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

PRINTED: 10/25/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | R<br>10/05/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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<br><br>An annual/abbreviated survey was conducted on 07/26/11 through 07/29/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of "G". Complaint KY #16127 was unsubstantiated with no deficiencies cited.<br><br>A re-visit survey was conducted on 10/04/11 through 10/05/11, and determined the facility corrected the deficiencies cited; however, the facility was found to remain out of compliance with a new deficiency cited at the highest S/S of a "D." | {F 000} | This plan of correction is submitted as the facility's credible allegation of compliance.<br><br>RECEIVED NOV 2011 OFFICE OF INSPECTOR GENERAL | |
| F 281<br>SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, it was determined the facility failed to follow the physician's order, for one resident (#36), not in the selected sample. The facility failed to obtain Resident #36's blood pressure prior to the administration of two (2) anti-hypertensive medications. | F 281 | F281 483.20(K)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>1. The corrective action accomplished for residents found to be affected by the deficient practice:<br>a. Resident # 36's blood pressure was taken after resident received medication. C.N.A. and L.P.N. found it to be within normal limits.<br>b. Licensed nurses/C.M.A's will obtain blood pressures prior to administration of anti-hypertensive medication with parameters.<br>2. Identification of other residents having the potential to be affected by the same deficient practice: | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Sandra J Dick | Deborah Houston RN DON | 11-7-11 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | R<br>10/05/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 281 | Continued From page 1<br>The findings include:<br><br>A record review revealed Resident #36 was admitted to the facility on 10/28/09 with a diagnosis to include Hypertension (high blood pressure).<br><br>A review of the physician's order, dated 10/01/11 through 10/31/11, revealed Zestril 20 milligrams (mg) one tablet by mouth (po) and Norvasc 5 mg po to be administered daily (qd) at 8:00 AM for Hypertension (HTN). Additionally, the physician's order revealed to withhold both medications if Resident #36's systolic blood pressure was less than or equal to 110 mm/hg.<br><br>An observation of a medication pass, on 10/05/11 at 7:35 AM, revealed Licensed Practical Nurse (LPN) #1 administered Zestril 20 mg po and Norvasc 5 mg po, without obtaining the resident's blood pressure.<br><br>An interview with LPN #1, on 10/05/11 at 7:40 AM, revealed, each morning, the Unit Coordinator made a list of the residents who required vital signs. A Certified Nurse Aide (CNA) was to obtain the vital signs and report to her if the resident's systolic blood pressure was at 110 mm/hg or below.<br><br>An interview with CNA #1, on 10/05/11 at 7:45 AM, revealed she received a list of residents for whom she was supposed to obtain vital signs. She stated she obtained vital signs that morning; however, Resident #36's name was not on her list, so Resident #36's vital signs were not obtained. An observation, of the CNA who did obtain Resident #36's blood pressure, revealed | F 281 | a. This was determined by reviewing all resident medication administration records for specific medication parameters.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Administrative staff reviewed current policy, "medication administration".<br>b. LPN who did not follow current policy for following physician orders was given a written corrective action by Director of Nursing.<br>c. Nursing Administration provided all licensed nurses and C.M.A's an in-service on medication administration, which included following physician orders and following general safety rules on 10/26/2011.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Nursing administration will monitor during weekly med pass audit for staff adherence to policy for following physician orders as it relates to obtaining blood pressure prior to administration of anti-hypertensive medication, on a weekly basis.<br>b. Weekly results will be given to Nursing Director.<br>c. Results of findings and corrective actions will be reported at quarterly Quality Assurance Committee meetings.<br>d. Action plans will be developed if indicated. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | R<br>10/05/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 281 | Continued From page 2<br>the systolic blood pressure was 127 mm/hg.<br><br>An interview with the Unit Coordinator for Nurse's Station #3, on 10/05/11 at 7:50 AM, revealed one of the nurses or herself made out a list each morning for the CNA. The list included residents who had to have vital signs taken due to receiving antibiotic therapy, being a skilled resident, being on oxygen or blood pressure medication, etc. She stated Resident #36's name must have been missed that day. | F 281 | "COMPLETION DATE"<br>5. The facility declares compliance with F281 deficiency effective 10/28/2011 | 10/28/2011 |

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

PRINTED: 08/12/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |
| NAME OF PROVIDER OR SUPPLIER<br>SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 | |

RECEIVED SEP 2011 OFFICE OF INSPECTOR GENERAL

| (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<br><br>An annual/abbreviated survey was conducted on 07/26/11 through 07/29/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of "G". Complaint KY #16127 was unsubstantiated with no deficiencies cited. | F 000 | This plan of correction is submitted as the facility's credible allegation of compliance. | |
| F 161<br>SS=D | 483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS<br><br>The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined the facility failed to ensure the surety bond was equal to or surpassed the amount of the residents' personal funds deposited with the facility to assure the security of all personal funds of all residents. The surety bond covered up to an amount of $10,000.00 and the sum of the Resident Accounts was $10,599.07.<br><br>The findings include:<br><br>A review of the facility's resident account fund bank statement revealed the facility currently had a total of $10,599.07 for a total of 34 residents in the account. Six (6) residents received Social Security checks and there were no Veterans' Administration (VA) accounts.<br><br>A review of the facility's surety bond revealed the | F 161 | F161 483.10(c)(7) SURETY BOND-SECURITY OF PERSONAL FUNDS<br><br>1. The corrective action accomplished for residents found to be affected by the deficient practice:<br>a. Facility purchased another $10,000.00 Surety bond for a total of $20,000.00 to assure security of all personal funds.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. This was determined by the resident census on 8/19/2011 and those having a resident trust account had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Administrative staff with Resident Trust Fund access were in-serviced on 8/18/2011. See attached in-service, surety bond and request for increase of surety bond and policy.<br>b. The facility will prevent reoccurrence by increasing the amount of the surety bond to be $20,000.00, which is an excessive | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra J Dick
TITLE: Administrator
(X6) DATE: 9-14-11

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 161 | Continued From page 1<br>amount of the surety bond would provide security for $10,000.00 of resident funds.<br><br>An interview with the Administrator, on 07/29/11 at 5:30 PM, revealed the facility just admitted a resident with a large amount of funds, which was transferred to Resident Accounts. In addition, a Social Security check recipient was due to have a check written out of this account to cover a bill due and the check had not been written at that time. The Administrator was not aware the funds were greater than the amount covered by the surety bond and stated the staff member responsible for the resident accounts was newly hired. The Administrator stated the staff member should have realized the account was $599.07 over the amount of coverage of the surety bond. | F 161 | balance.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Administration will perform weekly audits to ensure adherence to policy that funds are not greater than the amount covered by surety bond.<br>b. Results of findings will be reported at quarterly Quality Assurance Committee meetings.<br>c. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with F161 deficiency effective 8/22/2011 | 8/22/2011 |
