

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

PRINTED: 03/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 02/24/15 and concluded on 02/26/15 and found the facility not meeting the minimum requirements for recertification with the highest Scope and severity of an "E". An Abbreviated Survey was initiated on 02/24/15 and concluded on 02/26/15 to investigate KY22/53. The Division of Health Care substantiated the allegation with deficiencies cited.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crestview Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	<u>F157</u> 1. Resident #9 no longer resides at the facility. 2. All residents of the facility have the potential to be affected. An audit for all residents with a significant weight loss greater than 5% for the last three months was completed by the Director of Nursing on 3/17/15 to determine if the physician, resident and/or responsible party were notified of a significant weight loss with corrective action, if indicated, including physician order changes and changes in treatment plans if indicated.	4/07/15

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Steve McKinley</i>	TITLE X Administrator X	(X8) DATE 3/20/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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.

MAR 23 2015
OFFICE OF INSPECTION AND INVESTIGATION
U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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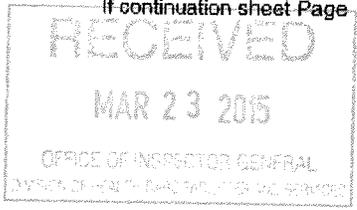
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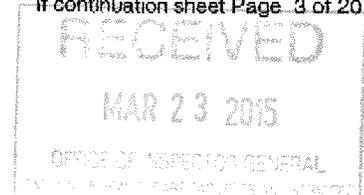
F 157	<p>Continued From page 1</p> <p>specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure the resident's legal representative was notified of a significant weight loss for one (1) of thirteen (13) sampled residents (Resident #9). The facility assessed Resident #9 with a significant loss of 6.5% in one (1) month and 8.6% in three (3) months from the day of admission on 11/28/14 to day of discharge to an acute care facility on 01/18/15 and the resident's legal representative was not informed of the weight loss.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Communication of Health Status, revised 10/01/12, revealed the resident and/or health care decision maker would be provided with information regarding the patient's total health status. This included functional status; medical care; nutritional status; rehabilitation and restorative potential; activities potential; cognitive status; oral health status; psychosocial status; and, sensory and physical impairment. Information would be communicated in a way that the resident/health care decision maker could</p>	F 157	<p>3. Licensed Nursing staff will be re-educated by the Director of Nursing and/or Nurse Practice Educator by 4/3/15 regarding following facility policy and procedure for notification of change in condition to include notification of physician, resident and/or responsible party. Re-education will include notification of significant weight loss. A post-test will be administered by the Director of Nursing and/or Nurse Practice Educator at the time of the re-education to validate understanding. Staff not available during this time frame will be provided re-education including completion of post-test by the Director of Nursing or Nurse Practice Educator upon return to work.</p> <p>4. The Unit Managers will audit resident medical records determined to have experienced significant weight loss daily Monday through Friday times one month, weekly times two months, then as determined by the monthly Performance Improvement Committee to ensure that the physician, resident and/or responsible party have been notified to include new orders and treatment plans, if indicated. The results of the audit will be submitted by the Director of Nursing to the monthly PI Committee for any additional follow up or re-education needs.</p>	
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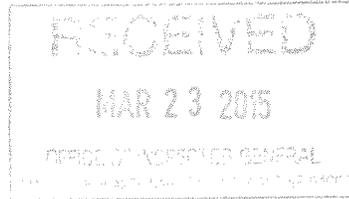
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F 157	<p>Continued From page 2 understand.</p> <p>Review of Resident #9's closed clinical record revealed the facility admitted the resident on 11/03/14 with diagnoses of Dementia, Muscle Weakness, Dysphasia, Urinary Tract Infection and Anorexia. Review of Resident #9 Plan of Care (POC) revealed a focused area that Resident #9 had a Do Not Resituate, with a goal that the healthcare decision maker would participate in decisions regarding medical care and treatment.</p> <p>Review of Resident #9's weekly weights revealed on 11/16/14 the facility weighed Resident #9 at 118.8 pounds and on 12/14/14 at 111.1 lbs. which idicated a 6.5 % significant weight loss for one month. On 01/11/15 the facility weighed Resident #9 at 103.1 lbs for a significant weight loss of 3.6 % in less than three (3) months.</p> <p>Interview with the Registered Nurse Educator, on 02/26/15 at 8:05 AM, revealed the facility utilized a Change of condition assessment form that required seventy-two (72) hours of follow up charting. He stated the nurse was to fax the form to the Physician and when it returned with orders, the nurse would document the order and notify the responsible party. He stated if the resident was his or her own responsible party, then the resident was notified.</p> <p>Interview with the Registered Dietitian, on 02/26/15 at 10:00 AM, revealed she never talked to the family about weight loss, that it was nursing's responsibility.</p> <p>Interview with the Director of Nursing, on 02/26/15 at 5:40 PM, revealed the Power of</p>	F 157		



