

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

PRINTED: 09/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  485125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/28/2015
NAME OF PROVIDER OR SUPPLIER  HILLCREST HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREETING ROAD CORBIN, KY 40702		
(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 225 SS=D	<p>An abbreviated survey (KY23688) was initiated on 08/26/15 and concluded on 08/28/15. The complaint was substantiated with deficient practice identified at "D" level.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 225	See Attached	

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

TITLE

(X6) DATE

*[Handwritten Signature]*

Administrator

9/21/15

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 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility policy, and review of the facility investigation, it was determined the facility failed to ensure all alleged violations involving misappropriation of resident property were reported to the Administrator and other officials in accordance with state law and facility policy for two (2) of three (3) sampled residents (Residents #1 and #2). On 08/06/15 at approximately 2:00 AM (3rd shift) Licensed Practical Nurse (LPN) #1 suspected LPN #3 (alleged perpetrator) had signed out medications (controlled pain medication) for Resident #1 and Resident #2, but did not administer the medications to the residents. However, LPN #1 failed to report the allegation to administrative staff or to other state agencies as required by facility policy until 4:45 PM on 08/06/15.</p> <p>The findings include:</p> <p>Review of the facility Abuse Policy dated December 2011 revealed all allegations that involved mistreatment, neglect, or abuse including injuries of unknown source or misappropriation of resident property would be reported immediately to the charge nurse.</p> <p>1. Review of the medical record for Resident #1 revealed the facility admitted the resident on</p>	F 225		

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F 225	<p>Continued From page 2</p> <p>08/01/15 with diagnoses that include Right Ankle Fusion, Diabetes Mellitus, Chronic Kidney Disease, Osteoarthritis, and Chronic Pain of the Right Foot/Ankle. Review of the physician's orders dated 08/01/15 revealed Resident #1 had pain medication ordered to be administered as needed. Review of an admission Minimum Data Set (MDS) assessment dated 08/13/15 revealed Resident #1 was interviewable with a Brief Interview for Mental Status (BIMS) score of 13. Review of the Medication Administration Record (MAR) revealed Norco (narcotic pain medication) 10 milligrams (mg) had been signed out by LPN #3 at 11:00 PM on 08/05/15.</p> <p>2. Review of the medical record for Resident #2 revealed the facility admitted the resident on 07/21/12 with diagnoses that include Chronic Pain Syndrome, Cerebrovascular Accident, Osteoporosis, Neuropathy, Coronary Artery Disease, and Diabetes Mellitus. Review of the physician's orders dated 07/29/15 revealed Resident #2 had pain medication ordered to be administered routinely and as needed. A review of a quarterly MDS assessment dated 06/02/15 revealed Resident #2 was interviewable with a BIMS score of 14. Review of the MAR revealed Percocet (narcotic pain medication) 5/325 mg had been signed out as administered at 2:00 AM on 08/06/15 by LPN #3.</p> <p>Interview with Resident #1 at 2:05 PM on 08/26/15 revealed he/she was given a different medication during the night a few weeks ago, that looked like the medication was generic. The resident stated the medication did not hurt him/her.</p> <p>Resident #2 stated in interview at 2:00 PM on</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>08/26/15 that he/she does not take medication during the night. The resident stated he/she would only need medication at night on rare occasions. The resident stated it had been several weeks since he/she required medication during the night.</p> <p>LPN #1 stated in interview at 3:25 PM on 08/26/15 that she went into the medication room around 2:00 AM on 08/06/15 to get medication for a resident. The LPN stated she noticed LPN #3 had already signed out 2:00 AM medications for Resident #1 and Resident #2. LPN #1 stated LPN #3 had been sitting in the dayroom since around 11:30 PM on 08/05/15 to chart in the medical records for his residents. LPN #1 stated LPN #3 had not been in the medication room since going to the dayroom. LPN #1 stated she was called to the bathroom by State Registered Nursing Assistant (SRNA) #1 at approximately 4:30 AM on 08/06/15. There they found crushed pill residue on the sink and floor. A straw wrapper was also in the floor. LPN #1 stated after she was off duty she called LPN #3 and left a message for LPN #3 to return her call. LPN #1 stated that LPN #3 returned the call in approximately 15 minutes, and LPN #1 confronted LPN #3 about the pain medications signed out for Resident #1 and Resident #2, and the crushed pill residue that she discovered in the employee bathroom. LPN #1 stated that LPN #3 admitted taking medication, but denied taking resident medication. LPN #1 said she told LPN #3 to contact the Director of Nursing (DON) to report the incident. LPN #1 stated that LPN #3 did not report the incident to the DON. Therefore, LPN #1 stated she reported the incident to the DON at 4:45 PM on 08/06/15.</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>A second interview was conducted with LPN #1 at 7:35 AM on 08/28/15. LPN #1 stated she did not report this incident when she saw the crushed pill residue in the employee bathroom because she did not know how LPN #3 would react. LPN #1 further stated she gave LPN #3 the opportunity to report the incident himself. LPN #1 stated LPN #3 did not appear to be impaired, or she would have reported the incident immediately. LPN #1 stated she saw LPN #3 was not going to report the incident; therefore, she knew she had to report. In addition, LPN #1 stated she knew LPN #3 would not be back in the facility around the residents before she could report the incident.</p> <p>Interview with SRNA #1 at 4:15 PM on 08/26/15 revealed she entered the employee bathroom around 4:30 AM on 08/06/15 and noticed a powder residue by the sink and commode. The SRNA stated she reported the powder residue on the bathroom floor to LPN #1.</p> <p>An interview was conducted by phone at 2:25 PM on 08/27/15 with LPN #3. LPN #3 stated he did go to the employee bathroom and took approximately one-fourth of the crushed pill. However, LPN #3 stated he had brought the medication from home. LPN #3 denied the medication belonged to residents.</p> <p>Interview with the DON at 5:00 PM on 08/26/15 revealed LPN #1 had reported the incident at 4:45 PM on 08/06/15. The DON said the policy was to report allegations of abuse or misappropriation of resident property immediately.</p> <p>Interview with the Administrator at 4:30 PM on 08/27/15 revealed LPN #1 did not report the incident immediately and asked LPN #3 to report</p>	F 225		

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F 225	Continued From page 5 the incident himself to the DON. The Administrator stated LPN #1 reported the incident when she saw LPN #3 was not going to report the incident.	F 225		