

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

PRINTED: 02/14/2014
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 01/31/2014
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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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(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	Preparation and/or execution of this plan of correction does not constitute admission or agreement in full or in part, by the provider, of the truth of the fact, or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and executed solely because it is required by the provisions set forth in Federal and State Law	
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and a review of physician orders, Medication Administration Records (MAR) and the facility policy on General Dose Preparation and Medication Administration, it was determined the facility failed to ensure the medication administration rate was less than five (5) percent. A review of 28 medication administration opportunities revealed two (2) medication errors, for a medication administration error rate of seven (7) percent, related to an incorrect medication dose, and a medication not administered before breakfast.</p> <p>The findings include: Review of the facility policy, "General Dose Preparation and Medication Administration," dated 12/01/07, revealed medications were to be administered within 60 minutes of the scheduled time of administration, except for before and after</p>	F 332	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure the medication administration error rate is less than five (5) percent.</p> <p>Corrective action for residents found to have been affected by the deficient practice: The Certified Medication Assistant (CMA) identified as not administering the Synthroid to resident E before breakfast was re-educated 1/30/14 by the Director of Nursing on the Guidelines for General Dose Preparation and Medication Administration. Resident E had no negative outcome related to deficient practice. Administration time for Synthroid was changed to 0700 to ensure resident E receives medication prior to breakfast as ordered.</p> <p>The Certified Medication Assistant (CMA) identified as administering one spray of Floxase rather than two for resident # 8 was re-educated 1/29/14 by the Director of Nursing on the Guidelines for General Dose Preparation and Medication Administration. Resident # 8 had no negative outcome as a result of the deficient practice.</p> <p>Staff are following the Guidelines for General Dose Preparation and Medication Administration for Resident # 8 and Resident E.</p> <p>How other residents having the potential to be affected by the same deficient practice were identified: All residents with physicians orders for thyroid medication were identified by the Unit Managers to verify Administration times were in accordance with physicians orders. There were no issues identified.</p> <p>What measures or systemic changes will be put into place to ensure the deficient practice will not recur: Re-education with licensed nurses and Medication Aides was completed by the unit managers on 1/30/14, 1/31/14, 2/4/14, and 2/5/14. Education included the guidelines for General Dose Preparation and Medication Administration.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained: The unit managers, the Assistant Director of Nursing, and the Director of Nursing will be conducting Medication Administration observations three (3) times per week for six (6) weeks, then weekly for three (3) weeks, then monthly for three (3) months to verify the Guidelines for General Dose</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Perkins, RNA TITLE: Administrator (X8) DATE: 2/24/14

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 332	<p>Continued From page 1</p> <p>meals, which are based on scheduled meal times and administered within 30 minutes of the meal. The medications were to have been prepared using the five 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 01/30/14 at 9:30 AM, revealed Synthroid, a thyroid medication, was administered to Resident E.</p> <p>Review of the Physician Orders for January 2014, revealed the Synthroid was ordered "before breakfast," at 7:00 AM.</p> <p>Review of the MAR, dated 01/30/14, revealed the medication was also to have been given "before breakfast" and the time of administration had been changed to 9:00 AM.</p> <p>Interview with Certified Medication Assistant (CMA) #2, on 01/30/14 at 10:20 AM, revealed Resident E "preferred to take all his/her medications at one time," and the CMT stated she should have administered the Synthroid before breakfast, as the physician ordered.</p> <p>Interview with the Pharmacist, on 01/30/14 at 12:31 PM, revealed "in a perfect world" the Synthroid should have been given before breakfast, ideally on an empty stomach, as the physician ordered.</p> <p>2. Observation of a medication administration pass, on 01/29/14 at 4:23 PM, revealed CMA #3 administered one spray of Flonase, a nasal spray, instead of two sprays to each nostril, for</p>	F 332	<p>F 332 continued</p> <p>Preparation and Medication Administration are followed. The observations will include licensed nurses and Medication Aides on all shifts on all units.</p> <p>Findings of the Medication Administration observations will be reported during monthly QA meetings. The QA committee will study the results from the observations and will make recommendations for further action based on the results.</p>	2/10/14	