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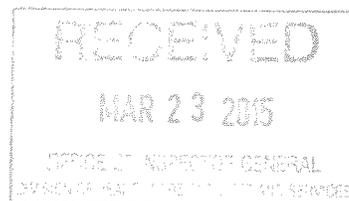
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F 157	Continued From page 3 Attorney should be notified when there was a change in status.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to afford the opportunity to be consulted about care and a treatment change with the initial care plan or with the significant change care plan for one (1) of thirteen (13) sampled residents. (Resident #9) The facility did not have an initial care plan meeting with the resident/legal	F 280 F280	1. Resident #9 no longer resides at the facility. 2. All residents of the facility have the potential to be affected. On 3/20/15, the Director of Nursing reviewed a list of MDS's due in the past 30 days and documentation in the resident medical record to determine that the care plan conference had occurred and the resident and/or responsible party had been invited to take part in the care planning process. No other areas of concern were identified. 3. The MDS Coordinator and the Director of Social Services will be re-educated by the Administrator on 3/24/15 to the facility policy on the care plan conference process to include notification of the resident and/or healthcare decision maker, when the care plan meeting would occur and an invitation would be sent to attend the meeting. A post-test will be administered by the Administrator at the time of re-education to validate understanding. 4. An audit will be conducted by the Administrator weekly times one month, every two weeks for one month then monthly times two months, then as	4/07/15



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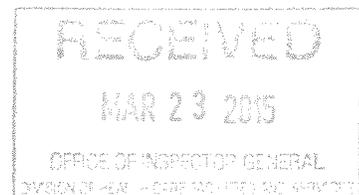
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F 280	<p>Continued From page 4 representative.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, revised 02/02/14, revealed residents and/or the health care decision makers would be invited to participate in care plan meetings.</p> <p>Review of Resident #9's closed clinical record revealed the facility admitted the resident on 11/03/14 with diagnoses of Dementia, Muscle Weakness, Dysphasia, Urinary Tract Infection and Anorexia. Review of Resident #9's Plan of Care (POC) revealed a focused area that Resident #9 had a Do Not Resituate, with a goal that the healthcare decision maker would participate in decisions regarding medical care and treatment.</p> <p>Phone interview with Resident #9's legal representative, on 02/23/15 at 12:30 PM, revealed he/she routinely visited the resident. The representative stated he/she was not notified of the resident's care plan conference or invited to participate.</p> <p>Interview with the Social Services Director, on 02/26/15 at 10:25 AM, revealed the Minimum Data Set (MDS) nurse would give her a list of the Care Plans due for the month, she then invited the legal representatives by letter and documented the letter was sent in a log she kept in her office. Review of the log revealed no entry for Resident #9's legal representative. Review during the interview of the Social Services progress notes from Resident #9's admission until discharge, revealed no note that a care plan conference had occurred. The Social Services</p>	F 280	<p>determined by the monthly Performance Improvement Committee with corrective action if indicated to ensure that residents and/or their responsible parties have been notified/invited to participate in care plan meetings. A summary of the audit findings will be submitted by the Administrator to the monthly Performance Improvement Committee monthly for any additional follow up or re-education needs.</p>	



