:</p> <p>Review of the facility policy for "Environmental Sanitation/Infection Control - Handwashing," revised August 2014, revealed the facility will store, prepare, and serve food under sanitary conditions and will wash hands frequently using proper handwashing procedures. The policy further stated hands should be properly washed before and/or after touching anything that can be a source of contamination.</p> <p>Review of the facility's policy, "Environmental Sanitation/Infection Control - Cleaning of Utility Carts/Tray Delivery Carts," revised August 2014, revealed all carts used in the food service area and for tray delivery would be cleaned and sanitized after each use.</p> <p>1. Observations in the kitchen on 11/17/15 at 11:57 AM during the lunch tray line revealed Dietary Aide #1 was observed to adjust her pants at the waist area and then proceeded to set up meal trays without washing her hands.</p> <p>2. Observations of the noon meal service on 11/17/15 at 12:00 PM and 12:47 PM, and during the supper meal service on 11/17/15 at 5:48 PM, revealed four of five meal delivery carts were observed to have a dust and grease buildup and were sticky on top of the meal carts.</p>	F 371	<p>No residents were identified as being affected by the deficient practice.</p> <p>All residents that consume food from the kitchen have the potential to be affected by the deficient practice. All residents were assessed by the DON and designee to ensure no residents were affected by the deficient practice on 11/20/15, 11/23/15 and 11/24/15.</p> <p>All carts were cleaned and are cleaned after each meal service in addition to weekly cleaning. All dietary staff was in-serviced by the Administrator on 11/20/15 the need to keep carts clean. All dietary staff was in serviced on hand washing policy by dietary manager on 11/20/15.</p> <p>Daily rounds will be completed for 1 month by the Dietary manager and or designee to ensure compliance with results being reported to the QAPI committee monthly.</p>	12/2/15

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F 371	Continued From page 17 Interview with Dietary Aide #1 on 11/17/15 at 5:04 PM revealed she should have washed her hands after adjusting her pants. Further interview with the Dietary Aide revealed she had been trained on appropriate handwashing during the meal service. Interview with the Dietary Manager on 11/18/15 at 1:23 PM revealed Dietary Aide #1 should have washed her hands after touching her clothing. Further interview with the Dietary Manager revealed the meal delivery carts were to be cleaned after each use, and taken outside and washed down weekly. Further interview with the Dietary Manager revealed the meal carts should not have a sticky, greasy, or dusty buildup on the top of them. Further interview with the Dietary Manager revealed she had not identified any problems with handwashing and/or cleaning of the food meal carts, and the carts had been cleaned on the mornings of 11/17/15 and 11/18/15.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431			

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F 431	<p>Continued From page 18 instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure medications available for resident use were not expired in one (1) of one (1) medication storage room. Observations on 11/13/15 of the medication refrigerator in the central medication room revealed it contained expired medication (Phenergan) that was available for resident use.</p> <p>The findings include: Review of the facility's policy titled "Medication Storage in the Facility," (undated) revealed medications and biologicals were to be stored</p>	F 431	<p>No residents were said to be affected by the deficient practice.</p> <p>The expired meds were discarded. All medications were audited on 11/23/15 to ensure that no expired medications were present. None were found.</p> <p>By 12/2/15 all licensed nurses were in-serviced by the DON or designee on auditing medications to ensure that none are expired.</p> <p>Weekly audits for two month will be completed by the DON to ensure audit process is being completed and expired medications are being identified. Finding of the audit will be reported to the QAPI committee on a monthly basis.</p>	12/2/15