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F 332	Continued From page 2 Resident #8. Review of the MARs, dated 01/29/14 and physician orders, dated January 2014, revealed an order for two sprays of Flonase to each nostril. An interview with CMA #3, on 01/29/14 at 4:30 PM, revealed she should have checked the MARs closer and given two sprays of the Flonase instead of one. Interview with the Assistant Director of Nursing (ADON), on 01/29/14 at 5:00 PM, revealed the medication should have been administered as ordered.	F 332			
F 441 SS=E	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 of disease and infection. (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. (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	F 441			

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F 441	<p>Continued From page 3</p> <p>isolate the resident.</p> <p>(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.</p> <p>(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 REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Infection Control and Glucose Meter policy/procedure, it was determined the facility failed to properly clean the glucometer which was used to take blood samples and determine the blood sugar level for two (2) out of thirty three (33) diabetic residents.</p> <p>The findings include:</p> <p>Review of the facility's policy for "Infection Control and Glucose Meters," undated, revealed the glucometer was to have been cleaned prior to use, after use and before storage, with a disinfectant wipe and staff were to have ensured the monitor was wet, from the disinfectant wipe, for two minutes and allowed to dry. A piece of foil was to have been utilized to prevent the spread of germs, between the meter and the table or medication cart, prior to obtaining the blood</p>	F 441	<p>F441</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>It is the normal practice of Creekwood Place Nursing and Rehab Center to properly clean glucometers which are used to take blood samples and determine the blood sugar levels for diabetic residents.</p> <p>Corrective action for residents found to have been affected by the deficient practice:</p> <p>The employee identified as not properly cleaning glucometers prior to usage with Residents B and C were provided re-education by the Director of Nursing on 1/29/14. The employee identified as not utilizing foil under the glucometer prior to usage with Resident D was provided re-education by the Director of Nursing on 1/29/14. Staff are now following appropriate steps for cleaning glucometers between the residents. There was no negative outcome to residents B and C as a result of the deficient practice.</p> <p>How other residents having the potential to be affected by the same deficient practice were identified:</p> <p>Other residents who have orders for fingerstick glucose monitoring were identified by the Unit Managers as having the potential to be affected by the deficient practice.</p> <p>What measures or systemic changes will be put into place to ensure the deficient practice will not recur:</p> <p>Re-education was done by the Unit Managers on 1/29/14-2/10/14 on the proper steps for cleaning glucometers. The education included all licensed nurses.</p> <p>Education will be continued by the Unit Managers with new nurses as part of the facility orientation process.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>Random observations of licensed nurses medication passes will be done by the Unit Managers to verify glucometers are being cleaned appropriately between residents.</p> <p>Observations will be done four (4) times per week for six (6) weeks, then weekly for three (3) weeks, then monthly for three (3) months. The observations will include licensed nurses on each shift and on each unit.</p> <p>Unit Managers will report the findings of their observations during monthly QA meetings. The QA committee will study the findings and will make recommendations for further action based on the results.</p>	2/10/14

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F 441	<p>Continued From page 4 sample.</p> <p>Observation of a medication pass with Licensed Practical Nurse (LPN) #1, on 01/29/14 at 5:20 PM, revealed the nurse to place a piece of foil under the meter, prior to administering glucometer testing on two (2) diabetic residents, Residents B and C, without cleaning the glucometer between the residents.</p> <p>Interview with LPN #1, on 01/29/14 at 5:30 PM, revealed she was unsure of the facility policy and stated the nurses were to use the foil under the bottom of the meter to prevent contamination of the meter. The disinfectant wipes were used, but usually at the start of each shift.</p> <p>Observation of a medication pass with Registered Nurse (RN) #3, on 01/29/14 at 5:30 PM, revealed the RN to clean the glucometer with a disinfectant wipe prior to obtaining Resident D's glucometer testing. However, the RN did not utilize the foil, under the meter, when placing the meter on the resident's bedside table and used a disinfectant wipe, instead, under the meter.</p> <p>Interview with RN #3, on 01/29/14 at 5:40 PM, revealed there was no foil available on the medication cart as the reason the disinfectant wipe was used.</p> <p>Interview with the Director of Nursing (DON), on 01/29/14 at 5:40 PM, revealed the facility policy was to use the disinfectant wipes between each use and stated she was not aware all the staff were not utilizing the wipes, in between each resident, as they had been trained on the procedures. She also stated the foil was to have been utilized between the meter and the table, for</p>	F 441		

