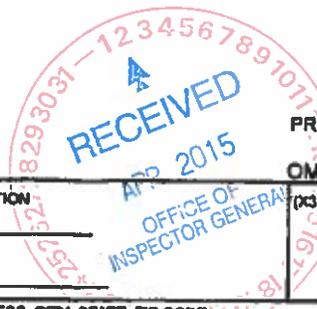


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2015
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2015
NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42276	

(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 A Recertification Survey and an Abbreviated Survey investigating Complaint KY#22827 was conducted on 02/24/15 through 02/27/15 with deficiencies cited at the highest scope and severity of a "E". KY #22827 was substantiated with deficiencies cited	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure each resident's right to voice grievances and to be assured that after receiving a complaint or grievance, the facility would actively seek a resolution and keep the resident appropriately apprised of its progress toward a resolution for five (5) of six (6) unsampled residents (Residents D, E, F, G, and H,) who attended the Group Interview and Resident Council. The facility failed to act upon repeated complaints, made during the monthly Resident Council Meetings, of staff talking and texting on their cell phones in the resident's rooms and care areas; beds linens not being changed in a timely manner; concerns with residents needing assistance back to their rooms after meals and having to wait, as much as two (2) hours, and out	F 166	F166 483.10(f)(2) Right to Prompt Efforts to Resolve Grievances It is the routine practice of this facility to make effort to resolve grievances voiced by residents or his/her representative. <u>Corrective Measures for Resident Identified in the deficiency:</u> The minutes from the Resident's Council meetings from the prior three months were reviewed to verify that all concerns had been addressed. Inservice with nursing staff was conducted on 2/25/15 regarding bed making, linen change, assisting residents after meals and activities. The care plan of resident requesting to be gotten up earlier, was revised to reflect that preference. <u>How other residents who may have been affected by this practice were identified</u> A Resident's Council Meeting was held on 2/27/15. Concerns expressed during this meeting were managed through the facility's	4/8/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sheila Keefe* TITLE *RN/DON* (X6) DATE *4/1/15*

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 166	<p>Continued From page 1</p> <p>of bed and dressed in the mornings. Additionally, the facility failed to keep the residents apprised of its progress toward a resolution to the complaints made by the Resident Council Members.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Resident Council/ Activities" and "Resident Council Guidelines", last revised 01/14/10, revealed the Resident Council was to enable the residents to exercise their rights and protect their interests by participating fully in the decisions and tasks which affect their everyday lives. The designated support person should complete the Secretary's Worksheet for Resident Council Notes, for each meeting and submit these to the Administrator, as soon as possible, so that concerns or suggestions can be acted upon timely. The Administrator or designee will respond to all suggestions following the meeting. The designated support person is to request a formal response to all identified concerns and follow up on all identified concerns to assure responses are available to the council prior to the next council meeting.</p> <p>A review of the facility policy for "Communication Devices and Cellular Telephones," last revised 01/01/13, revealed employees' personal cellular telephones may not be used during working times and in working areas of the facility, except in response to a facility or personal emergency and were to be used during non-working times, before clocking in or after clocking out, during authorized break or meal times, so long as this does not disturb residents or interfere with the work performed by the employee.</p>	F 166	<p>F166 (continued)</p> <p>grievance process and addressed by the appropriate discipline for the identified concern. Resolution to the grievance was communicated back to the individual (if known) that expressed it and was reviewed and signed by the Administrator. Resolution of the issues will be communicated to the group at the next residents council meeting.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The Activity Director, who is responsible for facilitating the Resident's Council Meetings, was provided education on 2/26/15 and was directed to provide copies of minutes to the Administrator following the meeting and to initiate the facility's grievance or missing items process for any concerns not immediately resolved. This education was provided by the Director of Nursing. He was further educated to report back to resident's council the resolution of issues reported in previous meeting. Reaffirmation of the education was conducted on 3/23/15 by the Director of Nursing.</p> <p><u>Monitoring for Ongoing Compliance:</u></p> <p>The Administrator will review the Resident's Council minutes following each meeting to assure a grievance was initiated for issues identified. The open grievance will be followed through the facilities Abbreviated Quality Assurance meeting until completed.</p>

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F 166	Continued From page 2 Interviews with six (6) residents, Residents D, E, F, G, H and I, on 02/24/15 at 3:15 PM, and reviews of the Resident Council Minutes for 12/01/14, 12/30/14, and 01/29/15 revealed on-going concerns with having to wait, as much as two (2) hours after meals, to be assisted back to their rooms after meals or out of bed in the mornings; bed linens not being changed often enough; and, staff talking and texting on their cell phones in the resident rooms and in hallways and not being available when needed. Interview with the Activity Coordinator, on 02/27/16 at 9:05 AM, revealed the staff member had reported the concerns from group, to the previous Administrator, verbally and at one time there was a sheet to have been filled out. Since that time, he has been reporting the concerns to various department heads, depending on what department was involved and these particular concerns were given to the Director of Nursing (DON,) verbally and in e-mails. He stated he had never given anyone a copy of the Resident Council Minutes, except the previous Administrator, but would have if asked. A review of e-mails to the DON revealed the concerns had been reported to her. Interview with the DON, on 02/27/15 at 1:42 PM, revealed she probably did see the e-mails from the Activity Coordinator but needed to do a better job of acting on them.	F 166	F166 (continued) Grievances will be reviewed by the facility's Quality Assurance Committee monthly to verify that efforts were made to resolve concerns. The Abbreviated Quality Assurance Committee includes the Administrator, DON, Assistant Director of Nursing, Unit Managers, Staff Development Coordinator, Social Service, Activities Director, Medical Records Director, Admissions Director, MDS Coordinator, Dietary Manager, Environmental Service Director. The Quality Assurance Committee consists of the same people plus the Consultant Pharmacist, Medical Director		
F 254 SS-E	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition.	F 254			