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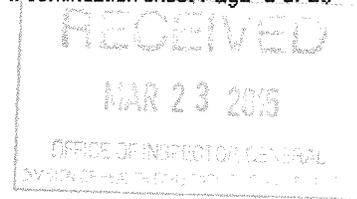
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F 282	<p>Continued From page 6</p> <p>patient. The care plan would include measurable objectives to meet patient needs and goals as identified by the assessment process, to promote necessary care and services to attain or maintain the patients's highest practicable physical, mental and psychosocial well being. However, the polocy did not reference staff responsibility to follow the care plan.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 05/09/13 with diagnoses of Paralysis Agitans, Muscle Weakness (generalized), Urinary Tract Infection, Neurogenic Bladder and Reactive Confusion.</p> <p>Review of the Resident #2 Comprehensive Minimum Data Set (MDS), dated 08/26/14, revealed the facility assessed Resident #1 as being at risk for development of pressure ulcers. Per the MDS the risk was secondary to Resident #2 requiring staff assistance to move sufficiently to relieve pressure over any one site and being confined to bed or chair all or most of the time.</p> <p>Review of the POC revealed a focused area of risk for skin breakdown as evidenced by decreased mobility and incontinence. One intervention was for the staff to float the resident's heels while in bed.</p> <p>Observation of Resident #2, on 02/24/15 at 3:25 PM, revealed Resident #2 was laying in bed without his/her heels being floated.</p> <p>Interview with SRNA #1, on 02/24/15 at 3:25 PM, revealed SRNA #1 worked the second shift and had just gotten to work. she was aware Resident #2 should have his/her feet floated while in bed.</p>	F 282	<p>indicated. A post-test will be administered at the time of re-education to validate understanding. Staff not available during this time frame will be provided re-education including completion of post-test by the Director of Nursing or Nurse Practice Educator upon return to work.</p> <p>4. The Director of Nursing and/or Nurse Practice Educator will conduct observation audits of five residents across all shifts daily times two weeks, three times per week times two weeks, weekly for two months, then as determined by the monthly Performance Improvement Committee to determine care is provided per the residents plan of care to include floating heels for residents at risk for skin breakdown. Any areas of concern will be corrected when identified. The results of the audits will be submitted by the Director of Nursing to the monthly Performance Improvement Committee for any additional follow up or re-education needs.</p>	



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F 282	<p>Continued From page 7</p> <p>She stated the SRNA's get report on their residents and there was a cardex with each residents care plan. SRNA #1 then obtained a pillow, folded it and placed it under Resident #1 ankles.</p> <p>Interview with the Registered Nurse Educator, on 02/26/15 at 8:05 AM, revealed all the nurses had been working at the facility for a while; he stated they discussed supervision responsibilities upon hire. He stated the nurses were to observe the residents as they do the medication pass and treatments, that they should do spot checks, to make sure residents are getting the assistance they need and getting turned as needed.</p> <p>Interview with Registered Nurse #3, on 02/26/15 at 3:02 PM, revealed she supervised the SRNA's by ensuring they were aware of anything new going on with a resident, making rounds, following up, keeping an eye on them and ensuring they are answering the call lights.</p> <p>Interview with SRNA #6, on 02/26/15 at 5:10 PM, via telephone revealed she had been assigned to Resident #1, she stated she was aware that Resident #1 required his/her heels to be floated. She stated everybody makes mistakes.</p> <p>During an interview with the Director of Nursing (DON), on 02/26/15 at 5:40 PM, revealed the nurses were expected to do rounds and spot checks to ensure care was provided per the POC.</p>	F 282		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive</p>	F 315	<p>F315</p> <p>1. The physician for Resident #2 was notified on 2/24/15 by the licensed nurse. Orders were received to change the foley</p>	4/07/15