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F 441	Continued From page 5 Infection control. Interview with the Administrator, on 01/31/14 at 6:40 PM, revealed the licensed staff were inserviced on the facility policy, regarding the cleaning of the monitors and she would have expected them to have followed the policy.	F 441			

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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: Five (5) 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 standard Life Safety Code survey was conducted on 01/30/2014. Creekwood Place Nursing and Rehab Center 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-Nine (99) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		

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

TITLE

(X6) DATE

Elizabeth S. [Signature], NHA Administrator 2/24/14

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 018 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, eighty-three (83) residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure four (4) corridor doors to the resident rooms were latching properly. The findings include: Observations, on 01/30/14 between 11:00 AM and 3:00 PM with the Regional Director of Plant Services, revealed the corridor doors to rooms #514, #217, #215, and #314 would not latch	K 018	K018 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure corridor doors to the resident rooms latch properly. Corrective action that will be accomplished for those residents found to have been affected by the deficient practice: Corridor doors to rooms # 514, #217, # 215, and # 314 were adjusted on 1/31/14 and 2/4/14 by the Plant Services Director to latch properly. How the facility will identify other residents having the potential to be affected by the same deficient practice: All corridor doors were checked on 1/31/14, 2/4/14, and 2/5/14 by the Plant Services Director, the Assistant Plant Services Director, and the Administrator to verify they latch properly. No additional issues were identified. What measures or systemic changes will be put into place to ensure that the deficient practice will not recur: The Plant Services Director and the Assistant Plant Services Director were re-educated by the Administrator on 2/4/14 on a preventative maintenance schedule to verify the corridor doors to the resident rooms latch properly. The education included the responsibility of the Plant Services Director to ensure the doors are fixed immediately if identified they do not latch appropriately. Re-education will be completed with staff to include nursing assistants, licensed nurses, medication aides, housekeepers, department managers, and activity staff on the requirement for resident room doors to latch properly and the procedure for reporting any issues to maintenance for repair. This education is scheduled for March 10th and will be completed by the Assistant Director of Nursing. How the facility plans to monitor its performance to ensure that solutions are sustained: The Administrator or designees from the QA committee will conduct random checks of corridor doors to the resident rooms to verify they latch properly. The checks will be conducted weekly and will be scheduled to ensure all facility doors are checked at least monthly for 6 months. Results of the checks will be presented to the QA committee. The QA committee will study findings and make recommendations for further action based on the results.	2/10/14

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K 018	Continued From page 2 properly when tested. Interview, on 01/30/14 between 11:00 AM and 3:00 PM with the Regional Director of Plant Services, revealed he was unaware the doors were not latching properly. Reference: NFPA 101 (2000 edition) 18.3.6.3.2 Doors shall be provided with positive latching hardware. Roller latches shall be prohibited. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3	K 025		