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F 254	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure an adequate supply of washcloths and towels were available for staff and residents use to provide care. Review of the Census with Licensed Practical Nurse (LPN) #8 revealed there were twenty-eight (28) residents, residing on 300 Hall on 02/25/15 at 8:30 AM. The findings include: Review of the facility's policy titled, "Laundry Services", last revised 04/10/13, revealed the facility should provide an adequate supply of hygienically clean and odor free linens to meet the needs of the residents. The laundry department will maintain an adequate supply of hygienically clean linens to provide resident care. Interview with Unsampled Resident #C, on 02/24/15 at 11:15 AM during initial tour, revealed he/she does not get a clean washcloth and towel daily when bathing. Further interview revealed there were mornings he/she had to wait for laundry staff to stock the linen on the unit. Interview with Resident #11, on 02/25/15 at 3:15 PM, revealed he/she had an "issue" with the facility not having washcloths available whenever he/she needed one. Resident #11 stated at times he/she had to use towels to bathe when washcloths were not accessible and she know the nursing staff had to wash linen when supplies were short during after hours when laundry staff	F 254	F254 483. 15(h)(3) LINEN It is the routine practice of this facility to provide a sufficient quantity of bed/bath linens that are in good condition. <u>Corrective Measures for Resident Identified in the deficiency:</u> Additional stock of wash clothes and towels that were in supply were placed into circulation. An additional 3000 washcloths and 200 towels were purchased on 3/3/15. <u>How other residents who may have been affected by this practice were identified</u> An inventory of washcloths and towels was conducted on all units by the environmental service director on 2/25/15. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> Par levels of linen were established to have on available for use. Laundry staff is now supplying a minimum of two washcloths and one towel per resident at the beginning of day and evening shift. The supply is replenished 2-3 times during the shift. An additional supply of linen, including at least 2 washcloths is being stocked at the end of the evening shift to be available for night shift. An additional supply of washcloths is being stored in the Main Clean Utility room across from the nurses station for easy access in the event there is an excessive use. Additional stock will be maintained for utilization as needed. When back up supply is accessed to meet stocking needs,	4/8/15

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F 254	Continued From page 4 off duty. Observation of 300 Hall linen storage closet, on 02/24/15 at 12:40 PM, revealed there were no wash clothes or towels. Further observation of the 300 Hall linen storage closet, on 02/25/15 at 8:25 AM, revealed there were seven (7) washcloths and eight (8) towels available. Review of resident census on 300 Hall 02/25/15 at 8:30 AM, twenty-eight (28). Interview with Certified Nurse Aide (CNA) #7, on 02/25/15 at 8:25 AM, revealed the (7) washcloths and (8) towels was the average number available to begin AM care prior to laundry services delivering linen to the unit. CNA #7 stated washcloths and towels are not always readily available for staff and residents to use. CNA #7 stated, "I'm surprised there are this many washcloths this morning, we usually have to search shower rooms or other units before laundry makes a delivery to the halls in the morning. The nurses do have access to the laundry room if we (nursing staff) have to wash a load of linen. Interview with CNA #6, on 02/24/15 at 3:40 PM, revealed towels and washcloths were not always available for residents and staff to provide care. CNA #6 stated the facility stopped using wet wipes in November 2014 which increased demand of washcloths and towels. CNA #6 stated, "There are times when giving a resident a shower or providing care that I have to go to the laundry and wash a load of washcloths and towels just to provide care to the patients". Interview with Housekeeper #1, on 02/25/15 at 12:45, revealed washcloths tend to get thrown in	F 254	F254 (continued) additional items will be ordered. Nursing Assistants will be educated from 3/23/15- 3/31/15 by the Staff Development Coordinator to report to Environmental Service Director and Administrator on the event linen is required to be obtained from the Clean Utility Room so distribution levels can be adjusted. After 3/31/15 SRNA's will be trained prior to their next shift worked. <u>Monitoring for Ongoing Compliance:</u> Linen inventory -vs- par levels will be reported to the quality assurance committee each month by the Environmental Service Director and Resident's Council will be queried regarding availability of linen in the Monthly Resident's Council Meeting. Rounds will be made by ADM, DON, ADON, SDC or UM as assigned weekly x 4 weeks, then monthly x6 to verify that the quantity of linen supplied is adequate. Findings of rounds will be reported to Administrator and QA Committee to determine if par levels require adjustment.		

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F 254	Continued From page 5 the trash by residents and staff. She stated there had been times when washcloths were in limited supply and not enough to stock linen shelves on units. Interview with Housekeeper #3, on 02/25/15 at 12:55 PM, revealed facility experienced a shortage of washcloths for approximately two (2) weeks in November when the facility stopped supplying wet wipes. She stated she and other laundry/housekeeping staff were getting complaints from staff and residents washcloths and towels were not being available to provide care. Interview with Plant Service Director of Laundry/ Housekeeping/Maintenance, on 02 /27/15 at 10:10 AM, revealed he became aware of the washcloth shortage in October 2014 when the facility stopped using wet wipes. He stated staff and residents disposing of soiled washcloths and underpad's in the trash caused a reduction of available linen. He revealed there had never been a time the facility was without washcloths, and the CNAs with a history of laundry experience had gone to the laundry and washed a load, if linen was unavailable. Interview with the Director of Nursing (DON), on 02/25/15 at 5:00 PM, revealed the facility stopped using wet wipes three (3) months ago because wet wipes were being flushed creating problems with the city sewer system. The DON stated she would not expect wet wipes to affect quantity of washcloths available for residents and staff use while providing care. The DON revealed staff had access to laundry during off hours of the laundry personnel.	F 254			

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F 281 F 281 SS-D	Continued From page 6 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policies, and review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 and #27, it was determined the facility failed to provide services to meet professional standards of quality for three (3) of nineteen (19) sampled residents (Resident #4, Resident #8, and Resident #8). The facility failed to complete a Full Risk Assessment on Resident #4 and Resident #9 to determine the size of the sling needed to transfer the resident with the transfer lift. In addition, there was no physician's order for the use of a soft lap top wheelchair tray on Resident #8's wheelchair that had been in use, on a trial basis since November 2014. Further review revealed Resident #8 had a physician's order for a velcro alarming seat belt and pressure sensitive alarms for the bed and wheel chair, however, observations during the four day survey (02/24/15-02/27/15,) revealed the items were not in use and review of the February 2015 Treatment Administration Record (TAR) revealed licensed staff had initialed the items were in place. The findings include: Review of the Kentucky Board of Nursing Patient Care Orders AOS #14, last revised 10/2010, revealed the licensed nurses were responsible for	F 281 F 281	F 281 483. 20(k)(3)(i) SERVICES MEET PROFESSIONAL STANDARDS It is the practice of this facility to provide or arrange for services <u>Corrective Measures for Resident Identified in the deficiency:</u> New Transfer-Lift Analysis' for Residents # 4 and #9 were completed that reflect the correct size indicated based on the manufacturer's recommendation. The Nurse Aide Data Sheet for Residents #4 and #9 were updated to reflect the evaluated sizes by unit nurses on 2/25/15. An order was obtained by the Unit Manager on 2/25/15 for Resident # 6 for use of the soft lap tray. The order for the alarming seat belt was discontinued on 2/25/15. The treatment Administration record, Care Plan and Nurse Aide Data Sheet were updated on 2/25/15 by the Unit Manager to reflect the current orders. <u>How other residents who may have been affected by this practice were identified</u> The Transfer Lift Analysis for all residents were audited by Director of Nursing, Assistant Director of Nursing and Unit Manager on 2/25/15 to verify that the analysis was complete and that sizing was accurate. Nurse Aide Data Sheets were audited to verify that the method of transfer and sling size when indicated was correctly transcribed onto the Nurse Aide Data Sheet on 2/25/15 by the MDS Nurses. The Physician's Orders, Treatment Administration Records (TAR) and Nurse	4/8/15