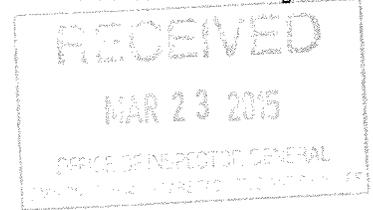
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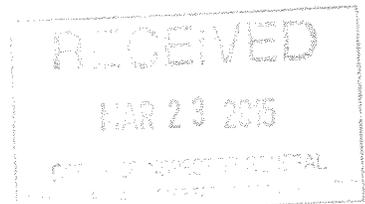
F 315	<p>Continued From page 8</p> <p>assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility staff failed to change indwelling catheters per physician order and failed to ensure an indwelling catheter bag was not touching the floor for one (1) of thirteen (13) sampled resident, Resident #2. Registered Nurse (RN) #1 changed Resident #2's indwelling catheter and increased the catheter gauge (diameter) without a Physicians order. In addition, staff failed to ensure Resident #2's indwelling catheter bag was not touching the floor.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care of the Indwelling Urinary Catheter, revised 01/02/14, revealed it did not address changing the indwelling catheter, obtaining an order to increase the size of the catheter or keeping the catheter bag off the floor.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 05/09/13 with diagnoses of Paralysis Agitans, Muscle Weakness (generalized), Urinary Tract</p>	F 315	<p>catheter as needed and the size of the catheter was verified. The catheter bag for Resident #2 was changed, placed in a dignity bag and secured off of the floor. Resident #2 was assessed for signs and symptoms of urinary tract infection on 2/24/15 by the licensed nurse. No signs of infection were identified. Registered Nurse #1 was re-educated on 2/14/15 by the Director of Nursing to follow physician orders for changing foley catheters and to place foley catheter bags in dignity bags and to secure the bag off of the floor.</p> <p>2. All residents of the facility have the potential to be affected. The medical record of residents with foley catheters were reviewed on 2/24/15 by the Director of Nursing to determine if orders to change foley catheter are present including observations to ensure foley catheter bag is contained in a dignity bag and secured off of the floor. No areas of concern were identified.</p> <p>3. Licensed Nurses will be re-educated by the Director of Nursing and/or Nurse Practice Educator by 4/3/15 regarding following physician orders in changing catheters, to use dignity bags and ensure that catheter bags are secured off of the floor. Certified Nursing Assistants will be re-educated by the Director of Nursing and/or Nurse Practice Educator by 4/3/14 to observe foley catheter bag location and</p>	
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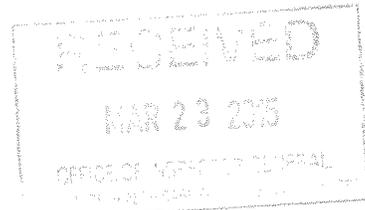
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F 315	<p>Continued From page 9</p> <p>Infection, Neurogenic Bladder and Reactive Confusion. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/26/14, revealed the facility assessed the resident as dependent on staff for all care.</p> <p>Review of the Physician's orders for January and February 2015 revealed no routine or as needed (PRN) order to change the catheter. Review of a nurses note, dated 01/12/15, revealed a nurse changed the indwelling catheter without an order and increased the size from a sixteen French (16 fr) to a twenty-four french (24 fr) without an order.</p> <p>Observation of Resident #2, on 02/24/15 at 3:25 PM, revealed him/her laying on the bed with the catheter bag on the floor and without a dignity bag. On 02/25/15 at 11:44 AM while Resident #2 was up in a wheelchair in the living room the catheter bag and tubing were observed touching the floor.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1, on 02/24/15 at 3:25 PM, revealed she worked the second shift and had just gotten to work. She was aware Resident #2 should not have his/her catheter bag on the floor due to risk of infection and should have a dignity bag covering the catheter bag.</p> <p>Interview with Registered Nurse #1, on 02/24/15 at 4:15 PM, revealed she had just changed the indwelling catheter at 3:00 PM and that could be why the catheter bag was on the floor and without a dignity bag. She also stated she had received a Physicians order to change the catheter due to minimal output and to increase the size, but had not written the order yet.</p>	F 315	<p>that bags are covered after providing care to a resident with a foley catheter. A post-test will be given to both Licensed Nurses and Certified Nursing Assistants at the time of each of their re-education to validate understanding. Staff not available during this time frame will be provided re-education including completion of post-test by the Director of Nursing or Nurse Practice Educator upon return to work.</p> <p>4. An audit will be conducted on all residents with foley catheter to determine physician orders contain when to change foley catheters, including size. Observations will be conducted across all shifts daily times two weeks, three times a week for two weeks, then weekly times two months to ensure foley catheter bags are in dignity bags and secured off of the floor by the Nurse Practice Educator or Weekend Manager. Areas of concern during audit will be corrected when identified. The results of the audit will be submitted by the Nurse Practice Educator to the monthly PI Committee for any additional follow up or re-education needs.</p>	



