

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

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

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING Division of Health Care Southern Enforcement Branch B. WING _____ | (X3) DATE SURVEY COMPLETED 04/24/2014 |
|--|--|--|--|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 |
|--|---|

| (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 standard health survey was conducted on 04/22-24/14. Deficient practice was identified with the highest scope and severity at "E" level. | F 000 | "Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation." | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies/procedures, it was determined the facility failed to ensure services were provided to maintain a sanitary and comfortable interior. Observations made from 04/22/14 through 04/24/14 revealed the threshold in resident room 7 was loose from the floor; handrails facing the West Hall nurses' station were sharp and had splintered edges; handrails next to the exit door near the kitchen were observed to be attached to boards that had sharp and splintered edges, and four metal screws were observed lying loose on top of the board and were accessible to residents; fire doors on the West Hall were chipped and splintered in multiple places; and the armrests of unsampled Resident B's wheelchair were ripped/torn and in need of repair. The findings include: Interview with the Maintenance Supervisor on 04/24/14 at 6:41 PM revealed the facility did not have a written policy that addressed maintenance | F 253 | 1. Resident room # 7 identified in sample; door entrance threshold has been tightened/repared and now fits tightly to the floor. Handrail at West Hall Nurses' station has been sanded, no longer with sharp, splintered edges. Handrail "board" at West Kitchen door; sharp edges have been sanded and painted. Metal screws found on West Hall handrail board have been removed. Fire doors at West Hall; chipped, splintered edges have been sanded and repaired. Torn arm rest on resident B wheelchair has been replaced. All of above repairs completed by Ryan Arnett, Maintenance Director on 04/29/14. 2. 100 % environmental, housekeeping audit has been completed facility wide to identify any other areas with chipped, rough, splintered edges needing repairs. Any areas identified have been repaired. Round Audit completed by Ryan Arnett, Maintenance Director and Nelda Beard, Administrator on 05/01/14. | 06/08/14 06/08/14 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nelda Beard TITLE: Administrator (X6) DATE: 5-16-14

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.