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F 281	<p>Continued From page 7</p> <p>the administration of medication or treatment as authorized by the physician. Review of Licensed Practical Nursing Practice AOS #27, last revised 06/2014, revealed licensed staff should document on the appropriate record to accurately describe all aspects of nursing care provided.</p> <p>Review of the facility's policy titled, "Lifts and Transferring Devices," revised 12/19/13, revealed documentation to include it was the policy of the facility to seek methods by which lifting and transferring of residents was conducted in the safest means possible for the safety of residents and the care of providers and residents would be evaluated for the need of a lift on admission and whenever there was a change in the resident's ability to bear weight or transfer. Further review revealed employees would be trained on the proper use of lifts and caregivers would have access to resident specific information on the type of lift, sling or transfer device and were to follow manufacturer instructions.</p> <p>Review of the Manufacturer Instructions, titled Hoyer Sling Guide, undated, revealed documentation to include a suggested size and weight range chart and recommended a full risk assessment be conducted before any sling was selected.</p> <p>1. Record review revealed the facility admitted Resident #4 on 01/31/12, with diagnoses which included Coronary Artery Disease, Congestive Heart Failure, Arthritis, Depression, Dementia and Alzheimer's type with Behaviors. Review of the quarterly Minimum Data Set (MDS) assessment, dated 01/18/15, revealed the facility assessed the resident's cognition as severely impaired with a Brief Interview of Mental Status</p>	F 281	<p>F281 (continued)</p> <p>Aide Data Sheets were audited by the Unit Manager (UM), Assistant Director of Nursing (ADON) and Director of Nursing (DON) between 3/23/15 and 3/25/15 to validate that the devices in use reflect the current orders and documentation.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Education was provided to Licensed Nurses on 3/19/15 through 3/27/15 by the Staff Development Coordinator (SDC) to educate regarding the proper completion of the Lift Transfer Analysis and proper method of sizing slings. Training also included transcription of analysis findings onto the Nurse Aide Data Sheet (NADS). After initiation of Transfer / Lift Analysis audit, only nurses who have completed training will be authorized to complete analysis.</p> <p>Training was provided at the same time regarding Professional Standards of Practice requirement to accurately record care provided. This training was extended to Licensed Nurses and Medication Aides responsible for documenting provision of such things as treatments and safety measures.</p> <p>State Registered Nursing Assistants were provided education by the SDC, DON, ADON or UM beginning on 3/23/15, continuing through 3/31/15, regarding process of sizing of slings by the nurse, method of communicating sling sizing and</p>	

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F 281	Continued From page 8 (BIMS) score of 99, and the resident required a mechanical lift with assist of two (2) staff for transfers. Review of Resident #4's Resident Lift/Transfer Analysis, dated 12/11/13, revealed documentation to include the resident lacked head control, exhibited involuntary movements and was unable to maintain an upright seated posture on the toilet or bedside commode and needed a basic sling. Further review revealed there was no evidence the facility evaluated the resident for the appropriate sling size. Review of Resident #4's Weight Record and review of the Hoyer Sling Manufacturer's Instructions revealed a Medium (yellow) sling was appropriate for Resident #4 whose weight was between zero (0) and two hundred (200) pounds. Observation of Resident #4, on 02/25/15 at 8:20 AM, revealed the resident was sitting in the main dining room on a yellow lift sling in a broda chair. 2. Record Review revealed the facility admitted Resident #9 on 05/21/14, with diagnoses which included Seizures and Post Operative Brain Surgery. Review of the quarterly MDS assessment, dated 02/03/15, revealed the facility assessed the resident in a comatose state, and the resident required a mechanical lift with assist of two (2) staff for transfers. Review of Resident #9's Resident Lift/Transfer Analysis, dated 05/21/14, revealed documentation to include that the resident was an "Active Lifter, evaluate for sling size. Proceed to Question A", Question A was not completed and Question B was answered by circling "Yes, Full	F 281	F281 (continued) method of identifying sling size for use. After 3/31/15 any SRNA not yet trained will be trained prior to next shift worked. Sizing charts denoting the weight capacity of each size sling and the color of binding used to quickly identify the sling size, was posted in the Lift Storage Room for quick reference when choosing the specified sling on 3/23/15 by the Quality Management Nurse. <u>Monitoring for Ongoing Compliance:</u> The MDS Nurses will check for proper completion of the Lift Transfer Analysis, when gathering info for the quarterly MDS. They will confirm that the master NADS contains the sling size specified on the completed analysis. In the event a sling size is not present, they will immediately report to DON for completion. Findings will be reported weckly in the Abbreviated Quality Assurance meeting and conveyed to full QAA committee for monthly review monthly x 3 months, then quarterly x3.	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/27/2015
NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42276		
(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 281	<p>Continued From page 9</p> <p>back Sling" plus two (2) person assist. There was no documented evidence the sling size was determined.</p> <p>Review of Resident #9's Weight Record and review of the Manufacturer's Instructions revealed a Medium (yellow) sling was appropriate for Resident #4 whose weight was between zero (0) and two hundred (200) pounds.</p> <p>Observation of Resident #9, on 02/24/15 at 3:45 PM, revealed the resident lying in bed in a right lateral position with the head of bed elevated, no lift sling visible in the room or beneath the resident.</p> <p>Interview with CNA #2, on 02/25/15 at 12:45 PM, revealed the yellow "medium" sling was used for Residents #4 and #9. CNA #2 said she used the medium (yellow) sling most of the time. She stated "I would not use the small (red), I just try to think about it, I have not been trained on how to select a sling size, therapy usually tells us." CNA #2 stated sling size was not discussed during shift change.</p> <p>Review of Resident #9 Resident Lift/Transfer Analysis, dated 08/24/12, revealed there was no evidence the facility evaluated the resident for the appropriate sling size.</p> <p>Interview with Medical Records Personnel, on 02/25/15 at 12:40 PM, revealed she previously worked as a CNA at the facility and was taught to measure residents from the neck to the lower back to determine the appropriate sling size. She stated sling size should be assessed prior to using of a lift and she was unsure if staff measured for sling size prior to use at this time.</p>	F 281			