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K 025	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, seventy-one (71) residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure three (3) smoke barriers were sealed around pipes, wires and complete to the roof to resist the passage of smoke.</p> <p>The findings include:</p> <p>Observations, on 01/30/14 between 9:00 AM and 10:00 AM with the Regional Director of Plant Services, revealed the smoke partitions, extending above the ceiling located at room #201, 501, and 322 were penetrated by pipes, wires, and around studs going through the walls. Further observation revealed the wall at room #201 wasn't sealed at the top and at the roof vent.</p> <p>Interview, on 01/30/14 between 9:00 AM and 10:00 AM with the Regional Director of Plant Services, revealed he was aware of the penetrations and had notified the contractors to come and repair the smoke walls.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through</p>	K 025	<p>K025</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>It is the normal practice of Creekwood Place Nursing and Rehab Center to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards.</p> <p>Corrective action accomplished for the residents found to have been affected by the deficient practice:</p> <p>There were no residents affected by the deficient practice.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice were identified:</p> <p>Residents in four (4) of the five (5) smoke compartments had the potential to be affected by the same deficient practice.</p> <p>Corrective measures or systemic changes put into place to ensure the deficient practice will not recur:</p> <p>Smoke partitions extending above the ceiling located at room #201, #501, and # 322 were repaired with fire-rated caulking to close the penetrations created by pipes, wires, and studs going through walls. These repairs were completed by the general contractor on 1/29/14, 1/30/14, 2/2/14, and 2/3/14. The wall at room #201 was also sealed at the top and at the roof vent using fire rated caulking.</p> <p>Smoke partitions in the additional smoke compartment were checked by the Regional Director of Plant Services to ensure there were no penetrations in smoke barriers. Penetrations discovered have been closed using Fire Rated Caulking. These repairs were completed by the general contractor on 2/4/14, 2/10/14, 2/11/14, 2/19/14, 2/20/14, and 2/21/14.</p> <p>The Plant Services Director and the Assistant Plant Services Director were re-educated on 2/4/14 by the Administrator on a preventative maintenance schedule to include verification that smoke barriers are maintained as such to prevent the passage of smoke between smoke compartments in accordance with NFPA standards. Any penetration noted in smoke barriers is to be repaired immediately by the Plant Services Director using fire rated caulking.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>The Plant Services Director or the Assistant Plant Services Director will audit the smoke barriers monthly for the next six months and report findings to the QA committee to validate ongoing compliance.</p>	

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K 025	Continued From page 4 floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025	K 025 continued The Regional Director of Plant Services will make random observations of the smoke barriers to ensure they are not penetrated and would resist the passage of smoke between smoke compartments. The Administrator will monitor the preventative maintenance records maintained by the Plant Services Director to verify smoke barriers have been checked and any issues were repaired. The QA committee will study the audits of the smoke barriers and will make recommendations for further action based on the results.	3/10/14
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a	K 027		

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K 027	Continued From page 5 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke doors that would self-close and resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure the doors located in the smoke barriers had a Fire Resistive rating of 20 minutes or were solid wood doors. The findings include:	K 027	K027 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure the doors located in the smoke barriers have a Fire Resistive rating of 20 minutes or are solid wood doors. Corrective action accomplished for residents found to have been affected by the deficient practice. There were no residents affected by the deficient practice. How other residents having the potential to be affected by the deficient practice were identified: Residents in five (5) of the five (5) smoke compartments had the potential to be affected by the deficient practice. Measures or systemic changes put into place to ensure the deficient practice will not recur: The glass in the doors in the smoke barriers of each corridor were replaced with glass having appropriate fire rating. The glass was replaced 2/12/14 and 2/13/14 by general contractors. The Plant Services Director and the Assistant Plant Services Director were re-educated 2/4/14 by the Administrator on the NFPA Life Safety Code Standard related to doors in smoke barriers. How the facility plans to monitor its performance to ensure that solutions are sustained. The Administrator has established a preventative maintenance schedule for the Plant Services Director to include the monitoring of doors in the smoke barriers. Any noted alteration in the doors that may affect their rating will be reported immediately for repair. The monitoring will be done monthly for the next 6 months and the results will be reported to the QA committee for review.	2/20/14