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO 0938-0391

| | | | | | |
|--|---|--|---|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 04/24/2014 |
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | | |
| (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 253 | <p>Continued From page 1</p> <p>concerns and stated the facility used The Equipment Lifecycle System (TELS) to identify and report repairs that were needed. The Maintenance Supervisor reported that all staff can log in to the computerized system and report anything that needed to be brought to the Maintenance Department's attention. According to the Maintenance Supervisor, after staff entered the information into the system, a "work order" was generated for Maintenance and they were to follow up on the request.</p> <p>1. Observations of resident room 7 on 04/22/14 at 3:35 PM and on 04/24/14 at 3:58 PM revealed the threshold was loose from the floor and presented a trip/fall hazard for residents entering/exiting the room.</p> <p>2. Observations of handrails facing the West Hall nurses' station on 04/22/14 at 5:34 PM and on 04/24/14 at 3:58 PM and 6:35 PM revealed the handrails had rough and splintered edges.</p> <p>3. Observations of a handrail on the right side of the exit door near the kitchen/dining room on 04/22/14 at 5:32 PM and on 04/24/14 at 3:58 PM and 6:35 PM revealed the handrail had been attached to a board that was splintered and had sharp edges. In addition, four screws were lying loose on top of the board and were accessible to residents.</p> <p>4. Observations on 04/22/14 at 5:35 PM and on 04/24/14 at 3:58 PM and 6:35PM revealed the right side fire door on the West Hall was splintered and chipped in multiple places and the left side fire door on same hall was splintered and chipped.</p> | F 253 | <p>3. Environmental, housekeeping weekly rounds audits have been developed, to be completed weekly with Maintenance Director, Housekeeping Supervisor and NHA. Round audits to be completed weekly and work order entry in facility maintenance TELS system for repairs. All staff have been re-trained on process of input of work orders via TELS system, which is sent directly to Maintenance Director I-Pod and E-mail. Also NHA receives each work order entered into TELS work order system and notification of when repairs have been completed. Round to be completed by Ryan Arnett, Maintenance Director, David Smith, Housekeeping Supervisor and Nelda Beard, Administrator on a weekly basis.</p> <p>4. QAPI Committee consisting of at least the Administrator, DON, ETD, Maintenance Director, Housekeeping Supervisor and the Medical Director to meet at least monthly beginning 6/2014 to review all Environmental, housekeeping round audit findings and revise plan as indicated and needed. This will be ongoing until issue considered corrected.</p> <p>5. Date of Compliance 06/08/14.</p> | 06/08/14 | 06/08/14 |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 04/24/2014 |
|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | | |
| (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 253 | Continued From page 2 5. Observations on 04/22/14 at 3:35 PM and on 04/24/14 at 6:13 PM and 6:35 PM revealed the armrests on the left and right side of Resident B's wheelchair were ripped/torn and in need of repair. | F 253 | | | |
| F 279 SS=E | Continued interview with the Maintenance Supervisor on 04/24/14 at 6:41 PM revealed he was not aware of the above noted concerns. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan to address a history of | F 279 | | | |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 04/24/2014 |
| NAME OF PROVIDER OR SUPPLIER CAMPBELLVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLVILLE, KY 42718 | |
| (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 279 | <p>Continued From page 3</p> <p>positive reaction to tuberculin skin testing for four (4) of (15) fifteen sampled residents (Residents #9, #10, #12, and #13).</p> <p>The findings include:</p> <p>A review of the Comprehensive Care Plan policy (dated July 2012) revealed the development of the comprehensive care plan should be an interdisciplinary approach to managing the acute and chronic needs of the residents and should have realistic goals and approaches/interventions to address the residents' needs.</p> <p>1. Review of the medical record revealed the facility admitted Resident #9 on 07/01/12 with diagnoses including Hypertension, Psychosis, Alzheimer's Disease, and Esophageal Reflux. A review of the immunization record revealed the resident had a history of a positive reaction to the Purified Protein Derivative (PPD) skin test (test to determine the presence of tuberculosis).</p> <p>Review of the comprehensive care plan for Resident #9 dated 01/27/14 revealed the facility failed to develop a plan of care to address the past positive PPD history to include monitoring for complications or signs/symptoms of tuberculosis.</p> <p>2. Review of the medical record revealed the facility admitted Resident #12 on 07/01/12 with diagnoses including Stage III Chronic Kidney Disease, Congestive Heart Failure (CHF), Atrial Fibrillation, and Alzheimer's Disease. Review of the immunization record revealed the resident had a history of a positive PPD reaction. However, there was no evidence the facility developed a comprehensive care plan to address Resident #12's history of the positive PPD skin</p> | F 279 | <p>1. All Residents identified in sample; R # 9, R#12, R#10, R#13 have had each individual Care Plans revised, updated to include: HX of past positive PPD and include monitoring for complications and/or signs and symptoms of tuberculosis. Care Plans for above residents were revised, updated by Karen Moore, Director of Nursing and Daily Care Plan Team on 05/05/14.</p> <p>2. 100% audit for all facility residents has been completed to identify any other residents with Hx of positive reaction to tuberculin skin testing. Any additional resident identified has had care plan revised, updated to included Hx of past positive PPD and include monitoring for complications and/or signs and symptoms of tuberculosis. Audit completed by Karen Moore, Director of Nursing 05/04/14.</p> | <p>06/08/14</p> <p>06/08/14</p> |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 04/24/2014 |
|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | | |
| (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 279 | Continued From page 5 history. LPN #3 stated she failed to develop the care plans due to an oversight. Interview with the Director of Nurses (DON) on 04/24/14, at 6:25 PM, revealed she was involved in the care planning process and changes in the care plan were discussed in the daily clinical meetings. The DON stated the history of positive PPDs should have been addressed in a care plan. The DON further stated she was not aware care plans had not been developed for residents with a history of positive PPDs. | F 279 | | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the pharmacist reported drug irregularities to the resident's attending physician and the Director of Nurses (DON) for two (2) of fifteen (15) sampled residents (Residents #8 and #9.) Residents #8 and #9 had physician's orders for antidepressant medications to be administered routinely; however, there was no evidence the consultant | F 428 | | | |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0936-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 04/24/2014 |