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F 281	Continued From page 10 Interview with the Licensed Practical Nurse (LPN) #3, on 02/25/15 at 12:20 PM, revealed the sling sizes were color coded and the red trimmed sling was a small, yellow was a medium, green was a large and blue was an extra large. She said the facility had not assessed the twenty-two (22) residents who required the use of a mechanical lift for the appropriate sling size. Interview with the DON, on 02/25/15 at 3:15 PM, revealed sling size should be assessed and documented on the Nurse Aide Data Sheet in the "device type" section and the proper size should be circled on the Resident Lift/Transfer Analysis form. She stated she expected the nurse to complete both forms on admission and when a resident's transfer ability changed. The DON revealed she expected all nurses to be trained on all forms and they should know how to mark the Resident Lift/Transfer Analysis form based on the resident's weight. She stated sling size was not determined by Physical Therapy, "they may recommend a lift but not the sling size." The DON stated she was not aware of any falls or significant injury related to the use of a lift. 3. Record review revealed the facility admitted Resident #6 on 04/14/08, with diagnoses which included Chronic Heart Failure, Alzheimer's Dementia, Renal Insufficiency, Arthritis and Diabetes Mellitus. Review of the quarterly MDS assessment, dated 12/15/14, revealed the facility assessed the resident's cognition as severely impaired with a BIMS score of "3" which indicated the resident was not interviewable. In addition, the resident was assessed as needing the extensive assistance of two (2) staff with Activities of Daily Living (ADL) and was listed as having a	F 281			

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F 281	<p>Continued From page 11 chair restraint that prevented rising.</p> <p>Review of the February 2015 Physician Orders revealed the resident required a pressure alarm to the bed and wheel chair and a velcro, alarming seatbelt to the wheelchair with a start date of 12/05/14. However, observation of Resident #8, on 02/25/15 at 1215 PM, revealed the resident was being assisted by staff for meals, in the dining room and was seated in the wheel chair, with an attached soft lap tray. There was no velcro alarming seat belt and pressure alarm in use.</p> <p>Further review of the February 2015 Physician's Orders revealed there was no order for the soft lap tray.</p> <p>Review of the February 2015 Treatment Administration Record (TAR) revealed the resident required a pressure alarm to the bed and wheel chair and the licensed staff were to have checked placement every shift and a velcro, alarming seatbelt to the wheel chair with a placement check. The TAR was initialed every twelve hours indicating the pressure alarms and velcro alarming seatbelt were in place. However, further observations of Resident #8 on 02/24/15-02/27/15 revealed the pressure alarm and alarming seatbelt were not in place.</p> <p>Interview with CNA #1, on 2/25/15 at 1:10 PM, revealed the CNA was unsure how long the alarms had not been in place and stated the resident had not been using the alarming seat belt.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 02/25/15 at 1:35 PM, revealed she updated</p>	F 281		

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F 281	<p>Continued From page 12</p> <p>the CNA Care Plan, adding a soft lap tray, per therapy communication, but did not ensure there was a physician's order for the soft lap tray.</p> <p>Interview with Registered Nurse (RN) #1, on 02/25/15 at 1:20 PM, revealed the nurse was unsure if an alarming seat belt had been used with this resident and stated the lap tray had been in place for "a good bit of time" and stated she did not know there was no physician order for the lap tray.</p> <p>Interview with the Director of Nursing (DON), on 2/26/15 at 11:05 AM, revealed the issue with the lap tray was with the process of following up on a trial that therapy recommended. She stated the staff failed to follow the TAR and the physician orders and the Velcro seat belt should not have been initiated on the TAR, if it was not being utilized.</p>	F 281	<p>F309 483.25 Provide Care/Services for Highest Well Being</p> <p>It is the routine practice of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u> An Admission/New Onset/ Weekly Wound Analysis was completed for residents #7 on 2/27/15 and #9 on 2/24/15 documenting the current status of each resident's wound. New analysis have been completed weekly since 3/4/15 to record the progress of the areas.</p> <p>Weekly skin observations were also completed and recorded for each of these residents to review for any additional skin concerns by Unit Nurses beginning on 3/1/15.</p> <p><u>How other residents who may have been affected by this practice were identified</u> Skin Observations were completed on all residents by Unit Nurses between 2/24/15 and 3/2/15. Records were audited to assure that each resident had the results of the Skin Observation recorded on his/her record. The clinical records of all residents having wounds were reviewed by the ADON on 2/27/15, to determine if an Admission / New Onset/ Weekly Wound Analysis had been</p>	4/8/15
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to provide the necessary care and</p>	F 309		

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F 309	Continued From page 13 services related to wound assessments for two (2) of nineteen (19) sampled residents (Resident #7 and #9). The facility failed to complete and document weekly skin observations for Resident #7 and assess and document the condition of the skin prior to resident #9's transfer to another facility and upon return from another facility. The findings include: Interview on 02/27/15 at 10:15 AM, with the Director of Nursing (DON), revealed the facility did not have a policy, specific to clinical assessments prior to transfer or upon return from another facility. She said when a resident returns from an emergency room visit the nurse should assess and complete a two (2) page document titled, Clinical Admission Checklist for New or Readmitted Residents, dated 11/19/14. The DON said new admissions or readmissions following hospital stays should be assessed using the two (2) page document titled, Comprehensive Resident Analysis, dated 10/29/13. Review of the facility policy for Pressure Ulcer/Wound Care, clinical practice guidelines, dated 12/19/13, revealed a review should be completed upon identification of a wound or pressure sore, and weekly until resolved. Documentation of the wound should be made on the "Admission/New Onset/Weekly Wound Analysis" form. Review of the facility's "Admission/New Onset/Weekly Wound Analysis Guidelines" form, dated 12/19/13, revealed the form included information used in completion of the weekly documentation of wounds "Weekly Wound Analysis (Form 250.3890.8), which included the	F 309	F309 (continued) completed for any wound that was present. All were found to be present. <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> Education was provided to licensed nurses, by the SDC on 2/27/15, instructing that unless a medical emergency exists, the condition of a resident's skin should be evaluated prior to transfer to another facility for treatment. The findings of that evaluation should be recorded either in the nurses notes or on a Weekly Skin Observation record. Upon return from the outside facility, the resident's skin should once again be checked for abnormalities or trauma that may have developed during the time he/she was away from the facility. The findings of that evaluation should also be recorded in the clinical record, either in the nurses notes or on the Weekly Skin Observation record. Reaffirmation of this training will be completed between 3/23/15 and 3/27/15. Education to all nurses was provided regarding completion of Weekly Skin Observations, for all residents to monitor for the emergence of skin concerns. The TAR was re-organized to facilitate easy recognition of scheduled Weekly Observations. This education will be provided by SDC, ADON, DON & UM between 3/23/15 and 3/31/15. A reference list for tasks to be completed following a short term transfer /return was	