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K 027	Continued From page 6 Observation, on 01/30/14 at 12:30 PM with the Regional Director of Plant Services, revealed all doors in the smoke barriers across the corridors had glass installed in the doors without steel wires. The doors were equipped with a rating tag of 20 minutes but looked as if the windows were added after the door received its rating. Interview, on 01/30/14 at 12:30 PM with the Regional Director of Plant Services, revealed that he was not aware the doors may not have the proper rating due to the glass installed in the door. NFPA Standard: NFPA 101 (2000 edition), 18.3.7.5*. Doors in smoke barriers shall be substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors, or shall be of construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Cross-corridor openings in smoke barriers shall be protected by a pair of swinging doors or a horizontal sliding door complying with 7.2.1.14. Swinging doors shall be arranged so that each door swings in a direction opposite from the other.	K 027			
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052			

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K 052 SS=F	<p>Continued From page 7</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection review, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure the fire alarm for the facility had been tested quarterly for the year 2013.</p> <p>The findings include:</p> <p>Fire alarm inspection review, on 01/30/14 at 2:24 PM with the Regional Director of Plant Services, revealed the facility failed to provide documentation to show the fire alarm had been tested for the 2nd and 3rd quarter of 2013.</p> <p>Interview, on 01/30/14 at 2:24 PM with the Regional Director of Plant Services, revealed he was aware the facility missed two (2) quarters of inspections and started a contract with a new company in December to complete the 4th quarter inspection.</p>	K 052	<p>K 052</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure the fire alarm for the facility is tested quarterly.</p> <p>Corrective action accomplished for residents found to have been affected by the deficient practice:</p> <p>There were no residents affected by the deficient practice.</p> <p>How other residents having the potential to be affected by the deficient practice were identified:</p> <p>The deficiency had the potential to affect all residents.</p> <p>Measures or systemic changes put into place to ensure the deficient practice will not recur:</p> <p>A contract with a new monitoring company was initiated 12/13/13 by the Administrator. The monitoring company is contracted to inspect and test the fire alarm system quarterly on an ongoing basis.</p> <p>The Plant Services Director was re-educated on 12/13/14 by the Administrator on the NFPA 70 requirements for inspecting fire alarm systems.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>The Plant Services Director will be responsible for ensuring the monitoring company inspects the fire alarm system quarterly. The Administrator will verify the inspections occur quarterly.</p>	2/10/14

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K 052	Continued From page 8 Reference: NFPA 101 (2000 ed.) 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to have quarterly inspections performed of the fire sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure the sprinkler system for the facility had been tested quarterly for the year 2013. The findings include: Sprinkler inspection review, on 01/30/14 at 2:24 PM with the Regional Director of Plant Services, revealed the facility failed to provide documentation to show the sprinkler system had	K 062	K062 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to have quarterly inspections performed of the fire sprinkler system in accordance with NFPA standards. Corrective action accomplished for residents affected by the deficient practice. There were no residents affected by the deficient practice. How other residents having to potential to be affected by the deficient practice were identified. The deficiency had the potential to affect all residents. Measure or systemic changes put into place to ensure the deficient practice will not recur: A contract with a new monitoring company was initiated 12/13/13 by the Administrator. The monitoring company is contracted to inspect and test the fire sprinkler system quarterly in accordance with NFPA standards. The Plant Services Director was re-educated on 12/13/14 by the Administrator on the NFPA requirements for inspections on sprinkler systems. How the facility plans to monitor its performance to ensure that solutions are sustained: The Plant Services Director will be responsible for ensuring the monitoring company inspects the fire sprinkler system quarterly in accordance with NFPA standards. The Administrator will verify the inspections occur quarterly.	2/10/14

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K 062	<p>Continued From page 9 been tested for the 2nd and 3rd quarter of 2013.</p> <p>Interview, on 01/30/14 at 2:24 PM with the Regional Director of Plant Services, revealed he was aware the facility missed two (2) quarters of inspections and started a contract with a new company in December to complete the 4th quarter inspection.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <p>Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5</p>	K 062		