|--|--|--|--|--------------------------|--|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | | |
| (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 428 | Continued From page 6 pharmacist reviewed these medications for consideration for possible dosage reduction. The findings include: Review of the facility policy for Psychopharmacological Medication Use (revision date 01/01/13) revealed the facility would ensure the medication plan for residents would be reviewed and a gradual dose reduction (GDR) would be considered for psychopharmacological medications for the purpose of finding the lowest effective dose unless a GDR was clinically contraindicated. 1. Review of the medical record revealed the facility admitted Resident #9 on 07/01/12 with diagnoses including Hypertension, Psychosis, Alzheimer's Disease, and Esophageal Reflux. Review of the annual comprehensive MDS assessment for Resident #9 dated 01/27/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. In addition, the resident was assessed to exhibit no episodes of delirium or behaviors during the assessment reference period. The resident was further assessed to have mood indicators of "feeling down, depressed or hopeless" and to have trouble sleeping for two to six days during the assessment reference date. The resident was assessed to have a depression score of 3, which indicated the resident experienced minimal depression. Review of the physician's orders from August 2013 to April 2014 revealed the physician | F 428 | 1. Consultant Pharmacist has completed a medication regimen review for resident # 8 and resident # 9 for consideration of GDR. Medication regimen review was completed by Tim Jenkins, R.Ph, Consultant Pharmacist on 05/15/14. Recommendations received and forwarded to each resident attending physician for consideration. 2. 100% of all psychotropic medications, routine and PRN; including antidepressants, anti-anxiety, sedatives and antipsychotics to identify any resident who requires a GDR will be completed. Recommendations will be sent to attending physicians for consideration of GDR. 100 % audit to be completed by 05/30/14 by Tim Jenkins, R.Ph, Consultant Pharmacist. | 06/08/14 06/08/14 | |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|--|--|--|----------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 04/24/2014 |
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | | |
| (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 428 | <p>Continued From page 7</p> <p>prescribed 25 milligrams (mg) of Sertraline HCL (antidepressant medication) to be administered routinely for Resident #9 at bedtime.</p> <p>Review of the Consultant Pharmacist's reviews from August 2013 to April 2014 revealed the Pharmacist had conducted a monthly medication regimen review for Resident #9; however, there was no evidence the Pharmacist (RPh) had considered a GDR for Sertraline HCL during this time period.</p> <p>Further review of the pharmacy consultant reports revealed the most recent GDR for Sertraline HCL was dated 03/18/11.</p> <p>Interview with the Consultant Pharmacist on 04/24/14, at 5:45 PM, revealed he conducted monthly medication regimen reviews for residents at the facility. The Pharmacist stated he also reviewed the use of psychopharmacological medications and considered these medications for a GDR as indicated. According to the Pharmacist, he had focused on psychotropic and hypnotic medication use and had not considered dosage reduction for the antidepressant medication for Resident #9.</p> <p>2. Review of the medical record revealed the facility admitted Resident #8 on 09/13/12 with diagnoses that included Depression, Anxiety, Disorientation, Hypersomnia, and Paranoia. Review of the recent quarterly Minimum Data Set (MDS) dated 02/18/14 revealed the facility assessed Resident #8 to have a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. The MDS assessment revealed the resident had mood indicators of "feeling down, depressed or</p> | F 428 | <p>3. A GDR Tracking Log Book has been developed with a rotating calendar for residents receiving any psychotropic medication which requires GDR, routine and PRN. GDR Tracking Log Book to include a tracking log for every resident who receives any anti-psychotropic medication to track GDR dates for each medication to be used for cross reference with the monthly Consulting Pharmacist GDR Monthly Report. Consulting Pharmacist GDR Monthly Report are included in the log book., Pharmacist recommendations for GDR and copy of signed Recommendation from attending physician, copy of any resulting physician order. GDR Tracking Log Book will also contain a copy of any consulting Psych recommendation of psychotropic medication changes and any resulting physician orders for medication changes. Audit of GDR Tracking Log Book will be completed monthly by SSD & DON and reviewed during monthly QAPI meeting.</p> <p>4. QAPI Committee consisting of at least the Administrator, DON, ETD, ADON, SSD and the Medical Director to meet at least monthly beginning 6/2014 to review all audit findings and revise plan as indicated and needed. This will be ongoing until issue considered corrected.</p> <p>5. Date of Compliance 06/08/14.</p> | 06/08/14 | |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 04/24/2014 |
|--|---|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | | |
| (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 428 | <p>Continued From page 8</p> <p>hopeless" for two to six days during the assessment period. The resident was assessed to have "trouble falling asleep or staying asleep, or sleeping too much" for seven to eleven days during the assessment period. The MDS also revealed the resident had a "poor appetite or overeating" for seven to eleven days during the assessment period. In addition, the facility assessed the resident to have a score of 6 for depression which indicated the resident experienced mild depression.</p> <p>Review of the physician's orders revealed on 09/13/12, Resident #8's physician prescribed 15 mg of BuSpar (anti-anxiety medication) to be administered three times daily. Review of the physician's orders dated April 2014 revealed the physician continued to prescribe 15 mg of BuSpar three times daily.</p> <p>Review of the consultant pharmacy reviews from June 2013 to April 2014 revealed the pharmacist had conducted a monthly medication regimen review for Resident #8. However, there was no evidence the pharmacist had considered a Gradual Dose Reduction (GDR) for the BuSpar since the medication had been prescribed.</p> <p>Interview with the Consultant Pharmacist on 04/24/14 at 5:55 PM revealed he conducted monthly medication regimen reviews for residents at the facility. He stated that he also reviewed the use of psychopharmacological medications and psychotropic medications for a GDR. The Pharmacist stated that he had not made a GDR for the resident's BuSpar (anti-anxiety medication) because he had made a GDR for the resident's Celexa (antidepressant medication) recently (01/27/14) and did not want to reduce</p> | F 428 | | | |