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F 309	<p>Continued From page 14</p> <p>location: describe the wound site, date wound first identified or admitted with, wound type: enter appropriate codes, diagnosis pertinent and contributing factors, and initial stage of the wound as it appeared when identified.</p> <p>1. Record Review revealed the facility admitted Resident #9 on 05/21/14, with diagnoses which included Seizures, Hypothyroidism, Hypertension, Post-Operative Brain Surgery and Comatose State. A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/03/15, revealed the resident was in a comatose state, and required a mechanical lift with assist of two (2) staff for transfers and was at risk for the development of pressure sores.</p> <p>Interview with Registered Nurse (RN) #2 during the initial tour, on 02/24/15 at 11:45 AM, revealed he noted Resident #9 had "shearing" on the left and right buttocks during his morning skin assessment. RN #2 stated he photographed the wound on Resident # 9's buttocks. RN #2 revealed he did not receive a verbal report from the night shift nurse because she left prior to his arrival at 6:00 AM; however, he stated he read the shift report from the twenty-four (24) hour report form and did not see a wound report or a nursing note about the areas on Resident #9's buttocks. In addition, RN #2 stated Resident #9 had been transferred by ambulance to the local emergency room last night because of an elevated temperature.</p> <p>Review of the photograph of Resident #9's buttock wound, dated 02/24/15, revealed a handwritten note on a measurement tool that read the wound was seven (7) by three (3) centimeters (cm).</p>	F 309	<p>F309 (continued)</p> <p>developed to be used for ER visits or outside treatments in which no actual discharge or readmission occurs triggering the admission/readmission processes and evaluations. The checklist includes a head to toe skin evaluation with findings documented, review & implementation of orders issued during visit, revision of care plan to reflect any new condition, treatment plan or change in abilities and communication of new conditions through written and verbal report. Licensed Nurses were provided training on pre- and post transfer evaluations of resident's skin condition beginning on 3/23/15 through 3/31/15 by the SDC, ADON, DON & UM. Implementation of the checklist will be on 4/1/15.</p> <p><u>Monitoring for Ongoing Compliance:</u></p> <p>The completion of Admission / New Onset /Weekly Wound Analysis for residents having wounds will be monitored weekly by the ADON to verify that all residents having a wound has an evaluation of the wounds status. She will review new physician orders to identify any new wounds that require evaluation and/or monitoring. In her absence the reviews will be completed by the DON or another Administrative nurse as assigned.</p> <p>Unit Managers will audit for the completion of Weekly Skin Observations 3x weekly to verify that planned observations have been completed. Any identified as not having been done will be completed on the day of audit.</p>		

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F 309	Continued From page 15 Review of the nurse's notes, dated 02/24/15 at 9:30 AM, revealed documentation to include "resident has two unstageable pressure areas on left and right buttocks. New order for calazime (every shift for fourteen (14) days and re-evaluate." Observation of a skin assessment, on 02/25/15 at 8:35 AM, by Licensed Practical Nurse (LPN) #4 and assisted by RN #4 revealed LPN #4 cleansed the areas on Resident #9's buttocks with wound cleanser, patted the areas dry and applied an antifungal cream to the wounds then sprayed buttocks with Lotrimin spray. LPN #4 stated the wound measured 7 by 3 centimeters and was a "shearing type" wound. Review of a weekly skin observation form with documentation to include a skin observation on 02/01/15, 02/15/15, and 02/22/15, revealed a weekly skin assessment was not completed on 02/08/15. Further review of the weekly skin observation form completed on 02/22/15 revealed "no open areas, redness on buttocks and under breast and treatment in progress." Interview on 02/25/15 at 9:15 AM, with LPN #4, revealed Resident #9 did not have the wounds on her buttocks when LPN #4 worked day shift (6:00 AM-6:30 PM) on 02/23/15. Review of Resident #9's clinical record revealed there was no documentation evidence in the Consolidated Nurses Notes that a skin assessment was conducted prior to the resident going to the hospital on 02/24/15 at 1:30 AM. Review of the hospital Emergency Room (ER)	F 309	F309 (continued) The Clinical Record of residents who are transferred to the hospital ER for treatment/eval will be audited by the Unit Manager, SDC, ADON or DON to verify that skin observations were recorded prior to transfer, unless contraindicated by pre-transfer condition, and upon return to facility. Findings of the audits will be reported in the next Abbreviated Quality Assurance Committee meeting, which meets M-F except holidays.		

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F 309	<p>Continued From page 18</p> <p>documentation, dated 02/23/15 at 10:47 PM, revealed on the "Assessment" section for "DERM: rash noted buttocks with some bloody drainage."</p> <p>Further review of Resident #9's record revealed there was no Clinical Admission Checklist for New or Readmitted Residents following the 02/24/15 emergency room visit and no new onset/weekly wound analysis form.</p> <p>Interview on 02/26/15 at 12:05 PM, with LPN #5, revealed she worked the night shift (8:30 PM-8:30 AM) on 02/23/15. LPN #5 stated she was the Charge Nurse for Resident #9 on 02/23/15 when the resident was sent to the local emergency room for an elevated temperature. The LPN said she assessed Resident #9 when he/she returned to the facility by ambulance at approximately 1:30 AM. LPN #5 revealed she saw a red, open area that was "a line about three (3) centimeters by one and a half (1.5) centimeters", and she should have documented the skin assessment in the chart and on the twenty-four hour shift report. LPN #5 said she did not report the skin assessment to anyone and only she and Resident #9's parent was in the room when she completed the assessment. LPN #5 said she was given permission by the Staff Development Coordinator to leave early and she left at approximately 6:00 AM on 02/24/15. LPN #5 said she left a written report on the twenty-four hour report form for the day shift nurses but did not leave any information about Resident #9's buttock wound.</p> <p>Interview on 02/26/15 at 8:10 PM, with Certified Nurse Aide (CNA) #4, revealed she worked night shift on 02/23/15, the evening Resident #9 was</p>	F 309		