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F 431	Continued From page 19 properly, following manufacturer's recommendations, or those of the supplier. The policy also stated outdated, contaminated, discontinued, or deteriorated medications, and those in containers that were cracked, soiled, or without secure closures were immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order existed. The policy also stated that medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified. Observation of the medication refrigerator in the centralized medication room on 11/13/15 at 3:00 PM revealed four expired Phenergan suppositories (used to treat nausea/vomiting). Each of the expired Phenergan suppositories had a different expiration date - 03/2015, 04/2015, 05/2015, and 08/2015. Interview with Licensed Practical Nurse (LPN) #6 on 11/19/15 at 3:00 PM revealed the night shift unit manager is responsible for checking the expiration dates on all meds. LPN #6 stated if an expired medication was found it was to be pulled from use, and the sticker from the medication placed on a piece of paper and faxed to the pharmacy. Pharmacy staff was to pick up and replace the next day.	F 431			
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	F 441			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE	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 441	<p>Continued From page 20 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 STANDARD is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to maintain an</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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 11/19/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE	STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635
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F 441	<p>Continued From page 21</p> <p>effective infection control program to prevent the development and transmission of disease/infection for two (2) of fifteen (15) sampled residents (Residents #1 and #3). During lunch meal service on 11/17/15 State Registered Nurse Aide (SRNA) #3 was observed to touch Resident #3's cheeseburger with her bare hands. In addition, staff was observed to omit hand washing and/or glove changes prior to placing a clean dressing into an open wound on Resident #1's sacral area.</p> <p>The findings include:</p> <p>Review of the facility policy, "Environmental Sanitation/Infection Control," revised August 2014, revealed employees involved in storing, preparing, distributing, and serving food should wash their hands frequently using proper handwashing procedures to prevent food contamination and the spread of foodborne illness.</p> <p>1. During lunch on 11/17/15 at 12:54 PM, SRNA #3 was observed to touch Resident #3's cheeseburger with her bare hands when setting up and serving the resident's tray.</p> <p>Interview with SRNA #3 on 11/17/15 at 12:56 PM revealed that although the SRNA stated she should not have touched the resident's food with her bare hands, she had not been specifically told not to do so.</p> <p>Interview with the Dietary Manager on 11/18/15 at 1:23 PM revealed no staff members are to touch residents' food with bare hands.</p> <p>Interview conducted on 11/17/15 at 3:46 PM with</p>	F 441	<p>Resident #3 was assessed by DON on 11/17/15 for s/s of infection or negative outcome with no issues identified. SRNA #3 was in-serviced on 11/17/15 by Administrator regarding not touching resident food with bare hands.</p> <p>No other residents were identified as being affected by the touching of resident #3's cheeseburger.</p> <p>Resident #1 was identified as being affected by the deficient practice. Resident #1 was assessed by the DON on 11/19/15 and no negative issues were identified with wound. RN #1 was in-serviced by DON on 11/19/15 regarding appropriate procedure for dressing change including washing hands and changing gloves.</p> <p>By 12/2/15 all nursing staff were in-serviced by the DON or designee regarding appropriate procedure for dressing change including washing hands and changing gloves. By 12/2/15 all SRNA's were in serviced by the DON or designee regarding not touching resident food with bare hands.</p>	12/2/15
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE			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 441	<p>Continued From page 22</p> <p>the Director of Nursing (DON) revealed staff was not to touch food with bare hands. Additional interview with the DON revealed she conducted random audits to monitor staff touching food with bare hands and/or other infection control concerns. Further interview with the DON revealed she had not identified any concerns with staff touching food with bare hands.</p> <p>Interview with the Administrator on 11/17/15 at 5:00 PM revealed staff was not to touch food with bare hands.</p> <p>2. Review of the facility Hand Hygiene policy (dated 11/01/12) revealed hand hygiene should be performed before moving from a contaminated body site to a clean body site during resident care, before and after changing a dressing, and after contact with a resident's mucous membranes, body fluids, or excretions.</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on 06/02/14 with diagnoses including Dementia, Anorexia, Stage IV Sacral Pressure Ulcer, and Dysphagia.</p> <p>Observation of wound care conducted on 09/18/15, at 9:50 AM, revealed an open wound was present on Resident #1's sacral area. The wound was noted to have visible tunneling. RN #1 was observed to wash her hands, put on clean gloves, and remove the soiled bloody dressing and packing from the sacral wound. RN #1 was observed to remove the soiled gloves and apply new gloves prior to irrigating the wound with a syringe containing Dakin's Solution and then patted the area dry with clean 4 x 4 gauze with the gloved hand. While still wearing the same soiled gloves, RN #1 picked up gauze soaked in</p>	F 441	<p>DON or designee will audit dressing change 3X a week for 4 weeks then 1X a week for 4 weeks to ensure appropriate procedures are being followed with results being reported to QAPI committee monthly.</p> <p>No other resident had wounds at that time therefore no other residents were identified being affected.</p>		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE		STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635	