| F 282<br>SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews and record reviews, the facility failed to adequately implement the written plan of care for two residents (#6 & #19) in the selected sample of twenty-seven, related to the use of safety alarms.<br><br>The findings include:<br><br>1. A record review revealed Resident #6 was admitted to the facility on 02/18/09 with diagnoses | F 282 | F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PESONS/PER CARE PLAN<br><br>1. The corrective action accomplished for residents found to be affected by the deficient practice:<br>a. Resident #6 and resident #19, written plans of care were reviewed by Station Three Unit Coordinator. The Unit Coordinator plugged in alarms and ensured proper function.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility and had alarms in place at the time had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 282 | Continued From page 2<br>to include Chronic Bronchitis, Chronic Obstructive Pulmonary Disease, History of Prostate Cancer, Failure to Thrive.<br><br>A review of a significant change Minimum Data Set (MDS) assessment, dated 04/27/11, revealed the facility assessed Resident #6 to have one fall with major injury and was at risk for falls. The facility assessed Resident #6 to require extensive assistance from the staff for mobility, dressing, eating, toilet use, personal hygiene and bathing. A review of a Comprehensive Care Plan, dated 07/22/11, revealed Resident #6 was care planned for potential falls related to a recent fall, weakness, decreased mobility, and a history of falls. Further review revealed an intervention for a bed alarm connected to the call light system to alert the staff of self-transfer.<br><br>A review of accident investigation form, dated 04/20/11, revealed Resident #6 sustained a fall at 7:05 PM. A review of a nurses' note, dated 04/20/11 at 7:25 PM, revealed Resident #6 was "found on the floor by the bedside next to the dresser, his/her head was bleeding. The resident was log-rolled holding C-spine for resident safety. A laceration/puncture was noted on his/her forehead." Resident # 6 was sent to the emergency room for evaluation/treatment and returned on 04/20/11 with a cervical collar in place and a diagnosis of a cervical (C1) fracture.<br><br>An observation, on 07/27/11 at 5:45 PM, revealed a bed mat alarm was under the resident, but did not function and the bed mat alarm was not hooked into the call light system as care planned, after the fall on 04/20/11. | F 282 | not recur:<br>a. Nursing staff was in-serviced on 8/18/2011 by D.O.N., A.D.O.N.s and R.N. Supervisor, regarding the subject: where employees reviewed and understood the policy regarding adequately implementing the written plan of care related to the use of safety alarms. The two policies reviewed were, 'Use of clinical alarms and medical equipment,' and 'Nurse Aide Care Plans.'<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Nursing administration will monitor nursing staff adherence to written plan of care related to the use of safety alarms on a weekly basis.<br>b. Weekly results will be given to Nursing Director.<br>c. Results of findings and corrective actions will be reported at quarterly Quality Assurance Committee meetings.<br>d. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>4. The facility declares compliance with F282 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 282 | Continued From page 3<br>Interviews with Unit Supervisor #1 and Licensed Practical Nurse (LPN) #8, on 07/27/11 at 5:45 PM, revealed the bed mat alarm was under the mattress; however, it did not function properly. The bed alarm was not hooked into the call light system as care planned, after the fall on 04/20/11, when Resident #6 sustained the cervical fracture.<br><br>Interviews with Certified Nurse Aides (CNAs) #7, #8 and #9, on 07/28/11 between 2:30 PM and 2:40 PM, revealed the staff checked the bed alarms and chair alarms at the beginning of each shift and during rounds. CNA #9 reported she did not check Resident #6's alarm on 07/27/11.<br><br>Interviews with CNA #4 and CNA #6, on 07/29/11 at 5:50 PM and 6:00 PM, respectively, revealed Resident #6 had a bed alarm, but they were unfamiliar with any bed alarm which went through the call light system.<br><br>An interview with the Assistant Maintenance Director, on 07/27/11 at 6:00 PM, 07/28/11 at 2:15 PM, and 07/28/11 at 3:20 PM, revealed he received work orders to request installation of a call light system bed alarm for Resident #6. He revealed that he hooked up the call light system bed alarm to Resident #6's bed, on 07/27/11 at approximately 6:00 PM. He stated he did not recall previously putting one in place for Resident #6. Furthermore, he stated they usually received a work order to put the alarm in place and was asked at the time to view a copy of the work order for initial placement of the call light system alarm. He was unable to provide documentation of a work order for the placement of a call light system alarm after the fall which occurred on 04/20/11. | F 282 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 282 | Continued From page 4<br><br>2. A record review revealed Resident #19 was admitted to the facility on 07/20/11 with diagnoses to include Urinary Tract Infection, Congestive Heart Failure, Hypertension, Coronary Artery Disease, Degenerative Disc Disease and Dementia.<br><br>The facility assessed Resident #19 to be at risk for falls upon admission and a wheelchair alarm and a bed alarm were added on 07/21/11. Resident #19 fell from the bed on 07/23/11 and an accident investigation form, dated 07/23/11 at 12:00 PM, revealed "the bed/chair alarms were in place, but not attached to the box."<br><br>An interview with Registered Nurse (RN) #2, on 07/29/11 at 5:35 PM, revealed Resident #19 was "the one who had the alarm which was not hooked in." She stated a Certified Nurse Aide told her the resident had the alarm, but it remained on the bedside table and was not attached to the box.<br><br>An interview with LPN #7, on 07/29/11 at 5:45 PM, revealed Resident #19's alarm was not connected at the time of his/her fall on 07/23/11. LPN #7 reported the alarm was not connected when the resident fell and sustained skin tears on the right and left forearm, the right ring finger and the left wrist.<br><br>An interview with CNA #4, on 07/29/11 at 4:10 PM, revealed she did an entire bed change for Resident #19 on 07/23/11 and she did not realize the bed alarm was not plugged in.<br><br>An interview with CNA #5, on 07/29/11 at 4:16 | F 282 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 282 | Continued From page 5<br>PM, revealed Resident #19's alarm was moved back and forth between the bed and the chair when the resident got up in the chair or requested to go back to bed.<br><br>An interview with Unit Supervisor #1, on 07/29/11 at 3:45 PM, revealed the alarm was not plugged in at the time of the incident on 07/23/11. She stated she expected the staff to follow the resident's plan of care and utilize the alarms as ordered. Additionally, she expected the staff to check the functioning of the alarms. | F 282 | | |
| F 315<br>SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, facility policy review, and record reviews, it was determined the facility failed to provide appropriate treatment and services to prevent urinary tract infections for two residents (#12 & #19), in the selected sample of twenty-seven, and for one resident (A), not in the selected sample. Observations of staff during provision of catheter care, for Residents #12 and A, revealed the Certified Nurse Aide (CNA) | F 315 | F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>1. The corrective action accomplished for residents found to be affected by the deficient practice:<br>a. Resident's # A received appropriate catheter care as C.N.A. cleaned the catheter away from the resident, proximal to distal direction and changed cloths each time.<br>b. Resident # 12 received appropriate catheter care as C.N.A. cleaned the catheter away from the resident (proximal to distal) direction and changed cloths each time.<br>c. Resident # 19 also received appropriate catheter care and his catheter bag was attached to the bed off of the floor and placed in a privacy bag.<br>2. Identification of other residents having the potential to be affected by the same deficient practice: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 315 | Continued From page 6<br>cleaned the catheter toward the resident's meatus and wiped back and forth in the groin area without changing the area of the cloth. The CNA used the same wipes to clean the resident's indwelling catheter without changing the area. Further observation revealed Resident #19's foley catheter was not secured to his/her leg and the resident was pulling on the catheter tubing.<br><br>The findings include:<br><br>A review of the facility's policy/procedure, "Catheter Care," dated November 2010, revealed "clean perineal tissue for a female resident with the dominant hand, clean the labia majora from anterior to posterior. Repeat the process using a clean section of the washcloth each time when cleansing. For the male resident, cleanse around the catheter first, then using a clean section of the washcloth, wipe in a circular motion around the meatus and the glans. Clean the exposed catheter with soap and water or the appropriate cleanser by wiping away from the meatus in a proximal to distal direction."<br><br>1. A record review revealed Resident A was admitted to the facility with diagnoses to include/ Dementia, Paraplegia and Lumbar Laminectomy.<br><br>Observation of incontinent care, on 07/26/11 at 2:28 PM, revealed CNA #3 provided catheter care for the resident. CNA #3 was observed to have wipes in his hand and wiped back and forth in Resident A's left and right groin without changing the area of the wipes. Additionally, CNA #3 was observed to use the same wipes in his hand to wipe the resident's indwelling catheter. | F 315 | a. All residents who reside in the facility and had catheters had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. D.O.N., A.D.O.N.s and R.N. Supervisor in-serviced on 8/18/2011 regarding catheter care and providing appropriate treatment and services to prevent UTI's and proper placement of catheter bags. Facility policy, 'Catheter care and emptying of the closed urinary collection system' and 'Urinary drainage bags, cleaning of' reviewed. See attached.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Nursing administration will monitor weekly adherence to policy by conducting observation of resident's catheter care and appropriate placement and positions of catheter bags.<br>b. Weekly results will be given to Nursing Director.<br>c. Results of findings and corrective actions will be reported at quarterly Quality Assurance Committee meetings.<br>d. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with F315 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 315 | Continued From page 7 | F 315 | | |