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F 315	Continued From page 10 Interview with SRNA #6, on 02/26/15 at 5:10 PM, via the telephone revealed she had been assigned to Resident #2 and she stated she was aware Resident #2's indwelling catheter bag needed to be off the floor and the indwelling catheter bag needed a dignity bag. She stated everybody makes mistakes. Interview with the Unit Manager, on 02/26/15 at 3:04 PM, revealed it was nursing judgement as to when the catheter needed to be changed, but stated a Physicians order was required to change the indwelling catheter and to increase the size of the catheter. She stated usually there was an as needed (PRN) order to change a catheter. The Unit Manager also stated the SRNA's were required to do change of shift rounds and the catheter on the floor without a dignity bag should have been caught during those rounds.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility	F 325	F325 1. Resident #9 no longer resides at the facility. 2. All residents of the facility had the potential to be affected. An audit of residents' medical record who had experienced significant weight losses in the past three months was completed by the Unit Manager, Nurse Practice Educator and the Director of Nursing on 2/26/15 to determine all orders had been transcribed to include appetite stimulants and house supplements. No areas of concern were identified. 3. Licensed nurses will be re-educated by the Director of Nursing and/or Nurse	4/07/15



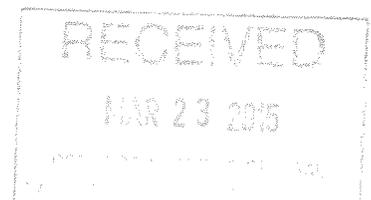
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F 325	<p>Continued From page 11</p> <p>policy review, it was determined the facility failed to ensure staff transcribed physician orders for an appetite stimulant and house supplements for one (1) of thirteen (13) sampled residents to help maintain acceptable body weight. (Resident #9) The facility staff wrote physician orders for an appetite stimulate that was never transcribed on to the MAR or sent to the pharmacy to be filled. In addition, the staff failed to monitor the consumption of the house supplement.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Weights and Heights, under Significant Weight Change Management, revised 01/02/14, revealed a significant weight change was defined as 5% in one month and 10% in six months. The licensed nurse would notify the Physician/mid-level provider and Dietitian of the significant weight change, notify the Physician /mid-level provider of the Dietitian recommendations, and notify family/health care decision maker of the weight change and Dietitian recommendation. Family notification would be documented.</p> <p>Review of the facility's policy regarding Reordering, Changing and Discontinuing Medication Orders, dated 08/01/02, revealed the facility would communicate any medication reorders, changes or discontinuations to the pharmacy in accordance with pharmacy guidelines and state/federal regulations.</p> <p>Review of Resident #9's closed clinical record revealed the facility admitted the resident on 11/03/14 with diagnoses of Dementia, Muscle Weakness, Dysphasia, Urinary Tract Infection</p>	F 325	<p>Practice Educator by 4/3/15 regarding the transcription of all orders, including residents with orders for appetite stimulants and house supplements and the administration of house supplements will be documented by the licensed nurse on the resident Medication Administration Record. A post-test will be administered at the time of re-education to validate understanding. Staff not available during this time frame will be provided re-education including completion of post-test by the Director of Nursing or Nurse Practice Educator upon return to work.</p> <p>4. An audit will be conducted by the Unit Managers five times a week for two weeks, three times per week for two weeks, weekly for two months, then as determined by the monthly Performance Improvement Committee to determine orders are transcribed and house supplements are administered and results documented as ordered. Areas of concern will be corrected when identified. The results of the audit will be submitted by the Director of Nursing to the monthly PI Committee for any additional follow up or re-education needs.</p>	



