

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

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/04/2013
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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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)	(X6) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>Amended SOD 01/09/13</p> <p>A recertification survey was initiated on 01/02/13 and concluded on 01/04/13 and deficiencies were cited with the highest scope and severity being an "E". The Life Safety Code survey was initiated and concluded on 01/03/13 with no deficiencies identified. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crestview Center does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Crestview Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies."</p>	
F 428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to identify and administer Levothyroxine in accordance with manufacturers recommendation, as evidenced by failure of the Pharmacy consultant and nursing staff to ensure residents received Levothyroxine (Synthroid) on an empty stomach for four (4) of thirteen (13) sampled residents and one (1) of</p>	F 428	<p>F428</p> <p>1. Residents #3, 8 and C administration time of Levothyroxin was changed to 6:00 a.m. on 1/10/12 by the licensed nurse. Residents #4 and #13 no longer reside in the facility.</p> <p>2. An audit of residents receiving Levothyroxin was completed by the Regional Nurse Consultant on 1/03/13 to determine if medication administration times were per the manufacturers recommendations. Additionally, on 1/11/13, the Pharmacy Consultant audited current resident's medications to ensure that medications are being administered</p>	02/05/13

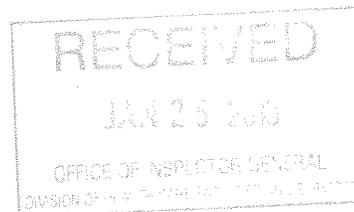
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Steve W. Kunkley</i>	TITLE <i>Administrator</i>	(X8) DATE <i>1/18/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be 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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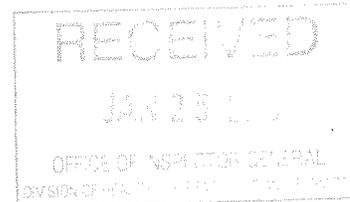
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F 428	Continued From page 1 four (4) unsampled residents. Residents #3, #4, #8, #13, and Unsampled resident C. The findings include: Review of the facility's policy "LTC Facility's Pharmacy Services and Procedures Manual (6.0 General Dose Preparation and Medication Administration)", dated 12/01/07, revealed facility staff should follow the manufacturer's medication administration guidelines, which states the medication should be given on an empty stomach, either 1 hour prior to meals or 4 hours after the last meal of the day. 1. Observation of the medication pass, on 01/03/13 at 8:05 AM, revealed Unsampled Resident C was sitting up in bed eating breakfast. Further observation revealed RN #3 administer Synthroid 50 mcg to the resident during the meal. Review of the physician's order, dated 10/12/13, for Unsampled Resident C revealed Synthroid 50 mcg by mouth every day to be given for Hypothyroidism. 2. Observation of Resident #4, on 01/03/13 at 7:50 AM, revealed the resident eating breakfast. Review of the clinical record for Resident #4, revealed the facility admitted the resident with diagnoses of Thyroid Disorder and Hypertension. The physician ordered Synthroid 100 mcg be administered daily. Review of the January 2013 Medication Administration Record (MAR) for Resident #4, revealed the facility administered the Synthroid at	F 428	per manufacturer recommendations. Identified concerns were addressed by 1/15/13 by the licensed nurse. 3. Licensed Nurses will be re-educated by the Director of Nursing as of 2/4/13 to follow manufactures' recommendations related to medication administration times. Licensed Nurses will complete a post education evaluation, which will be reviewed by the DNS to determine competency. A copy of the Omnicare Pharmacy "Drug Administration Recommendations Regarding Meals" was provided to each licensed nurse for further reference. In addition, a copy of "Drug Administration Recommendations Regarding Meals" was placed in the front of the facility Medication Administration Records binder. The Pharmacy Consultant will review each resident's drug regimen monthly and report any irregularities to the attending physician and DNS. All new orders will be reviewed daily M-F by the DNS, ADNS and/or Unit Manager for appropriate administration times based on manufacturer recommendations. 4. The DNS will report monthly drug regimen findings to the PI Committee for three months for review and further recommendations, then quarterly as determined by the PI Committee.	



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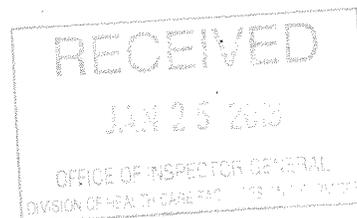
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F 428	<p>Continued From page 2 8:00 AM daily.</p> <p>3. Review of the clinical record for Resident #13, revealed the facility admitted the resident with a diagnosis of Hypothyroidism.</p> <p>Review of the physician orders for Resident #13, revealed Synthroid 50 mcg daily was ordered by the physician.</p> <p>Review of the December 2012 MAR for Resident #13, revealed the facility administered the Synthroid daily at 8:00 AM.</p> <p>4. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 04/23/12 with diagnoses of Dementia, Toxic Encephalopathy, Hypothyroidism, Esophageal Reflux, Hypertension, and Anxiety. Review of the physician's orders revealed Levothyroxine Sodium (Synthroid) 175 mcg was ordered as 1 TAB P.O. daily, with a start date of 09/15/12.</p> <p>Review of the Medication Administration Record (MAR) revealed Levothyroxine Sodium 175 mcg was scheduled at 8 AM daily for Resident #3.</p> <p>5. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 04/25/12 with diagnoses of Alzheimer's Dementia, Hypothyroidism, Edema, and Anxiety State. Review of the physician's orders revealed Levothyroxine Sodium 125 mcg was ordered as 1 TAB P.O. daily, with a start date of 05/09/12.</p> <p>Review of the Medication Administration Record (MAR) revealed Levothyroxine was scheduled for administration at 8 AM daily for Resident #8.</p>	F 428	