| | An interview with CNA #3, on 07/27/11 at 12:45 PM, revealed he realized the provision of catheter care was inappropriate. He stated when cleaning the resident's groin area, he failed to change the area of the wipe and wiped back and forth in the resident's left and right groin. CNA #3 stated he did not wipe away from the resident when he cleaned his/her catheter. He stated "I know what to do when completing catheter care. We are supposed to change areas of the cloth each time we wipe. We are supposed to wipe away from the resident when we are cleaning the catheter." | | | |
| | An interview with the Unit Supervisor, on 7/27/11 at 12:40 PM, revealed she preferred the staff to use a separate cloth to clean the groin area. She stated the staff should start at the meatus and wipe away from the resident. The staff should change the area of the cloth with each wipe. | | | |
| | 2. A record review revealed Resident #12 was admitted to the facility on 06/08/11 with diagnoses to include Right Hip Fracture Post Hemiarthroplasty, Atrial Fibrillation and Urinary Tract Infection. | | | |
| | A review of the admission MDS, dated 06/21/11, revealed Resident #12 was assessed to be severely cognitively impaired and required extensive assistance with mobility and transfers. | | | |
| | A review of the comprehensive care plan, undated, revealed a 18 French Foley Catheter was to be in place for wound healing. | | | |
| | An observation of catheter care, on 07/27/11 at 9:00 AM, revealed CNA #7 used a soapy | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 315 | Continued From page 8 washcloth to clean the catheter from the distal part in the direction of the resident (proximal).<br><br>An interview with CNA #7, on 07/27/11 at 9:20 AM, revealed she had received catheter care training. She stated she should clean the catheter away from the resident (proximal to distal direction).<br><br>An interview with Unit Supervisor #2, on 07/27/11 at 9:30 AM, revealed she was made aware of the error in technique by CNA #7. She expected the CNA to clean the catheter away from the resident (proximal to distal direction).<br><br>An interview with the Assistant Director of Nursing (ADON), on 07/28/11 at 5:35 PM, revealed she expected the CNA to clean the catheter away from the resident (proximal to distal direction).<br><br>3. A record review revealed Resident #19 was admitted to the facility on 07/20/11 with diagnoses to include current Urinary Tract Infection, Congestive Heart Failure, Dementia, Coronary Artery Disease and Hypertension. Admission Nursing Care Plan dated 07/20/11 revealed that facility assessed Resident #19 to require staff assist of two for ambulation, dressing, grooming, bed mobility; he was incontinent of bowel and had foley catheter.<br><br>During the initial tour, on 07/26/11 at 3:45 PM, Resident #19's foley catheter bag and tubing were noted to be laying on the floor under his/her bed. The bag was not attached to the bed or covered appropriately and was laying on the floor. | F 315 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 315 | Continued From page 9<br>An observation, on 07/29/11 at 4:15 PM, revealed Resident #19 was sitting on the edge of the bed, uncovered from the waist down with only an adult brief in place. Resident #19 had a foley catheter in his/her hand and was pulling on the tubing. The foley catheter was not secured to his/her leg at the time.<br><br>An interview with LPN #7, on 07/29/11 at 5:45 PM, revealed when Resident #19 fell, on 07/23/11, he/she was found on the floor with his/her foley catheter stretched across the bed and the bag was attached to the opposite side of the bed. She stated she did not realize that he/she had a catheter and verbalized the foley catheter was not secured to Resident #19 at the time of the fall. LPN #7 stated the residents usually have a leg strap in place. | F 315 | | |
| F 323<br>SS=G | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure the residents' environment remained as free from accident hazards as is possible related to the failure to assess for the safe use of specialty mattresses for ten residents (#1, #2, #4, #6, #7, #17, #18, | F 323 | 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>1. The corrective action accomplished for residents found to be affected by the deficient practice:<br>a. Resident's # 1, #2, #4, #6, #7, #17, #18, #19, #21, and #22 have been assessed for the risk versus benefits for the safe use of the air mattresses.<br>b. Resident assessment includes reviewing if the resident attempts to exit bed and is a fall risk. Resident was also assessed for assistance with bed mobility and transfers. Updated skin assessment attached which includes specialty mattress | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 323 | Continued From page 10<br>#19, #21, and #22), in the selected sample of twenty-seven residents. Each of these residents were placed back on the specialty mattress with no evidence and assessment had been completed related to the safe use of the air mattress. The facility failed to thoroughly investigate to determine the causal factor for the falls and implement new interventions to prevent future falls.<br><br>The findings include:<br><br>1. A record review revealed Resident #6 was admitted to the facility on 02/18/09 with diagnoses to include Chronic Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), History of Prostate Cancer, Failure to Thrive.<br><br>A review of the quarterly Minimum Data Set (MDS) assessment, dated 07/22/11, revealed the facility assessed Resident #6 to require extensive assistance of two staff for bed mobility and toilet use. He/she required total dependence of one staff for dressing, eating, personal hygiene and bathing. Additionally, Resident #6 was frequently incontinent of bowel and bladder.<br><br>A review of the Comprehensive Care Plan, dated 07/22/11, revealed Resident #6 to be at risk for falls related to weakness, decreased mobility and history of falls.<br><br>Further record review revealed Resident #6 experienced four (4) falls from a specialty air mattress (EasyAir), dated 09/02/10 through 04/20/11, two falls were with injury. On 09/02/10 at 7:30 PM, Resident #6 attempted to self-transfer from the bed to a chair with no injury | F 323 | assessment.<br>c. Facility Fall Risk Program was reviewed with Risk Manager.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility and have specialty mattresses had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Nursing staff was in-serviced on 8/18/2011 by D.O.N., A.D.O.N.s and R.N. Supervisor to new policy for risks versus benefit assessment for specialty mattresses.<br>b. The weekly skin assessment has been updated to include the assessment of specialty beds. This includes a fall risk score, physical function assessment and risk versus benefits. See attached copy of skin assessment and specialty mattress policy.<br>c. Treatment nurses will be responsible for ongoing completion of assessments for risks versus benefits of specialty mattresses currently being used and those in future prior to implementation.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Nursing administration will monitor adherence to policy of air mattress slips and copies of completed assessments being submitted to Nursing Director on a daily basis. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 323 | Continued From page 11<br>noted. The facility added a bed alarm to the care plan at that time. An accident investigation form, dated 09/02/10, revealed resident had a previous history of falls with interventions of a low bed and his/her call light within reach. On 09/03/10 at 7:00 PM, Resident #6 attempted to self-transfer from his/her wheel chair back to the bed with no injury noted. An accident investigation form, dated 09/03/10, revealed an intervention was added for a pull alarm while up in chair.<br><br>A review of a nurses' note, dated 03/19/11 at 12:15 AM, revealed Resident #6 reported he/she was "reaching for the urinal and rolled out of the bed onto the floor." The resident was sent to the emergency room for an evaluation and treatment due to the skin tears on his/her right arm and a swollen right wrist. An accident investigation form, dated 03/19/11, listed the causative factor to be "resident was reaching for urinal." The facility added a pull away alarm to the bed on 03/19/11. Interventions in place at the time of the fall, on 03/19/11, were for the staff to place frequently used items within easy reach, the bed was to be in an appropriate position for safe transfer, staff assistance with all transfers and a pull away alarm in place to the wheelchair. On 04/20/11 at 7:05 PM, Resident #6 was found on the floor next to his/her dresser and was sent to the emergency room for an evaluation and treatment due to a laceration on his/her forehead. The resident sustained a cervical fracture and sutures to the forehead. A review of the Comprehensive Care Plan, dated 04/20/11, revealed an intervention was added for a bed alarm into the call light system.<br><br>Resident #6 was observed on a Plexus 2500 air | F 323 | b. Nursing Director will review assessments for completion and adherence to policy.<br>c. Results of findings and corrective actions will be reported at quarterly Quality Assurance Committee meetings.<br>d. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with F323 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 323 | Continued From page 12<br>mattress, on 07/26/11 at 3:50 PM , 07/27/11 at 9:15 AM, 07/28/11 at 4:14 PM, and 07/29/11 at 6:05 PM; he/she was on an EasyAir mattress at the time of his/her falls per the staff. Resident #6 was moved from an EasyAir mattress to the Plexus 2500 air mattress in May 2011, when he/she began receiving hospice services, related to a hospice contract.