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K 062	Continued From page 10 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062			
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers per NFPA standards. The deficiency had the	K 064			

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K 064	Continued From page 11 potential to affect one (1) of five (5) smoke compartments, twenty-nine (29) residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure the extra fire extinguishers located in the maintenance shop where properly mounted. The findings include: Observations, on 01/30/14 at 10:00 AM with the Regional Director of Plant Services, revealed the extra portable fire extinguishers located in the maintenance shop were not mounted to the wall and were placed on the floor. Interview, on 01/30/14 at 10:00 AM with the Regional Director of Plant Services, revealed he was unaware the extra fire extinguishers were required to be properly mounted. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	K064 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to maintain the installation of portable fire extinguishers per NFPA standards. Corrective action accomplished for residents affected by the deficient practice: There were no residents affected by the deficient practice. How other residents having the potential to be affected by the deficient practice were identified. The deficient practice had the potential to affect residents in one (1) of five (5) smoke compartments. Measure or systemic changes put into place to ensure the deficient practice will not recur: The extra portable fire extinguishers located in the maintenance shop were secured in accordance with NFPA standards on 1/30/14 by the Plant Services Director. All remaining fire extinguishers in the facility were checked by the Plant Services Director on 2/5/14 to ensure they were mounted or secured in accordance with NFPA standards. There were no further issues identified. The Plant Services Director was re-educated on 1/29/14 by the Regional Director of Plant Services on the NFPA standards for fire extinguishers. How the facility plans to monitor its performance to ensure that solutions are sustained: The Administrator has established a preventative maintenance schedule for the Plant Services Director to include the monitoring of fire extinguisher placement in the facility. Any fire extinguisher noted to be installed improperly will be immediately repaired. The monitoring will be done monthly for the next six (6) months and the results will be reported to the QA committee for review. The QA committee will study findings and make recommendations for further action based on the results.	2/10/14
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 069		

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K 069	<p>Continued From page 12</p> <p>Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the cooking appliances in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty-nine (29) residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure the grease fryer was properly separated from the stove top.</p> <p>The findings include:</p> <p>Observation, on 01/30/14 at 10:09 AM with the Regional Director of Plant Services, revealed the grease fryer was located seven (7) inches from the cooking surface.</p> <p>Interview, on 01/30/14 at 10:09 AM with the Regional Director of Plant Services, revealed he was unaware the grease fryer did not have proper separation from the cook top.</p> <p>Reference: NFPA 96 (1998 Edition) 9-4.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed</p>	K 069	<p>K069</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>It is the normal practice of Creekwood Place Nursing and Rehab Center to maintain cooking appliances in accordance with NFPA standards.</p> <p>Corrective action accomplished for those residents identified to have been affected by the deficient practice: There were no residents affected by the deficient practice.</p> <p>How other residents having the potential to be affected were identified: The deficiency had the potential to affect residents in one (1) of five (5) smoke compartments.</p> <p>Measures or systemic changes put into place to ensure the deficient practice will not recur: A steel plate was installed by the Plant Services Director on 2/10/14 between the fryer and the surface of the stove top. The steel plate is at least 8 in in height between the fryer and surface flames of the stove top. The Dietary Manager was educated on 1/31/14 by the Plant Services Director on the NFPA requirements for properly separating the grease fryer from the stove top</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained. The Dietary Manger will observe the steel plate at least monthly for the next six months during her kitchen observations to ensure its placement is still appropriate. The Dietary Manager will report any issues to the Plant Services Director for immediate repair.</p> <p>The Dietary Manager will report her findings to the QA committee who will make recommendations for further action based on the findings.</p>	2/15/14