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F 309	Continued From page 17 transferred to the emergency room. CNA #4 stated she and the Charge Nurse along with the resident's mother and two (2) ambulance personnel transferred the resident from the stretcher to the bed. CNA #4 said she cared for Resident #9 for two (2) or three (3) days prior and at that time the residents bottom was red with little blisters. The CNA said the resident returned to the facility on 02/24/15 at approximately 12:30 AM. The CNA said there was a "bloody abrasion type area" on Resident #9's bottom that was "an inch in length" and she saw blood on the washcloth when the resident's mother cleaned the resident's buttocks. CNA #4 revealed on 02/24/15 at approximately 6:00 AM, CNA #8 and CNA #9 repositioned Resident #9 prior to his/her physical therapy session. CNA #4 stated in addition, 02/24/15 at approximately 7:00 AM, a day shift male nurse came into Resident #9's room, measured, and made pictures of Resident #9's bottom. Interview on 02/27/15 at 11:00 AM, with Resident #9's mother, revealed the resident "has always had the redness" and the redness had improved when she saw the resident on 02/22/15. The resident's mother said she first saw the buttock wound on 02/24/15 at approximately 12:30 AM, in the emergency room and made pictures. On 02/24/15 at approximately 9:00 AM, she went to the nursing facility, spoke with the Staffing Coordinator and showed the pictures of Resident #9's buttocks. She said the Staffing Coordinator made notes during their conversation. She said, "It was a flabbergasting experience and the Staffing Coordinator got on it immediately and called later in the day and said staff had been reprimanded and new procedures were put in place."	F 309			

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F 309	<p>Continued From page 18</p> <p>Interview on 02/27/15 at 9:50 AM, with LPN #2 revealed Resident #9's skin assessment was not completed prior to or upon return from the emergency room and the night shift nurse had been "written up".</p> <p>Interview on 02/27/15 at 1:25 PM, with the ADON, revealed she was the wound care nurse. She said she was aware skin assessments for Resident #9 were missed but she was unaware of missed skin assessments for any other residents. She said RN #2 told her about Resident #9's buttocks on 02/24/15 at approximately 8:30 or 9:30 AM. In addition, the ADON said she was present when the Staffing Coordinator informed LPN #5 it was the nurse's responsibility to make sure a resident was groomed and a skin assessment completed prior to transfer from the facility and upon return to the facility. In addition, the ADON said the Staffing Coordinator told LPN #5 the nurse was responsible for care provided by a CNA. The ADON said the nurse should complete and document a skin assessment prior to transfer to another facility and upon return from another facility.</p> <p>Interview on 02/27/15 at 10:15 AM, with the Director of Nursing (DON), revealed the night shift nurse, LPN #5, would be "written up" when she returned to work. The DON said the Charge Nurse should look at the skin assessment assignment sheet at the beginning of each shift and ensure skin assessments were completed as assigned. In addition, the DON said the Assistant Director of Nursing (ADON) was responsible for reviewing skin observations and placing them in the charts. The DON said she noticed on Monday (02/23/15) several weekly skin</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42276		
(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 309	<p>Continued From page 19</p> <p>observations were missed and the Staffing Coordinator began in-servicing staff on 02/24/15.</p> <p>2. Record review revealed the facility readmitted Resident #7 on 01/20/15 with diagnoses which included Atrial Fibrillation, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and stage three (3) Kidney Disease. Review of Significant Change MDS assessment, dated 02/11/15, revealed the facility assessed Resident #7's cognition as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fourteen (14).</p> <p>Interview with Resident #7, on 02/24/15 at 11:35 AM during initial tour, revealed "I have a sore on my butt that they putting cream on". Further interview revealed he/she have been receiving treatment to wound for over a month.</p> <p>Observation of Resident #7's skin assessment, on 02/25/15 at 10:25 AM, revealed an open area to the right buttock with measurements of four (4) centimeters (cm) by three (3) cm obtained per LPN #6. Further observation revealed LPN #6 cleansed the right buttock with wound cleanser and applied calazime ointment and left the wound open to air.</p> <p>Review of Resident #7 Nurses Note, dated 01/25/15, revealed the resident acquired wound to right buttock while being repositioned in bed. Further review of the medical record revealed there are no weekly skin assessments or documentation to reveal ongoing assessment of area.</p> <p>Interview with LPN #6, on 02/25/15 at 10:40 AM, revealed the wound to Resident #7's right buttock</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 167 BOYLES DRIVE RUSSELLVILLE, KY 42276	
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F 309	Continued From page 20 was identified as "shearing". Further interview revealed weekly skin assessments have not been conducted to assess and reevaluate changes in the wound. Interview with the DON, on 02/27/15 at 2:30 PM, revealed she was not aware Resident #7's wound to the right buttock had progressed to a pressure related area. Further interview revealed she would expect any changes in a wound to be assessed weekly or as needed, documentation on wound, and notify physician of any changes that may require a change in treatment.	F 309	F332 483.25(m)(1) Free of Medication Error Rates of 5% or More It is the routine practice of this facility to administer medications as ordered. <u>Corrective Measures for Resident Identified in the deficiency:</u> The medications that were initially omitted, were administered later in the morning upon recognition of the omission. <u>How other residents who may have been affected by this practice were identified</u> Audit of MARs for omitted medication was completed on 3/23/15 by Unit Manager, SDC, ADON or DON.	4/8/15
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 a review of the facility policy on General Dose Preparation and Medication Administration, it was determined the facility failed to ensure the medication administration error rate was less than five (5) percent (%). Observation of medication passes revealed thirty-three (33) medication administration opportunities with two (2) medication errors, for a medication administration error rate of six percent (6%). Certified Medication Aide (CMA) #1 failed to administer two medications that were ordered to have been given with the 8:00 AM medication pass.	F 332	<u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> Education was provided to licensed nurses and medication aides regarding administration of medication on 3/14/15 by the SDC, utilizing the Six Rights of Medication Administration. Education for nurses for the requirement to add new orders for routine medications to the end of a routine medication page or start a new page and not add routine medications to the PRN page was conducted by the SDC on 3/3/15. Additional Med Pass observation was conducted with CMA#10 by Unit Manager to verify accuracy in medication administration. The Medication Administration Records were reviewed during the month end process to assure that routine medications were separate from PRN medications.	