<br><br>Observations, on 07/26/11 at 3:50 PM, 07/27/11 at 9:15 AM, 07/28/11 at 4:14 PM and 07/29/11 at 6:05 PM, revealed Resident #6 to be lying on a Plexus 2500 air mattress.<br><br>An observation, on 07/27/11 at 5:45 PM, revealed a bed mat alarm was under the resident, but did not function when the staff tested it and the bed mat alarm was not hooked into the call light system as care planned, after the fall on 04/20/11.<br><br>Interview with Unit Supervisor #1 and Licensed Practical Nurse (LPN) #8, on 07/27/11 at 5:45 PM, revealed the bed mat alarm was placed under Resident #6 but did not function. The bed alarm was not hooked into the call light system as care planned, after the fall on 04/20/11, when Resident #6 sustained the cervical fracture.<br><br>A record review revealed there was no documented evidence Resident #6 was assessed for the safe use of a specialty air mattress.<br><br>2. A record review revealed Resident #19 was admitted to the facility on 07/20/11 with diagnoses to include Dementia, Osteoarthritis, Hypertension, Anemia and Back Pain. | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 323 | Continued From page 13<br>A review of the admission Nursing Care Plan, dated 07/20/11, revealed Resident #19 was disoriented and required the assistance of two staff with ambulation and transfer. He/she required staff assistance with positioning, dressing, and grooming and was incontinent of bowel.<br><br>A review of a nurses' note, dated 07/20/11 at 4:56 PM, revealed Resident #19 "was fearful of falling" at the time of admission. He/she grabbed the therapists' arms and stated " I'm falling, I'm falling."<br><br>Further review of a nurses' note, dated 07/23/11 at 12:00 PM, revealed Resident #19 was found "laying beside his/her bed on his/her left side on the floor". He/she was noted to have skin tears on his/her left forearm, right forearm, right ring finger and left wrist.<br><br>A review of accident investigation form, dated 07/23/11 at 12:00 PM, revealed Resident #19's "bed/chair alarms were in place, but not attached to the box." The reason listed as to why the intervention was not successful was "alarms do not keep residents from falling." The accident investigation form revealed the mat was added to the left side of the bed. A review of the falls risk care plan, dated 07/23/11, did not reflect the bed and chair alarm or a mat on the left side of the bed as interventions.<br><br>Further record review revealed Resident #19 was assessed to be a falls risk upon admission; however, he/she was not care planned for falls until after his/her fall on 07/23/11. A review of the admission care plan, dated 07/20/11, revealed | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 323 | Continued From page 14 the bed alarm and chair alarm were added on 07/21/11. A review of a Resident Care Plan, dated 07/21/11, revealed the pressure reducing mattress was added due to a stage III pressure ulcer to the coccyx area. Resident #19 was not assessed for the safe use of the specialty air mattress before or after the fall on 07/23/11.<br><br>Observations, on 07/28/11 at 4:15 PM and 07/29/11 at 4:15 PM, revealed Resident #19 was lying on a specialty air mattress.<br><br>An interview with Certified Nurse Aide (CNA) #4, on 07/29/11 at 5:50 PM, revealed she completed an entire bed change for Resident #19 on 07/23/11 and did not realize his/her bed alarm was not "hooked up." She stated she checked the bed alarm and chair alarm when she arrived at work; however, she did not notice it was not connected on 07/23/11, the date of the fall.<br><br>An interview with Licensed Practical Nurse (LPN) #7, on 07/29/11 at 5:45 PM, revealed Resident #19 did not function well alone. She expressed concern about his/her confusion, about being very "busy" while in the bed and he/she did better with people around. She stated that Resident #19's alarm was not plugged in at the time of the incident on 07/23/11. She verbalized her expectation of the CNA was to check residents' bed alarms and chair alarms during rounds to ensure they functioned.<br><br>3. A record review revealed Resident #21 was admitted to the facility on 02/28/11 with diagnoses to include Alzheimer's Disease with Behavior Disturbance, Degenerative Joint Disease of the Spine, Osteoarthritis, Osteoporosis, Peripheral | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 323 | Continued From page 15<br>Neuropathy and Anxiety.<br><br>An annual MDS assessment, dated 06/20/11, revealed the facility assessed the resident to require total assistance with all Activities of Daily Living (ADLs). The resident was cognitively impaired and at increased risk for falls related to poor vision and poor decision-making skills. The resident required extensive assistance of two staff for bed mobility and transfers. He/she required extensive/total dependence with the assistance of two staff and was not able to follow directions at all times.<br><br>A review of the Resident #21's comprehensive care plan, dated 06/29/11, revealed potential for falls related to a history of falls, Dementia, unsteady balance and poor safety awareness.<br><br>A record review revealed, on 06/19/11 at 12:37 AM, Resident #21 was found on the mat next to his/her bed. The resident was assisted back to his/her specialty air mattress and then assisted into the wheel chair due to being wide awake and was brought to the nurses' station. Further review revealed there was no documented assessment for the safe use of an air mattress.<br><br>Observations, on 07/29/11 at 1:30 PM, 3:00 PM and 5:00 PM, revealed Resident #21 was resting on a specialty air mattress.<br><br>4. A record review revealed Resident #22 was admitted to the facility on 06/14/10 with diagnoses to include History of Stroke, Coronary Artery Disease, Dementia and Diabetes Mellitus.<br><br>A review of the quarterly MDS, dated 07/06/11, | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 323 | Continued From page 16 revealed the facility assessed the resident to be moderately cognitively impaired. The resident made poor decisions and required cues and supervision. The resident required extensive assistance of two staff and was totally dependent on the staff for ADLs.<br><br>A review of nurses' notes revealed, on 12/18/10 at 4:45 AM, Resident #22 was found sitting on the floor on the left side of his/her bed. The resident sustained no visible injuries and he/she was assisted back to bed with staff assistance and a mechanical lift. Further record review revealed there was no completed assessment for the safe use of the specialty mattress after the resident was found sitting on the floor.<br><br>An observation, on 07/28/11 at 9:55 AM, revealed he/she was sitting up in a chair with bilateral heel lift boots in place. Resident #22's bed was observed to have a specialty mattress (Easy Air Mattress), with the setting on rotating and the comfort level was set at "5".<br><br>5. A record review revealed Resident #1 was admitted to the facility on 05/13/11 with diagnoses to include History of Falls, Osteoporosis, Osteoarthritis, and Recurrent Urinary Tract Infection.<br><br>A review of the significant change MDS, dated 06/10/11, revealed the facility assessed Resident #1 to be severely cognitively impaired and his/her range of motion was impaired on one of his/her upper extremities.<br><br>A review of the Comprehensive Care Plan, dated 06/02/11, revealed the resident was a potential | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 323 | Continued From page 17<br>for falls related to a history of falls, unsteady balance, lack of coordination and decreased cognition.<br><br>A review of the nurses' notes, dated 07/18/11, revealed Resident #1 rolled out of the bed at 1:30 AM. The resident was assisted back to bed by staff. Further review revealed there was no assessment for the safe use of the specialty air mattress.<br><br>An observation, on 07/27/11 at 3:15 PM, revealed Resident #1 was lying on a specialty air mattress with settings of ROTATION-NORMAL and COMFORT LEVEL #3. Further observation, on 07/28/11 at 4:50 PM, revealed the resident was lying on a specialty air mattress with settings of ALTERNATING-NORMAL and COMFORT LEVEL #3.<br><br>6. A record review revealed Resident #17 was admitted to the facility on 08/05/10 with diagnoses to include Pneumonia, Heart Failure and Low Magnesium.<br><br>A review of the significant change MDS, dated 06/29/11, revealed the facility assessed Resident #17 to be cognitively independent and required extensive assistance with transfer and ambulation.<br><br>A review of the Comprehensive Care Plan, dated 04/14/11, revealed the resident was at risk for falls related to history of a fall, episodes of syncope and decline in functional mobility.<br><br>A review of the nurses' notes, dated 02/20/11, revealed Resident #17 slid off the low bed at 6:16 | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 323 | Continued From page 18<br>AM. The resident was assisted back to bed. Further review revealed there was no assessment for the safe use of the specialty air mattress.<br><br>An observation, on 07/28/11 at 2:40 PM, revealed Resident #17 was lying on a specialty air mattress with settings of COMFORT LEVEL #5.<br><br>7. A record review revealed Resident #4 was admitted to the facility on 09/29/06 with diagnoses to include History of a Fractured Pelvis, Rheumatoid Arthritis, Senile Dementia and Hypertension.<br><br>A review of the quarterly MDS, dated 06/29/11, revealed the facility assessed Resident #4 to be severely cognitively impaired and required extensive assistance with mobility and transfer.<br><br>A review of the Comprehensive Care Plan, dated 07/06/11, revealed the resident was at risk for falls related to a history of falls, restlessness, unsteady gait and unsteady balance.