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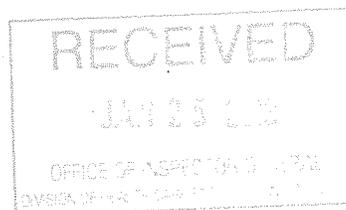
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F 428	Continued From page 3 Review of the monthly Pharmacy Medication Reviews for Residents #3, #4, #8, #13 and Unsampled Resident C revealed the no documentation of medication irregularities by the pharmacy consultant that included the administration of Synthroid on an empty stomach one hour prior to meals or four hours after the last meal. Interview with RN #3, on 01/03/13 at 8:15 AM, revealed she normally used her 7:00 AM window for giving the medication; however, stated the medication should be changed to a 6:00 AM medication to make sure the resident got the medication prior to eating. Interview with the facility's Pharmacist, on 01/04/13 at 2:20 PM, revealed there were new manufacture's instructions that were provided in November 2012, which instructed that Synthroid should be taken on an empty stomach or 4 hours after the last meal of the day. The pharmacist revealed in her experience, this should have been picked up on the monthly pharmacy review as a recommendation and could not provide a reason why it had not been noted. The pharmacist stated any recommendations are given to the Director of Nursing as well as placed in the resident's record to be acted upon by the physician. Interview with the Director of Nursing, on 01/04/13 at 2:30 PM, revealed the physician's orders are followed with specific time designated by the physician, and if not in the physician's orders, then nursing would normally rely on the	F 428		



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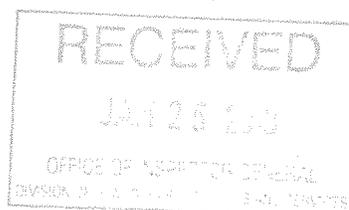
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F 428	Continued From page 4 pharmacy to give this in their recommendations, at which time they would refer to the physician and obtain orders.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission 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 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441	<u>F441</u> 1. Resident #10 was provided a bedside commode by the licensed nurse on 1/3/13. Resident's #7 and #10 were educated on contact precautions and to remain in their rooms while under contact precautions on 1/4/13 and resident #10 no longer resides in the facility. Resident D was assessed on 1/3/13 for signs or symptoms of infection by the licensed nurse; there were none noted. RN #2 was re-educated on 1/3/13 by the DNS to use gloves with administering nasal inhalers. Resident D no longer resides in the facility. 2. The Infection Control log was reviewed by the Director of Nursing Services on 1/17/13 for the previous 30 days to determine if there had been any trends related to resident illness/infection. There were none noted. The Director of Nursing also conducted observations within the center 1/8/13 - 1/17/13 to determine staff/resident adherence to contact precautions with no concerns noted.	02/05/13



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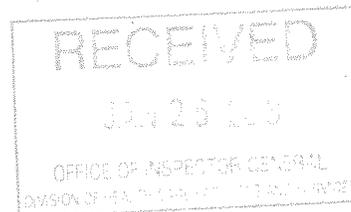
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F 441	<p>Continued From page 5</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the staff followed isolation and standard precautions for two (2) of thirteen (13) sampled residents and one (1) of four (4) unsampled residents. The facility failed to maintain contact precautions for Resident #7 and #10 who were placed in isolation and failed to utilize standard precautions during the administration of nasal medications to Unsampled Resident D.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Standard Precautions, dated October 2009, revealed staff should wear gloves when coming into contact with mucus membranes and excretions of a resident.</p> <p>Review of the facility's policy regarding Contact Precautions, dated October 2009, revealed staff were to wear gowns and gloves when entering a room where contact precautions were in use. Staff would limit resident movement and when transport was necessary, ensure that precautions were maintained and infective material was contained. Colonization would be confirmed with one (1) positive screen and the physician would write an order stating that the resident was colonized and could be removed from</p>	F 441	<p>3. Nursing staff will be re-educated by the Infection Control Nurse by 2/4/13 to the Infection Control Policy as it relates to Isolation and Contact Precautions using current CDC recommendations and following standard precautions, including to wear gloves whenever coming into contact with a resident's mucous membranes and/or excretions. Nursing staff will complete a post education evaluation, which will be reviewed by the DNS to determine competency.</p> <p>4. The Director of Nursing and/or Unit Managers will complete medication administration competency audit with 3 licensed nurses per month for at least 3 months to validate that standard precautions are followed during medication administration to include nasal inhalers; any concerns will be addressed immediately. The Infection Control Nurse will monitor compliance for at least 3 months by making rounds when there are any residents on Isolation Precautions to validate staff/resident adherence to contact precautions and immediately address any concerns if noted. The Director of Nursing/Infection Control Nurse will present findings and trends of resident infections, need for transmission based precautions/isolation and staff/resident adherence to</p>	