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NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42276		
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F 332	<p>Continued From page 21</p> <p>The findings include:</p> <p>Review of the facility policy, "General Dose Preparation and Medication Administration," dated 12/01/07, revealed the medications were to have been prepared using the five (5) rights of medication administration: the right resident, right medication and strength, the right time of administration, the right frequency and route of administration.</p> <p>1. Observation of a medication administration pass, on 02/25/15 at 8:00 AM, revealed CMA #1 failed to administer two medications, Zantac, a medication for the treatment of Gastric Reflux and Methotrexate, a medication for the treatment of Rheumatoid Arthritis.</p> <p>Review of the Physician Orders for February 2015, revealed the Zantac was ordered on 02/14/15 to be given daily and the Methotrexate was ordered to have been administered one (1) time a week on Wednesday.</p> <p>Review of the MAR, dated 02/25/15, revealed that both medications were scheduled to have been given that morning.</p> <p>Interview with Certified Medication Assistant (CMA) #1, on 02/25/15 at 8:30 AM, revealed she "just missed" the order, as the medication were printed with the PRN, or as needed medications and the CMT did not see them.</p> <p>Interview with the Director of Nurses (DON), on 02/26/15 at 10:10 AM, revealed the medications should have been administered with the 8:00 AM medication pass.</p>	F 332	<p>F332 (continued)</p> <p>Med Pass Observations of CMTs and licensed nurses have been scheduled and will be completed by 4/8/15 by DON, ADON, SDC, UM or Pharmacy representative.</p> <p>Monitoring for Ongoing Compliance: Med Pass Observations will be completed monthly, by administrative nurses or a pharmacy representative, for three different staff members for three months then, two staff members monthly for the next six months. Results of observations will be reviewed by the QAA Committee and future frequency for further monitoring will be established based on findings.</p>		

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<p>F 431 Continued From page 22</p> <p>F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>SS=D</p>	<p>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.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary 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>F 431</p> <p>F 431</p>	<p>F 431 483. 60(b),(d), (e) Drug Records, Label /Store Drugs & Biologicals</p> <p>It is the routine practice of this facility to store, administer and dispose of Controlled Substances utilizing a system which enables accurate reconciliation and accounting of the drugs.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u> The Ativan for the discharged resident was given to the Director of Nursing, reconciled with the count sheet, properly stored in a double locked secured compartment in a locked room, until destruction occurred.</p> <p><u>How other residents who may have been affected by this practice were identified:</u> Remaining controlled substances were audited by the DON, ADON, SDC and Unit Manager on 2/26/15 to verify that all were for current residents, count on reconciliation sheet corresponded with medication and were properly stored.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> Education was conducted with Licensed Nurses on 2/26/15 by the SDC, to instruct them to give narcotics of residents who discharge or expire, to the Unit Manager as soon as possible following discharge. Meds will then be logged with the Director of Nursing and stored in the double</p>	<p>4/8/15</p>
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F 431	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy on Controlled Substance Disposal, it was determined the facility failed to ensure medications and biologicals were appropriately counted and destroyed, after one unsampled resident (Resident B) had expired. The findings include: Review of the facility's policy titled, "Controlled Substance Disposal Policy", undated, revealed after a controlled substance listed as Schedule II, III, IV and V, is discontinued, or the resident is discharged, the medication will be taken directly to the Director of Nursing (DON) or his/her alternate, as specified within the facility. The medication will be stored in a designated non-portable location that is behind two (2) locked doors/drawers. Observation, on 02/26/15 at 9:05 AM, of the Main Medication Room revealed one (1) opened vial of Alivan, a medication used in the treatment of anxiety and seizures, in the locked box of the medication refrigerator, with approximately 28 milliliters (ml) of medication left. Further observation revealed the medication was for Unsampled Resident B and was not accounted for in the Narcotic Count Sheets used on the 300 Wing. Review of Resident B's Narcotic Count Sheet, obtained from Medical Records, on 02/26/15 at 10:00 AM, revealed the last time the narcotic had been counted was 10/26/14.	F 431	F431 (continued) locked area until destruction. Follow-up education was initiated on 3/20/15, by the Staff Development Coordinator to clarify that the medication is to be conveyed directly to the DON to be secured in the double locked location. <u>Monitoring for Ongoing Compliance:</u> The DON will check locked narcotic storage weekly to verify that controlled substances have been discontinued or for residents that have been discharged, were removed. In the event a medication is found to be remaining on the unit, during the weekly DON audit, the med will be removed by the DON at that time. Results of weekly Audits will be reported monthly to the Quality Assurance and Assessment committee for review and further recommendation.		

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F 431	Continued From page 24 Interview with Licensed Practical Nurse (LPN) #1, on 02/26/15 at 9:10 AM, revealed Unsampld Resident B had expired several months earlier and the LPN was not aware there was a narcotic in the refrigerator locked box. Interview with the LPN #2, Unit Manager, on 02/26/15 at 9:55 AM, revealed nursing staff was responsible to monitor the medication room for expired medications and this was never brought to the Unit Manager's attention, as she rarely passes medications. The resident expired on 10/30/14 and the Narcotic Count Sheet was sent to medical records. Interview with the DON, on 02/26/15 at 10:10 AM, revealed the narcotic should have continued to have been counted, until turned in to the DON and disposed.	F 431			

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NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42276
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based on implementation of the acceptable POC, the facility was deemed to be in compliance 04/08/15, as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 2012.</p> <p>SURVEY UNDER: 2000 New.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (000).</p> <p>SMOKE COMPARTMENTS: eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2013, with 99 smoke detectors and 16 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 2013.</p> <p>GENERATOR: Type II generator installed in 2013. Fuel source is Diesel.</p> <p>A recertification Life Safety Code survey was initiated on 02/25/15 and concluded on 02/26/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred one (101) beds, with a census of ninety-three (93) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
A. Compey AM 3/23/15
(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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K 027	Continued From page 2 with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of eight (8) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and at the time of the survey, the census was ninety-three (93). The findings include: 1. Observation, on 02/26/15 at 9:00 AM, with the Regional Maintenance Director and the Maintenance Director revealed the cross-corridor doors located in the 200 Hall would not close completely when tested. This was due to the self-closing device not being adjusted properly. Interview, on 01/14/15 at 9:01 AM, with the Regional Maintenance Director and the Maintenance Director revealed they were not aware the self-closing devices were out of adjustment. 2. Observation, on 02/26/15 at 9:15 AM, with the Regional Maintenance Director and the Maintenance Director revealed the cross-corridor doors located in the 300 Hall would not close completely when tested. This was due to the self-closing device not being adjusted properly. Interview, on 01/14/15 at 9:16 AM, with the Regional Maintenance Director and the Maintenance Director revealed they were not aware the self-closing devices were out of adjustment. 3. Observation, on 02/26/15 at 9:35 AM, with the Regional Maintenance Director and the Maintenance Director revealed the cross-corridor	K 027	K 027 (continued) <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> On 2/28/15 the facility maintenance Director was in-serviced by the Regional Maintenance Director regarding the NFPA standards as they relate to adjusting self closing devices on all facility doors and ensuring doors are able to fully close. Additionally, on 2/28/15, the Regional maintenance Director in-serviced the facility maintenance Director regarding implementing processes that allows for periodic checks to ensure door closing devices remain in compliance with NFPA standards. <u>Monitoring Measures to Maintain On-going Compliance:</u> The facility Maintenance Director will complete facility audits weekly x 3 weeks, then monthly x 12 months, surveying the entire facility/all cross corridor doors/doors that require and have a self-adjusting device to ensure all doors will properly close in accordance with NFPA standards. Results of the audits will be brought monthly to the Quality assurance committee for review and further recommendations.	