<br><br>A review of the nurses' notes, dated 05/20/11 at 9:00 PM, revealed Resident #4 was sitting on the left side of the bed with his/her legs stretched forward. A review of another nurses' note, dated 05/21/11 at 3:08 PM, revealed Resident #4 rolled out of the bed and was found on the gray mat by the bed. The resident was assisted back to the bed on both occasions. Further review revealed there was no assessment for the safe use of the specialty air mattress.<br><br>An observation, on 07/26/11 at 2:55 PM, revealed Resident #4 was lying on a specialty air mattress | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 323 | Continued From page 19 with settings of NORMAL AIR FLOAT and COMFORT LEVEL #4.<br><br>8. A record review revealed Resident #2 was admitted to the facility on 11/23/10 with diagnoses to include Cerebrovascular Accident with Residual Right Hemiparesis, Aphasia and Colon Cancer.<br><br>A review of the significant change MDS, dated 06/14/11, revealed the facilty assessed Resident #2 to be severely cognitively impaired. The resident required total care with all of his/her ADLs.<br><br>A review of the nurses' note, dated 07/23/11 at 7:17 AM, revealed Resident #2 fell from the bed. The resident was assisted back to bed by the staff. He/she received a one inch cut to his/her right eyebrow. Further review revealed there was no assessment for the safe use of the specialty air mattress.<br><br>An observation, on 07/27/11 at 9:00 AM, revealed Resident #2 was lying on a specialty air mattress with settings of ALTERNATING-NORMAL and COMFORT LEVEL #2.<br><br>9. A record review revealed Resident #7 was admitted to the facility on 01/13/11 with diagnoses to include Alzheimer's Disease, Dementia and Congestive Heart Failure.<br><br>A review of the significant change MDS, dated 06/09/11, revealed the facility assessed Resident #7 to have a BIMS score of four (4). Resident #7 was non-ambulatory and required extensive to total assistance with all ADLs. | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 323 | Continued From page 20 | F 323 | | |
| | A review of the Post Fall Assessment, dated 01/25/11 at 12:30 AM, revealed Resident #7 sat up on the side of his/her bed and attempted to transfer himself/herself and fell. A gray mat was placed on the right side of his/her bed. Further review revealed there was no assessment for the safe use of the specialty air mattress.<br><br>An observation, on 07/27/11 at 9:05 AM, revealed Resident #7 was lying on a specialty air mattress with a setting of 225.<br><br>10. A record review revealed Resident #18 was admitted to the facility on 01/10/11 with diagnoses to include Coronary Artery Disease, Dementia, Anxiety Disorder and Schizophrenia..<br><br>A review of the significant change MDS, dated 03/10/11, revealed the facility assessed Resident #18 to have a BIMS score of seven (7). Resident #18 required extensive assistance with all of his/her ADLs.<br><br>A review of the nurses' note, dated 03/10/11 at 1:30 AM, revealed Resident #18 fell from the bed. The resident was assisted back to his/her bed with a mechanical lift.<br><br>A review of the nurses' note, dated 04/19/11 at 5:00 AM, revealed Resident #18 rolled out of the bed. The resident was transferred back to his/her bed with a lift.<br><br>A review of the nurses' note, dated 05/11/11 at 11:06 PM, revealed Resident #18 was found on the floor next to his/her bed. The resident was transferred back to his/her bed with assistance of | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 323 | Continued From page 21<br>two staff and a lift.<br><br>A review of the nurses' note, dated 06/16/11 at 3:30 AM, revealed Resident #18 attempted to self-transfer from the bed. He/she was transferred back to bed.<br><br>A review of the nurses' note, dated 07/02/11 at 5:45 AM, revealed Resident #18 was found on the gray mat beside his/her bed. He/she attempted to self-transfer self from the bed, but was transferred back to the bed by the staff. Further review revealed there was no assessment for the safe use of the specialty air mattress following any of the five (5) falls.<br><br>Observations, on 07/26/11 at 2:55 PM and on 07/29/11 at 5:55 PM, revealed Resident #18 was lying on a specialty air mattress with settings of ALTERNATING-NORMAL and COMFORT LEVEL #2.<br><br>An interview with Treatment Nurse #1, on 07/29/11 at 12:15 PM, revealed "it was a nursing call as to what type of bed was to be used." Treatment Nurse #1 verbalized there was no specific form used to assess for risks versus benefits before using a specialty mattress. She stated settings for the specialty mattress were to be set on what the resident liked; however, there was no facility protocol to determine the settings.<br><br>Interviews with Treatment Nurse #2 and #3, on 07/29/11 at 1:10 PM, revealed the Treatment Nurses were responsible to determine who required a specialty mattress. Treatment Nurse #2 and #3 stated it was nursing judgement as to what type of bed was used. They were not aware | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 323 | Continued From page 22 of any type of assessment to be completed prior to placement of a resident on a specialty air mattress.<br><br>Interviews with members of the Falls Committee which included Unit Supervisor #3, Minimum Data Set (MDS) LPN, Social Worker, Assistant Director of Nursing (ADON), and the Administrator, on 07/29/11 at 2:55 PM, revealed there was no assessment currently in place for the specialty mattress. The Administrator stated the ADON and Unit Supervisor #3 were working on a policy, "Safety issues related to Specialty Beds and Bed Rails," but the policy was not completed and was not currently being implemented. It was reported no training was completed as of yet related to the identification of a safety concern with the specialty mattresses. When questioned if anyone assessed to see if residents felt unsafe in bed, had a fear of falling, felt unstable, or whether or not the specialty bed enabled a fall, it was reported no assessment was completed for the use of the specialty mattress at that point.<br><br>An interview with the Administrator, on 07/28/11 at 3:00 PM, revealed no assessments were conducted to address the risks verses benefits for the safe use of the air mattresses. She stated, "I have not considered the air mattresses a fall risk until now". | F 323 | | |
| F 332<br>SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater. | F 332 | F332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>1. The corrective action accomplished for residents found to be affected by the deficient practice: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 332 | Continued From page 23<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and interviews, it was determined the facility failed to ensure that it was free of medication error rates of 5% or greater. A total of 49 opportunities were observed with three (3) medication errors, which affected two residents (#10 & #12), in the selected sample of twenty-seven residents. The facility's medication error rate was six percent (6%).<br><br>The findings include:<br><br>1. A record review revealed Resident #10 was admitted to the facility with diagnoses to include End Stage Renal Disease, Hypertension and Congestive Heart Failure.<br><br>A review of the physician's orders, dated 07/01/11 through 07/31/11, revealed an order for Midodrine (ProAmatine), which is a medication for raising blood pressure, 10 milligrams (mg) three times a day (TID) at 8:00 AM, 12:00 PM and 4:00 PM.<br><br>An observation during the medication pass, on 07/27/11 at 3:42 PM, revealed Licensed Practical Nurse (LPN) #6 did not administer Midodrine (ProAmatine) 10 mg tablet as ordered. A Certified Nurse Aide (CNA) checked the resident's blood pressure at that time and it was 160/88.<br><br>An interview with LPN #6, on 07/27/11 at 2:16 PM, revealed she withheld the resident's Midodrine (ProAmatine) due to his/her blood pressure being elevated. She was expected to | F 332 | a. Resident #10 and #12, physician orders for medications were assessed by Station One Unit Coordinator on 07/26/2011, 7/27/2011 and 8/9/11 and Physician contacted for review of medication discrepancies and any new orders by Station One LPNs and RNs.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility and receive medication had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Nursing staff was in-serviced on 8/18/2011 by D.O.N., A.D.O.N.s and R.N. Supervisor to facility Medication Administration Policy for appropriate medication administration including notification of M.D. if medication is omitted/held/ refused. See Medication Administration Policy attached.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Nursing administration/pharmacist will monitor medication passes on a weekly basis and adherence to facility policy. See attached.<br>b. Weekly results will be given to Nursing Director.<br>c. Results of findings and corrective actions will be reported at quarterly Quality Assurance Committee meetings. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 332 | Continued From page 24<br>administer the residents' medications, as ordered by the physician. LPN #6 stated the medication was part of his/her regimen; however, there were no established parameters to direct the staff as to when to withhold the medication.<br><br>An observation during a medication pass, on 07/28/11 at 7:35 AM, revealed LPN #4 did not administer Midodrine (ProAmatine) 10 mg tablet as ordered. Resident #10's blood pressure was checked and noted to be 159/91, therefore, LPN #4 withheld the medication.<br><br>An interview with LPN #4, on 07/28/11 at 10:05 AM, revealed she did not administer the Midodrine (ProAmatine). She stated there were no established parameters to withhold the medication; however, she used her nursing judgement when it came to administration of the resident's blood pressure medication. She stated the medication was ordered when he/she returned from the hospital and the resident had problems with low blood pressure. LPN #4 stated she was expected to follow the physician's order and contact the physician when the resident's condition changed.