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F 441	<p>Continued From page 23</p> <p>Dakin's Solution and proceeded to pack the gauze into the open sacral wound with a Q-tip while holding the gauze with the soiled gloved hand. RN #1 then removed the soiled gloves and put on clean gloves and placed a 4 x 4 gauze padded dressing over the sacral wound, taped the dressing, removed the gloves, and then washed her hands. RN #1 failed to remove her gloves, wash her hands, and apply clean gloves prior to cleaning the wound, packing the wound, and applying the clean dressing to the resident's wound.</p> <p>Interview conducted with RN #1 on 09/19/15, at 11:10 AM revealed she had been trained to wash her hands and change gloves after removing a soiled dressing, after cleaning a wound, packing a wound, and before applying a clean dressing. RN #1 stated she should have performed handwashing and glove changes when doing wound care on Resident #1's sacral area.</p> <p>Interview with LPN #3 on 11/19/15 at 2:30 PM, revealed she was the Infection Control Coordinator. LPN #3 stated a skills check was conducted annually as well as periodic checks to evaluate the nurses' wound care performance to determine if the nurses performed handwashing and glove changes appropriately during wound care. LPN #3 stated no problems had been identified.</p> <p>Interview with the Director of Nursing (DON) on 09/19/15, at 3:15 PM, revealed the nurses should wash their hands and change gloves whenever they remove a soiled dressing, after irrigating a wound, before packing a wound, and before applying a clean dressing. The DON stated she was not aware of any problems related to</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE			STREET ADDRESS, CITY, STATE, ZIP CODE 68 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 441	Continued From page 24 handwashing and glove changing during wound care.	F 441		
F 514 SS=D	483.75(l)(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 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and facility policy review, the facility failed to ensure an accurate clinical record was maintained for three (3) of fifteen (15) sampled residents (Residents #2, #5, and #6). The resident's plan of care did not contain the accurate code status for Residents #2, #5, and #6. The findings include: 1. Review of the facility's "Designation of Resuscitation Status-Kentucky" policy revealed "The facility will maintain a "Do Not Resuscitate"	F 514		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42835		
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F 514	<p>Continued From page 25</p> <p>(DNR) master list in the front of each Medication Administration Record (MAR) binder and the front of each Treatment Administration Record (TAR) and at each Nurses Station." However, the policy did not address other areas staff could refer to should they need to access resuscitation status. Further review of the policy revealed no information regarding how the medical record was updated when a change of resuscitation status occurred. According to interview with the Director of Nursing on 11/19/15 at 4:17 PM, the facility did not have a policy regarding updating care plan information.</p> <p>Review of the medical record revealed the facility admitted Resident #2 on 05/16/15 with diagnoses of Stage III Chronic Kidney Disease, Parkinson's Disease, Dementia without Behavioral Disorder, Major Depressive Disorder, Hypertension, and Anxiety. Further review of the medical record revealed Resident #2 was admitted with Full Code status. The resident's code status was changed to DNR when DNR documents were signed on 09/14/15. Further review of the medical record revealed the CNA Care Plan dated 10/15/15 had Full Code status documented; however, at that time Resident #2 had a DNR document in place.</p> <p>2. Review of Resident #5's medical record revealed the facility admitted the resident on 07/11/13 with diagnoses of Hemiplegia, Unspecified Cerebrovascular Disease, Hypertension, and Unspecified Atrial Flutter. The record revealed Resident #5 was admitted with a Do Not Resuscitate (DNR) status. However, review of the Comprehensive Plan of Care revealed four of nine care plan pages had Full Code listed as the code status.</p>	F 514	<p>No residents were adversely affected by the deficient practice. Resident's #2, #5, and #6 code status was verified and all pages of care plans updated on 11/20/15.</p> <p>The DON and designee did a 100% audit of CNA care plans, comprehensive care plans and color code designation outside each resident's room to ensure appropriate code status matched and appeared on each page of the comprehensive care plan on 11/23/15 and 11/24/15.</p> <p>On 11/24/15 IDT was in-serviced on making sure each page of the comprehensive care plan had correct code status written on it.</p> <p>Administrator/DON or designee will perform random audits of the comprehensive care plan, CNA care plans and the color code designation outside each resident's room once a week for 4 weeks and then once a month for 6 months with results being reported to QAPI committee monthly.</p>	12/2/15	

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE			STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635	
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F 514	Continued From page 26 3. Review of the medical record for Resident #8 revealed the facility admitted the resident on 06/01/15 with diagnoses of Unspecified Atrial Fibrillation, Atrial Flutter, and Heart Disease. Further review revealed Resident #8 was admitted with Full Code status. However, review of the Comprehensive Plan of Care revealed one of eleven pages of the plan listed DNR for the resident's code status. Interview with Certified Nurse Aide (CNA) #5 on 11/19/15 at 2:15 PM revealed she referred to the CNA care plan as well as the color code designated for each resident that was located outside the door of the resident's room. Interview with Licensed Practical Nurse (LPN) #2 on 11/19/15 at 2:30 PM revealed for code status designation she referred to the front of the resident's chart, the front cover of the Medication Administration Record (MAR), and the color-coded designation located outside the resident's door to determine code status. Interview with the Director of Nursing (DON) on 11/19/15 at 3:00 PM revealed facility staff relied on the DNR document, the color-coded designation of the resident located outside the resident's door, the Nursing Care Plan, the CNA Care Plan, and the MAR to determine the code status of residents. The DON stated the Care Plan Team consists of Minimum Data Set (MDS) staff, Social Services Director, Restorative staff, Dietary Director, Activities Director, and DON. Further interview with the DON on 11/19/15 at 4:15 PM revealed that the facility did not have a policy related to updating and revision of the care plan.	F 514		

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE		STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MCCREARY COUNTY REHAB & WE		STREET ADDRESS, CITY, STATE, ZIP CODE 58 CAL HILL ROAD PINE KNOT, KY 42635		
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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1988 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 11/17/15. 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. The census on the day of the survey was fifty-nine (59), with a licensed capacity of sixty (60). Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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

TITLE

(X5) 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.