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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 01/30/2014
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 069	Continued From page 13 at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.	K 069		
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect one (1) of five (5) smoke compartments, twenty-nine (29) residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire rated door and frame that had a one (1) hour fire resistive rating, proper floor, and proper ventilation.	K 143	K143 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to assure rooms being used to transfer liquid oxygen are rated per NFPA requirements. Corrective action accomplished for residents found to have been affected by the deficient practice: There were no residents identified as affected by the deficient practice. How other residents having the potential to be affected by the deficient practice were identified: The deficient practice had the potential to affect residents in one (1) of five (5) smoke compartments. Measures or systemic changes put into place to ensure the deficient practice will not recur. The linoleum flooring was removed from the floor by the Plant Services Director and the Assistant Plant Services Director on 2/14/14 leaving just a concrete floor. On 2/14/14, the Administrator replaced signage on the door with signage indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. The Plant Services Director has spoken with the contractors in relation to the door tag. The contractors will verify and tag the door and frame appropriately or will replace the door frame to meet the required fire rating if needed by 3/15/14. The Administrator and Plant Services Director have contracted with Knights Electric to install mechanical ventilation to the outside. The anticipated date of completion is 3/15/14. How the facility plans to monitor its performance to ensure that solutions are sustained. The Administrator has established a preventative maintenance schedule to include observation of the oxygen room weekly X six (6) weeks, then monthly X six (6) months. The observations will be the responsibility of the Plant Services Director or the Plant Services Assistant to verify appropriate signage is present and the ventilation system is operating appropriately. If any issues are noted during observations they will be reported immediately for repair. The Plant Services Director will report the findings of the observations to the QA committee for review. The QA committee will review and will make additional recommendations if necessary.	3/15/14

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K 143	Continued From page 14 The findings include: Observation, on 01/30/14 at 10:42 AM with the Regional Director of Plant Services, revealed the oxygen trans-filling room had a fire rated door installed but it was unclear what the door was rated for. The door frame is steel but there is no fire rating tag installed on the door frame. Further observation revealed the room was not mechanically vented to the outside, there was linoleum flooring installed, and the door did not have the proper signage for the room. Interview, on 01/30/14 at 10:42 AM with the Regional Director of Plant Services, revealed the facility had recently switched to trans-filling oxygen and he was unaware of all steps to properly make the room a trans-filling room. Reference: NFPA 99 (1999 Edition). 8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.	K 143		
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K 143	Continued From page 15 Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator according to NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, twenty-nine (29) residents, staff and visitors. The facility is certified for One-Hundred One (101) beds with a census of Ninety-Nine (99) on the day of the survey. The facility failed to ensure there was battery backup lighting at the generator transfer switch. The findings include:	K 144	K144 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to maintain the emergency generator in accordance with NFPA standards. Corrective action accomplished for those residents found to have been affected by the deficient practice. There were no residents identified as affected by the deficient practice. How other residents with the potential to be affected by the deficient practice were identified: The deficient practice had the potential to affect residents in five (5) of five (5) smoke compartments. Corrective measures or systemic changes made to ensure the deficient practice will not recur: The Administrator and the Plant Services Director have contracted Kalght's Electric to install battery backup lighting at the generator transfer switch. The anticipated date of completion is 3/15/14. How the facility plans to monitor its performance to ensure that solutions are sustained: The Administrator has established a preventative maintenance schedule to include observation of the generator transfer switch room weekly X six (6) weeks then monthly X three (3) months. The observations will be the responsibility of the Plant Services Director or the Plant Services Assistant to verify the battery backup lighting in the transfer room is working appropriately. If any issues are noted during observations they will be reported immediately for repair. The Plant Services Director will report the findings of the observations to the QA committee for review. The QA committee will review the findings and will make additional recommendations if necessary.	3/15/14

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K 144	<p>Continued From page 16</p> <p>Observation, on 01/30/14 at 10:22 AM with the Regional Director of Plant Services, revealed the facility did not have any battery-powered lighting installed in the room where the transfer switch for the emergency generator was located.</p> <p>Interview, on 01/30/14 at 10:22 AM with the Regional Director of Plant Services, revealed he was not aware of the requirement for the battery backup lighting in the transfer switch room.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p>	K 144		