<br><br>Further review of the physician's orders revealed there were no established parameters to direct the staff as to when to withhold the medication.<br><br>An interview with the Unit Supervisor, on 07/27/11 at 12:40 PM, revealed the nurses were to administer the medication as ordered by the physician. When the nurses circled their initials on the Medication Administration Record (MAR), this indicated the medication was not administered. The nurses should notify the | F 332 | d. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with F332 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 332 | Continued From page 25<br>physician related to the resident's elevated blood pressure and receive direction about what they need to do next. They were expected to contact the physician when a medication was to be withheld and document the information in the nurses' notes.<br><br>2. A record review revealed Resident #12 was admitted to the facility on 06/08/11 with a diagnosis to include Right Hip Fracture.<br><br>A review of the admission MDS, dated 06/21/11, revealed Resident #12 to be severely cognitively impaired.<br><br>A review of the medication administration record (MAR), dated 07/22/11, revealed an order for Norco 5/325 mg two (2) tablets at 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM, with an additional order to administer Norco 5/325 mg two (2) tablets every four hours as needed (PRN) for pain.<br><br>An observation, on 07/26/11 at 3:35 PM, revealed LPN #1 administered Norco 5/325 mg one (1) tablet to Resident #12. LPN #1 initialed the 6:00 PM dose, on the MAR, as given at this time.<br><br>An interview with LPN #1, on 07/26/11 at 4:55 PM, revealed Resident #12 was "overly sedated" on 07/25/11, and she withheld the resident's medications at that time. LPN #1 revealed, during the medication pass on 07/26/11, the resident was able to verbalize pain and only administered Norco 5/325 mg one (1) tablet instead of two (2) tablets, because she did not want to sedate the resident. Additionally, she stated the physician was not notified. | F 332 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 332 | Continued From page 26<br><br>An interview with Unit Supervisor #2, on 07/29/11 at 5:00 PM, revealed she expected the physician to be notified if medication was not administered according to the physicians' orders. The medication should be administered one hour before or one hour after the scheduled time indicated on the MAR. | F 332 | | |
| F 371<br>SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions related to unlabeled and undated bags of food in the freezer, an accumulation of blackened substances noted on the stove drip tray, deep fryer backsplash and brown and rust colored substances splattered on the range hood. In addition, there were areas of debré and a buildup of discoloration on the floors and grouted areas under appliances and throughout the walkways in the kitchen.<br><br>A review of the Census and Condition form, dated | F 371 | F371 483.35(i) FOOD PROCURE, STORE/PREPARE/ERVE-SANITARY<br><br>1. The corrective action accomplished for residents found to be affected by the deficient practice:<br>a. No residents were found to be affected by deficient practice.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility and eat prepared food from the dietary department had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Dietary staff in-serviced by Dietary Manager, on 8/19/2011 regarding facility cleaning and labeling policy to store, prepare, distribute and serve food under sanitary conditions.<br>b. Dietary staff in-serviced regarding cleanliness of kitchen area.<br>c. Dietary staff has cleaned the store drip tray on convection oven doors, walls, deep fryer back splash, range hood and above | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/29/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 371 | Continued From page 27<br>07/26/11, revealed the facility census was 177. It was determined 175 of 177 residents were served food stored and prepared in the facility's kitchen. \<br><br>The findings include:<br><br>1. An observation of the refrigerator and freezer shelves, on 07/26/11 at 3:40 PM, revealed three (3) large bags of chicken strips, two (2) bags of diced onions and a large bag of biscuits which were unlabeled and undated.<br><br>An interview with the Dietary Manager, on 07/26/11 at 3:45 PM, revealed the dietary staff members were aware that food placed in storage bags in the refrigerator or freezer should be labeled and dated. She was unsure why this was not done.<br><br>2. An observation of the cooking surfaces, on 07/27/11 at 12:20 PM, revealed a build-up of a blackened substance on the stove drip tray, on the convection oven doors and walls and on the deep fryer back splash. Additionally, there were streaks and drips of a brown-colored substance on the range hood and over the stove.<br><br>An interview with the Dietary Manager, on 07/29/11 at 4:10 PM, revealed the blackened surfaces were cleaned, but the facility was unable to completely remove the build-up.<br><br>3. An observation of the kitchen and food service areas, on 07/26-29/11, revealed dirt and debris on the flooring surfaces and dark discoloration of the tile grout throughout pathways and edges around the appliances. There was a rust-colored | F 371 | stove and floor.<br>d. Kitchen floor was professionally cleaned on 8/22/11.<br>e. Facility contracting professional floor care company for monthly service on 8/22/2011.<br>f. Commercial cleaning company cleaned hood, duct, fans and filters on 8/24/11.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Administration will weekly monitor adherence to policies in regard to labeling and dating of items in the kitchen as wells as cleanliness of the kitchen.<br>b. Weekly results will be given to Dietary Manager.<br>c. Results of findings and corrective actions will be reported at quarterly Quality Assurance Committee meetings.<br>d. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with F371 deficiency effective ~~8/24/2011~~ 8/25/11 | ~~8/24/2011~~ 8/25/11 per phone conversation w SD-Adm. CM |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 07/29/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 371 | Continued From page 28 substance noted on the floor, around the juice and dessert cooler and patches of water by the freezer doorway.<br><br>An interview with the Dietary Manager, on 07/27/11 at 12:10 PM, revealed the floor was mopped after each shift and cleaned monthly, but was never deep cleaned, pressure washed or professionally cleaned. | F 371 | | |

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

PRINTED: 08/12/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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<br><br>CFR: 42 CFR 483.70(a)<br><br>BUILDING: 01<br><br>PLAN APPROVAL: 1964,1971,1983,2006<br><br>SURVEY UNDER: 2000 Existing<br><br>FACILITY TYPE: SNF/NF<br><br>TYPE OF STRUCTURE: One (1) story, Type V Unprotected<br><br>SMOKE COMPARTMENTS: Nine (9) smoke compartments<br><br>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.<br><br>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.<br><br>GENERATOR: Type II generator installed in 2006. Fuel source is diesel.<br><br>A standard Life Safety Code survey was initiated on 07/27/11, and concluded on 07/28/11. Spring Creek Healthcare was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from | K 000 | RECEIVED AUG 2011 OFFICE OF INSPECTOR GENERAL | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra J Dick
TITLE: Administrator
(X6) DATE: 8-19-11

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 | Continued From page 1<br>Fire)<br><br>Deficiencies were cited with the highest deficiency identified at F level.<br>CFR: 42 CFR 483.70(a) | K 000 | | |
| K 018<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>/<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, according to NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, | K 018 | K018 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for resident room doors #102, #106, #226, #227 AND #216:<br>a. Repaired doors so they would latch.<br>b. Moved trash can.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Maintenance staff in-serviced regarding the importance of no impediments to the closing of corridor doors.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Maintenance will monitor doors for compliance by conducting visual rounds and latch doors for no impediments.<br>b. Weekly results will be maintained in a log book.<br>c. Results of findings will be reported at quarterly Quality Assurance Committee meetings. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 018 | Continued From page 2<br>residents, staff,and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 07/27/11 between 12:30 PM and 6:00 PM, with the Maintenance Staff and the Administrator revealed the corridor door to rooms 102, 106, 226, 227, did not latch. The corridor door to room 216 was held open with a trash can.<br><br>Interview, on 07/27/11 between 12:30 PM and 6:00 PM, with the Maintenance Staff and the Administrator confirmed the observations.<br><br>Reference: NFPA 101 (2000 edition)<br>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shallbe constructed to resist the passage of smoke. Compliancewith NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.<br>Exception No. 1: Doors to toilet rooms, | K 018 | d. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K018 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 018 | Continued From page 3<br>bathrooms, shower rooms, sink closets, and similar<br>auxiliary spaces that do not contain flammable or combustible materials.<br>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.<br>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.<br>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar<br>auxiliary spaces that do not contain flammable or combustible materials.<br>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in<br>service.<br><br>19.3.6.3.3*<br>Hold-open devices that release when the door is pushed or pulled shall be permitted.<br><br>A.19.3.6.3.3 | K 018 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 018 | Continued From page 4<br>Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches. | K 018 | | |