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K 027	<p>Continued From page 3</p> <p>doors located in the 400 Hall would not close completely when tested. This was due to the self-closing device not being adjusted properly.</p> <p>Interview, on 01/14/15 at 9:36 AM, with the Regional Maintenance Director and the Maintenance Director revealed they were not aware the self-closing devices were out of adjustment.</p> <p>4. Observation, on 02/26/15 at 10:00 AM, with the Regional Maintenance Director and the Maintenance Director revealed the cross-corridor doors located in the 500 Hall would not close completely when tested. This was due to the self-closing device not being adjusted properly.</p> <p>Interview, on 01/14/15 at 10:01 AM, with the Regional Maintenance Director and the Maintenance Director revealed they were not aware the self-closing devices were out of adjustment.</p> <p>The census of ninety-one (91) was verified by the Administrator on 02/26/15. The findings were acknowledged by the Administrator and verified by the Regional Maintenance Director and the Maintenance Director at the exit interview on 02/26/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 18.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with</p>	K 027	
			(X5) COMPLETION DATE

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NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42276	
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K 027	<p>Continued From page 4</p> <p>Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor.</p> <p>Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.</p> <p>Reference NFPA 101 (2000 Edition) 18.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 18.2.2.2.6.</p> <p>Reference NFPA 101 (2000 Edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=D</p> <p>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8)</p>	K 027	<p>NFPA 101 LIFE SAFETY CODE STANDARD K029</p> <p>It is the practice of Creekwood Place to meet the Life Safety Codes as stated in the NFPA 101 Life Safety Code Standard.</p> <p><u>Corrective Actions for those identified in the deficiency:</u></p> <p>The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and the census was ninety-three (93) on the day of the survey. On 2/28/15 the facility immediately began the process to order doors that would be in compliance with the NFPA standard. On 4/6/15, the (20) minute fire rated door in the basement copy room will be replaced by a contracted vendor, supervised by the facility Maintenance Director, with the required (45) minute fire rated door. On 4/6/15 the (20) minute fire rated door in the medical records basement office will be replaced by a contracted vendor, supervised by the facility maintenance Director, with the (45) minute required door, in accordance with NFPA standards.</p> <p><u>Other Identified who may have been impacted by the deficient practice:</u></p> <p>The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and the census was ninety-three (93) on the day of the survey. On 2/28/15, the facility maintenance director conducted a 100% audit on all facility doors to ensure the firing rating was in conjunction with NFPA standards. Prior to the audit on 2/28/15, the facility maintenance Director was re-educated by the regional maintenance Director regarding the NFPA standards and the specific facility fire door rating requirements. There were no other issues</p>
			4/8/15

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: 185313	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42278		
(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 029	<p>Continued From page 5</p> <p>smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and the census was ninety-three (93) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/26/15 at 11:30 AM, with the Regional Maintenance Director and the Maintenance Director revealed the door to a hazardous storage room had a twenty (20) minute fire rated door installed instead of the forty-five (45) minute fire rated door. The room was identified as the Basement Copy Room.</p> <p>Interview, on 02/26/15 at 11:31 AM, with the Regional Maintenance Director and the Maintenance Director revealed he was not aware the door was not rated properly.</p> <p>Observation, on 02/26/15 at 11:35 AM, with the Regional Maintenance Director and the Maintenance Director revealed the door to a hazardous storage room had a twenty (20) minute fire rated door installed instead of the forty-five (45) minute fire rated door. The room was identified as the Basement Medical Records Storage Room.</p> <p>Interview, on 02/26/15 at 11:36 AM, with the Regional Maintenance Director and the Maintenance Director revealed he was not aware the door was not rated properly.</p> <p>The census of ninety-three (93) was verified by the Administrator on 02/26/15. The findings were acknowledged by the Administrator and verified by the Regional Maintenance Director and the</p>	K 029	<p>K029</p> <p>noted in the audit.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> On 2/28/15 the facility maintenance Director was re-educated by the regional maintenance Director regarding the NFPA standards and the specific facility fire door rating requirements and to ensure a system is in place to only order the proper fire rated doors when replacing these items within the facility.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u> The facility maintenance Director will audit the facility doors monthly to ensure they are in accordance with current NFPA standards. The facility maintenance Director will pull the NFPA standards monthly to ensure he/she has the latest regulatory information regarding fire rating requirements on doors and will order future new doors, as needed, according to the standards. The facility maintenance Director will bring audit findings monthly to the quality assurance committee for review and further recommendations.</p>	

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NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42276
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K 029 Continued From page 6
Maintenance Director at the exit interview on 02/26/15.

Actual NFPA Standard:

Reference: NFPA 101 (2000 Edition) 18.3.2 Protection from Hazards.
18.3.2.1* Hazardous Areas.
Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.

Reference: NFPA 101 (2000 Edition) 8.4 SPECIAL HAZARD PROTECTION
8.4.1 General.
8.4.1.1*
Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means:
(1) Enclose the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.2.
(2) Protect the area with automatic extinguishing systems in accordance with Section 9.7.
(3) Apply both 8.4.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 12 through 42.
8.4.1.2
In new construction, where protection is provided with automatic extinguishing systems without fire-resistive separation, the space protected shall be enclosed with smoke partitions in accordance with 8.2.4.
Exception No. 1: This requirement shall not apply to mercantile occupancy general storage areas and stockrooms protected by automatic sprinklers

K 029

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NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 107 BOYLES DRIVE RUSSELLVILLE, KY 42276		
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K 029	Continued From page 7 in accordance with Section 9.7. Exception No. 2: This requirement shall not apply to hazardous areas in industrial occupancies protected by automatic extinguishing systems in accordance with 40.3.2. 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.	K 029		