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

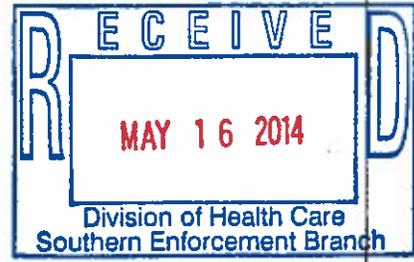
PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 04/24/2014 |
|--|--|--|---|----------------------|--|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1880 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | | |
| (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 428 | Continued From page 9 two psychotropic medications at the same time. | F 428 | | | |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 04/23/2014 |
|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLVILLE, KY 42718 | |
| (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 000 | INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1990 SURVEY UNDER: 2000 Existing (Short Form) FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (000) SMOKE COMPARTMENTS: Four FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system GENERATOR: Type II natural gas generator A life safety code survey was initiated and concluded on 04/23/14, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. | K 000 | "Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation." | |
| 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. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 | K 062 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nelda Beard TITLE: Administrator (X5) DATE: 5-16-14

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.

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 04/23/2014 |
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | |
| (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 062 | <p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain their sprinkler system by NFPA standards. This deficient practice affected four (4) of four (4) smoke compartments, staff, and all of the residents. The facility has the capacity for 67 beds with a census of 60 on the day of the survey.</p> <p>The findings include:</p> <p>An interview and record review on 04/23/14 at 10:45 AM, with the Director of Maintenance (DOM), revealed the facility's fire sprinkler system's interior pipe inspection was last completed on 09/27/07. This inspection is due every five years to ensure the sprinkler system is operating as intended.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> | K 062 | <ol style="list-style-type: none"> 1. A bid has been obtained from Armor Fire Protection Company for the facility's fire sprinkler system internal inspection. The bid proposal has been approved and scheduled for completion by 06/08/14 by Armor Fire Protection Company. 2. No other residents identified in the sample for the deficient practice. 3. Facility maintenance management system TELS, a web based system for Senior Living building management system. TELS provides daily, monthly due task list for facility life safety compliance, Scheduled Tasks, Work Orders, Equipment tracking, Loss Prevention, Education, reporting, and Emergency Plan modules. The completed sprinkler system internal inspection report will be scanned into the TELS system for tracking of next due date. TELS report printed and reviewed monthly in QAPI meeting. TELS maintenance management program completed by Ryan Arnett, Maintenance Director weekly. 4. QAPI Committee consisting of at least the Administrator, DON, ADON, ED/ Infection QA Nurse, Housekeeping Supervisor, Maintenance Director and the Medical Director to meet at least monthly beginning 6/2014 to review all TELS audit findings and revise plan as indicated and needed. This will be ongoing until issue considered corrected. 5. Date of Compliance 06/08/14. | 06/08/14 |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B WING _____ | (X3) DATE SURVEY COMPLETED 04/23/2014 |
|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLVILLE, KY 42718 | |
| (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 062 | Continued From page 2 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. | K 062 | | |
| K 070 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the safety of residents, staff, and other occupants of the building by allowing unapproved portable space heating units in office areas. This deficient practice affected two (2) of four (4) smoke compartments, staff, and approximately sixty (60) residents. The facility has the capacity for 67 beds with a census of 60 on the day of the survey. The findings include: Observation and interview on 04/23/14 at 9:15 AM with the Director of Maintenance (DOM), revealed a portable space heater in the office of the Therapy room. Facilities must provide factory documentation that the heater is approved for use in these areas. An interview with the DOM revealed he was not aware of the requirements | K 070 | | |

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

PRINTED: 05/08/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185330 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 04/23/2014 |
|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER CAMPBELLSVILLE NURSING AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718 | |
| (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 070 | Continued From page 3 for the proper use of portable space heaters. During the survey two portable space heaters were observed to be located in the Medical Records office. The findings were revealed to the Administrator upon exit. | K 070 | 1. Portable space heaters have been removed from therapy department and 2 from the medical records office removed. These were removed by Ryan Arnett, Maintenance Director on 04/24/14. 2 100% environmental facility round completed to identify any other space heaters in the facility; all heaters removed from the facility. Environmental facility round completed by Ryan Arnett, Maintenance Director on 04/25/14. 3. Environmental, housekeeping weekly rounds audits have been developed, to be completed weekly with Maintenance Director, Housekeeping Supervisor and NHA. Audit includes verifying no portable heaters in the facility. 4. Environmental weekly round audits to be presented by Ryan Arnett, Maintenance Director and reviewed during monthly QAPI meeting. QAPI Committee consisting of at least the Administrator, DON, ADON, ED/ Infection QA Nurse, Housekeeping Supervisor, Maintenance Director and the Medical Director to meet at least monthly beginning 6/2014 to review all audit findings and revise plan as indicated and needed. This will be ongoing until issue considered corrected. 5. Date of Compliance 06/08/14. | 06/08/14 |