| K 025<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoke barriers are constructed to provide at least a one half 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 and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include: | K 025 | K025 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. No residents were affected by deficient practice.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>b. Facility now has smoke barriers that would resist passage of smoke between smoke compartments per NFPA standards in attic.<br>c. Maintenance will visually check barriers to ensure compliance.<br><br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Maintenance will monitor adherence to NFPA standards by visually checking barriers to ensure compliance.<br>b. Weekly results will be maintained | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 025 | Continued From page 5<br><br>Observation, on 07/28/11 at 8:00 AM, with the Maintenance Staff revealed the smoke partitions extended above the ceiling and located throughout the facility were noted to have penetrations by wires. Qwik Foam had been used in some areas to seal penetrations. The spaces around the wire penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.<br><br>Interview, on 07/28/11 at 8:00 AM, with the Maintenance Staff revealed he was unaware of the penetrations, and not sure who had used the Qwik Foam, in the smoke partitions.<br><br>Reference: NFPA 101 (2000 Edition).<br><br>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:<br>(a) The space between the penetrating item and the smoke barrier shall<br>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or<br>2. Be protected by an approved device designed for the specific purpose.<br>(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<br>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or<br>2. Be protected by an approved device designed | K 025 | in a log book.<br>c. Results of findings will be reported at quarterly Quality Assurance Committee meetings.<br>d. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K025 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAC | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 025 | Continued From page 6<br>for the specific purpose.<br>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall<br>1. Be made on either side of the smoke barrier, or<br>2. Be made by an approved device designed for the specific purpose. | K 025 | | |
| K 027<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Door openings in smoke barriers have at least a 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. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure access doors in smoke barriers were installed to meet NFPA Standard. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff, and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 07/28/11 at 8:05 AM, with the | K 027 | K027 NFPA 101 LIFE SAFETY CODE<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. No residents were affected by deficient practice.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be affected by the deficient practice<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Facility has ordered and will install approved access doors in smoke barrier areas to meet NFPA standard.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Maintenance will adhere to NFPA standards by visually checking doors in attic to ensure compliance.<br>b. Weekly results will be maintained in a log book.<br>c. Results of findings will be reported at quarterly Quality Assurance Committee meetings.<br>d. Action plans will be developed if indicated. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 027 | Continued From page 7<br>Maintenance Staff revealed unrated homemade smoke barrier access doors located in the attic.<br><br>Interview, on 07/28/11 at 8:05 AM, with the Maintenance Staff confirmed the observation and indicated he was unaware that the doors in the attic must be rated for use.<br><br>Reference: NFPA 101 (2000 Edition)<br>19.3.7.3<br>Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.<br><br>Continuity 8.3.2<br>Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. | K 027 | "COMPLETION DATE"<br>5. The facility declares compliance with K027 deficiency effective 9/01/2011 | 9/01/2011 |
| K 050<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 | K 050 | K050 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. No residents were affected by deficient practice.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 07/28/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 050 | Continued From page 8<br><br>This STANDARD is not met as evidenced by: Based on interview and fire drill review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include:<br><br>Fire Drill review, on 07/27/11 at 1:30 PM, with the Maintenance Staff, and the Administrator revealed the fire drills were not being conducted at unexpected times under varied conditions.<br><br>Interview, on 07/27/11 at 1:30 PM, with the Maintenance Staff, and the Administrator revealed they were unaware the fire drills were not being conducted as required.<br><br>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. | K 050 | not recur:<br>a. Maintenance in-serviced to NFPA standard 101 19.7.1.2.<br><br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Fire drills will be presented at monthly safety meetings to ensure NFPA 101 19.7.1.2. will be followed.<br>b. Results of findings will be reported at quarterly Quality Improvement Committee meetings.<br>c. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K050 deficiency effective 8/22/2011 | 8/22/2011 |
| K 056<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the | K 056 | K056 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. No residents were affected by deficient practice.<br>2. Identification of other residents having | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | (X3) DATE SURVEY COMPLETED 07/28/2011 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071 | |

| (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 056 | Continued From page 9<br>Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff, and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 07/27/11 between 12:30 PM and 5:30 PM, with the Maintenance Staff and the Administrator revealed eleven (11) porches located outside exit doors throughout the facility to extend out four (4) foot or greater, made of combustible materials, and were not sprinkler protected.<br><br>Interview, on 07/28/11 at 9:00 AM, with the Maintenance Staff confirmed the observation, by verifying all porch measurements with a tape measure. | K 056 | the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Porches located outside exit doors throughout facility to extend out 4ft or greater will be sprinkled according to NFPA standards.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Maintenance will maintain sprinklers according to NFPA standards<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K056 deficiency effective 9/26/2011<br><br>A bid has been received by West Kentucky Sprinklers and has been contracted to complete this work. A copy of the contract will b forwarded to you next week. Contractor unable to complete project until 9/26/11 due to other demands. Administration notified Jim in Louisville Office. | 9/26/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 056 | Continued From page 10<br><br>Observation, on 07/27/11 at 4:40 PM, with the Maintenance Staff revealed a walk-in cooler located in the Kitchen, was not sprinkler protected.<br><br>Interview, on 07/27/11 at 4:40 PM, with the Maintenance Staff revealed he was unaware the walk-in cooler was required to be sprinkler protected.<br><br>Reference: NFPA 13 (1999 Edition) 5-13 8.1<br><br>Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.<br><br>Reference: NFPA 13 (1999 Edition) | K 056 | | |
| K 062<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of | K 062 | K062 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. No residents were affected by deficient practice.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 11<br>one hundred seventy seven (177) on the day of the survey.<br><br>The Findings Include:<br><br>Observation, on 07/27/11 at 2:15 PM, with the Maintenance Staff and the Administrator revealed items being stored within 18 inches of a sprinkler head located in the Med Room and Activities Storage, Station 2.<br><br>Interview, on 07/27/11 at 2:15 PM, with the Maintenance Staff and the Administrator confirmed the observations.<br><br>Observation, on 07/28/11 at 8:10 AM, with the Maintenance Staff revealed electrical and data wiring hanging from attic sprinkler piping located in the attic above Station 2.<br><br>Interview, on 07/28/11 at 8:10 AM, with the Maintenance Staff confirmed the observation.<br><br>Reference: NFPA 13 (1999 Edition)<br><br>5-5.5.2* Obstructions to Sprinkler Discharge | K 062 | a. Findings were repaired day of visit for moving items stored.<br>b. Electrical and data wiring has been repaired.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Maintenance will monitor sprinkler to ensure systems are continuously maintained in reliable operating conditions and free of items 18 inches from ceiling.<br>b. Logs will be maintained by maintenance.<br>c. Results of findings will be reported at quarterly Quality Assurance Committee meetings.<br>d. Action plans will be developed if indicated.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K062 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 12<br>Pattern Development.<br>5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.<br><br>Reference: NFPA 13(1999 edition)<br><br>6-1.1.5 Sprinkler piping or hangers shall not be used to support nonsystem components.<br><br>Reference: NFPA 25 (1999 Edition).<br><br>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. | K 062 | | |