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F 441	<p>Continued From page 6</p> <p>precautions. Resolution of the infection was confirmed with one (1) positive screen and the physician would write an order stating the resident's infection was resolved and precautions were no longer needed.</p> <p>Observation of Resident #7, on 01/02/13 at 1:45 PM, on 01/03/13 at 7:25 AM, 8:30 AM, 9:15 AM, 10:00 AM, and 11:30 AM, revealed the resident was in the therapy room for rehabilitation with other residents, in the resident dining room for meals with other residents and in activities with other residents.</p> <p>Review of the clinical record for Resident #7, revealed the resident had a diagnosis of Clostridium Difficile Colitis and continued with diarrhea as noted by the physician in a progress note dated 01/02/13. The facility admitted the resident with the diagnosis of Clostridium Difficile Colitis and placed the resident on Isolation; however, the sign on the resident's door read Contact Precautions. The facility completed a significant change Minimum Data Set (MDS) assessment on 11/02/12 which revealed the resident required extensive assistance with transfers, ambulation, dressing, and hygiene. The resident was incontinent of bowel and bladder.</p> <p>Interview with Certified Nurse Aides (CNA) #1 and #2, on 01/03/13 at 11:45 AM, revealed they had received some training on contact precautions; however, the nurses on the unit told them how to handle the isolation rooms. They were to wash their hands and wear gloves and gowns if they touched the resident to provide care.</p>	F 441	<p>following standard and transmission based precautions per policy and outcomes of medication administration competency audit to the PI Committee for three months for further review and recommendations, then quarterly as determined by the PI Committee.</p>



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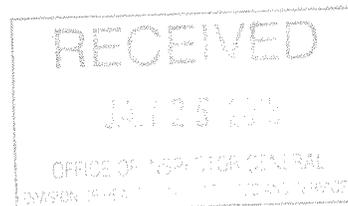
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F 441	<p>Continued From page 7</p> <p>Interview with Registered Nurse (RN) #2, on 01/02/13 at 1:40 PM, revealed Resident #7 was in therapy.</p> <p>Interview with RN #1, on 01/02/13 at 1:50 PM, revealed the resident would continue to move about the facility freely per the Director of Nursing instructions.</p> <p>Interview with the Medical Director, on 01/02/13 at 1:42 PM, revealed Resident #7 should not be in therapy and that therapy should be completed in the resident's room since the resident continued on an antibiotic for the colitis diagnosis.</p> <p>2. Observation of Resident #10, on 01/03/13 at 11:30 AM and 2:00 PM, revealed the resident was on Contact Precautions. There was another resident in the room not on contact precautions. There was a single bathroom for the room with one commode. There was no bedside commode noted in the room.</p> <p>Review of the clinical record for Resident #10, revealed the resident was re-admitted to the facility late on 01/02/13 with a diagnosis of Clostridium Difficile Colitis (C Diff) requiring contact precautions as ordered by the physician.</p> <p>Interview with the Director of Nursing, on 01/04/13 at 2:30 PM, revealed the facility did not obtain a bedside commode for the resident until the evening shift on 01/03/13. She stated the resident had been using a bedpan which staff emptied into the one commode for the room. She stated she was not aware residents with C Diff were not to use the same commode residents</p>	F 441		
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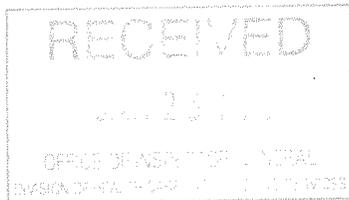
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F 441	<p>Continued From page 8 without the infection used.</p> <p>3. The facility did not provide a policy regarding precautions to use when administering nasal medications.</p> <p>Interview with the Director of Nursing, on 01/04/13 at 2:30 PM, revealed her expectations for nurses giving Miacalcin would be to wash hands and use gloves. She stated there was no specific facility policy for this, and would refer to their standard of practice manual "Perry and Potter".</p> <p>Review of the Perry and Potter manual revealed the staff should wear gloves when administering nasal inhalers.</p> <p>Observation during the medication pass, on 01/03/13 at 7:45 AM, revealed the medication Miacalcin spray to be administered to Unsampled Resident D, without the use of standard precautions. RN #2 failed to apply gloves throughout the administration of the medication.</p> <p>Interview with RN #2, on 01/03/13 at 8:00 AM, revealed she did not come in contact with the resident's skin, so she didn't wear gloves. The RN revealed she was not sure what the policy was regarding administering nasal Inhalers and the use of gloves.</p>	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: 1964, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 50KW generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/03/13. Crestview Care and Rehabilitation Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility has fifty-eight (58) certified beds and the census was fifty-one (51) on the day of the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Steve M. Kanley</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/18/13</i>
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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.