| K 070<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by: | K 070 | K070 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. No residents were affected by deficient practice.<br>2. Identification of other residents having the potential to be affected by the same deficient practice: | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 13<br>Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were according to NFPA standards. The deficiency had the potential to affect three (3) of nine (9) smoke compartments, residents, staff and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 07/27/11 between 12:30 PM and 5:50 PM, with the Maintenance Staff, and the Administrator revealed portable space heaters located in the Administrators Office, MDS Coordinator Office, Nutrition Office, and the Marketing Representatives Office.<br><br>Interview, on 07/27/11 between 12:30 PM and 5:50 PM, with the Maintenance Staff, and the Administrator revealed, they were unaware the heaters could not exceed 212 degrees, and had no documentation on the heaters. Interview also revealed they thought the heaters were compliant, because a previous inspector had approved the heaters. They had no documentation from the previous inspector to confirm the approval.<br><br>Reference: NFPA 101 (2000 edition)<br>19.7.8 Portable Space-Heating Devices. Portable space-heating<br>devices shall be prohibited in all health care occupancies.<br>Exception: Portable space-heating devices shall | K 070 | a. All residents who reside in the facility had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Space heaters have been removed from office areas.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Maintenance will be responsible for assessing any portable space heaters for appropriate documentation of acceptable heaters that do not exceed 212°F (100°C). for use in non-sleeping staff and employee areas.<br>b. Maintenance will maintain a log with approve heaters in use and their locations.<br>c. Any variances and correction of use of heaters will be reported at safety meetings.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K070 deficiency effective 8/22/2011<br><br>/ | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 14<br>be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). | K 070 | | |
| K 130<br>SS=E | NFPA 101 MISCELLANEOUS<br><br>OTHER LSC DEFICIENCY NOT ON 2786<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This deficiency had the potential to affect three (3) of nine (9) smoke compartments, residents, staff, and visitors. The facility is licensed for two hundred twenty six (226) beds, with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 07/27/11between 12:30 PM and 5:30 PM, with the Maintenance Staff and the Administrator revealed an unapproved lock (slide bolt type) was installed on the egress side of doors located in the Beauty Shop #2, Station 2, Kitchen door to the Dining Room, Station 4, Nourishment, clean utility G room, station 4, and the Admissions Office bathroom door, Station 4.<br><br>Interview, on 07/27/11 between 12:30 AM and 5:30 PM, with the Maintenance Staff and the Administrator revealed they were aware of the locks, but not aware they could not be used. | K 130 | K130 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. No residents were affected by deficient practice.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. All unapproved (slide bolt) locks have been removed.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Maintenance will visually monitor the doors when making rounds to ensure locks have not been replaced as maintenance is responsible for all locks.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K130 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 130 | Continued From page 15<br><br>Reference: NFPA 101 (2000 Edition) 19.2.2.2.4<br><br>Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. | K 130 | | |
| K 147<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect four (4) of nine (9) smoke compartments, residents, staff, and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 07/27/11 between 1:30 PM and 5:50 PM, with the Maintenance Staff, and the Administrator revealed:<br><br>1) A refrigerator plugged into a power strip in the Social Services Office.<br>2) An extension cord buried in the ground, in the station 2 courtyard.<br>3) An extension cord in use in resident room | K 147 | K147 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. No residents were affected by deficient practice.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. All findings have been corrected.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Maintenance will monitor adherence to national electrical code 9.1.2.<br>b. Electrical contractor will be contacted for additional receptacles if deemed necessary by Maintenance Director.<br>c. Maintenance will report any issues or concerns resulting from non- | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 147 | Continued From page 16<br>124.<br>4) Power strips with hair dryers and curling irons, located in Beauty Shops 1 and 2.<br>5) An extension cord in use in the Environmental Services Office.<br>6) A light fixture with open electrical wiring located in the Quiet Lounge, station 4.<br><br>Interview, on 07/27/11 between 1:30 PM and 5:50 PM, with the Maintenance Staff, and the Administrator revealed they were unaware of the extension cords and power strips being misused. They were also unaware of the open wiring in the light fixture.<br><br>Reference: NFPA 99 (1999 edition)<br><br>3-3.2.1.2 D<br><br>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.<br><br>Reference: NFPA 70 (1999 edition)<br><br>110-26. Spaces | K 147 | compliance of facility at the safety meeting from room inspections.<br>d. Immediate action will be implemented to ensure compliance.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K147 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 147 | Continued From page 17<br><br>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.<br><br>370.28(c) Covers.<br><br>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception. | K 147 | | |
| K 211<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:<br>o The corridor is at least 6 feet wide<br>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)<br>o The dispensers have a minimum spacing of 4 ft from each other<br>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.<br>o Dispensers are not installed over or adjacent to an ignition source.<br>o If the floor is carpeted, the building is fully | K 211 | K211 NFPA 101 LIFE SAFETY CODE STANDARD<br><br>1. The corrective action accomplished for residents affected by deficient practice:<br>a. Alcohol based hand rub dispensers have been installed appropriately.<br>2. Identification of other residents having the potential to be affected by the same deficient practice:<br>a. All residents who reside in the facility had the potential to be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 211 | Continued From page 18<br>sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure that Alcohol Based Hand Rub dispensers were not installed over or adjacent to an ignition source, per NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is licensed for two hundred twenty six (226) beds with a census of one hundred seventy seven (177) on the day of the survey.<br><br>The findings include:<br><br>Observation, on 07/27/11 at 5:30 PM, with the Maintenance Staff and the Administrator revealed Alcohol Based Hand Rub dispensers were installed over or adjacent to the light switches in the 400 Hall, Station 4 resident rooms. This is a repeat deficiency from 2009.<br><br>Interview, on 07/27/11, at 5:30 PM, with the Maintenance Staff and the Administrator revealed they were unaware that the dispensers with plastic drip guards under them were still not allowed to be mounted above an ignition source. | K 211 | affected by the deficient practice.<br>3. Measures and systemic changes to ensure that the deficient practice will not recur:<br>a. Environmental Services Director notified not to change location of dispensers without administrative approval.<br>4. The facility plans to monitor its performance to ensure that solutions are sustained by:<br>a. Working environmental service staff will visually observe dispenser and notify Environmental Services Supervisor if dispensers have been moved.<br>b. Environmental Services Supervisor will be responsible to correct immediately if variance occurs.<br>c. Results of findings will be reported at the safety meetings.<br><br>"COMPLETION DATE"<br>5. The facility declares compliance with K211 deficiency effective 8/22/2011 | 8/22/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185005 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 07/28/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING CREEK HEALTH CARE | 1401 SOUTH 16TH STREET<br>MURRAY, KY 42071 |

| (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 211 | Continued From page 19<br><br>Reference:<br><br>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:<br>o The corridor is at least 6 feet wide<br>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)<br>o The dispensers have a minimum spacing of 4 ft from each other<br>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.<br>o Dispensers are not installed over or adjacent to an ignition source.<br>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 | K 211 | | |