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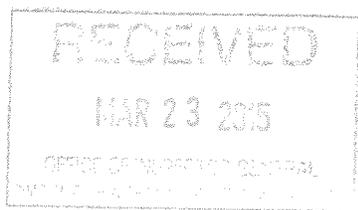
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F 325	<p>Continued From page 12 and Anorexia.</p> <p>Review of the weekly weights for Resident #9 revealed on 11/16/14 the facility weighed the resident at 118.8 pounds and on 12/14/14 the resident weighed 111.1 lbs. This was a 6.5 % significant weight loss for one month. On 01/11/15 the facility weighed Resident #9 at 103.1 lbs for a significant weight loss of 8.6 % in less than three (3) months.</p> <p>Review of the Physicians telephone order sheet revealed an order, dated 12/31/14, for Periactin (used as an appetite stimulate) 4 milligrams twice a day. Review of the MAR for December 2014 and January 2015 revealed the resident never received the Periactin. Continued review of the Physicians orders revealed an order dated 12/12/14 for a house supplement every day that was increased to three (3) times a day on 01/14/15.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #2, revealed she had taken care of Resident #9 and she had assisted Resident #9 with eating, but did not remember for sure if Resident #9 had received a supplement. She stated there was no place to document if the house supplements were taken by the resident, but the fluid amount would be counted in with the meals or snacks.</p> <p>Interview with the Registered Dietitian, on 02/26/15 at 10:00 AM, revealed she had requested an appetite stimulate and had recommended Marinol, Megace or Periactin. She stated she had thought the resident was receiving one of those. The RD stated she had seen positive results with Periactin. She stated as far</p>	F 325		
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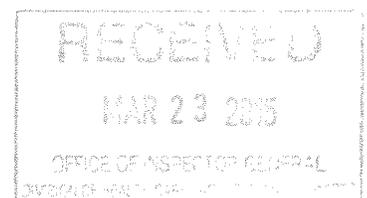


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F 325	<p>Continued From page 13</p> <p>monitoring; if a resident was consuming their supplement, she would usually ask a nurse how the resident was accepting/tolerating the supplement.</p> <p>Interview with the Registered Nurse Unit Manager, on 02/26/15 at 3:04 PM, revealed when the Physicians did rounds a nurse had to be consistently with them. The Physician would usually leave the chart open to the page the order was written, and the nurse would take the order off when the Physician left. She had no explanation how the Periactin had been missed.</p> <p>Interview with the Director of Nursing (DON), on 02/25/15 at 10:10 AM, revealed the order for the Periactin was noted in the nurse's notes, but no one took the order off. She stated a nurse or the Unit Manager usually took the orders off. On 02/26/15 at 5:45 PM, the DON stated at one time the facility had documented the amount of the supplements the residents consumed and documented it on the Medication Administration Record, but did not know why they no longer documented the intake.</p>	F 325		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>	F 329	<p>F329</p> <p>1. The physician for Resident #3 was notified on 2/26/15 by the licensed nurse regarding the signed physician order to decrease the Ativan as recommended by the pharmacy drug regimen review. The physician refused the medication reduction.</p> <p>2. All residents of the facility had the potential to be affected. An audit was</p>	4/07/15



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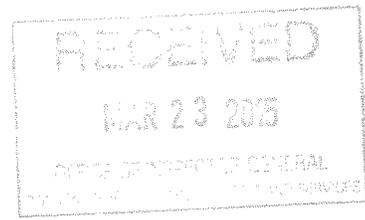
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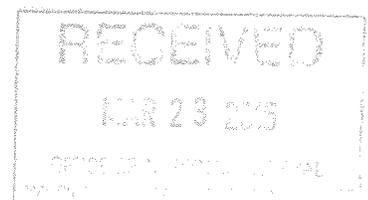
F 329	<p>Continued From page 14</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy, it was determined the facility failed to ensure the drug regimen for one (1) of thirteen (13) sampled residents (Resident #3) was free from unnecessary drugs. The staff failed to transcribe a physician's order to the Medication Administration Record (MAR) for dose reduction of an antianxiety and failed to send the order to the Pharmacy to be changed/filled.</p> <p>The findings include: Review of the facility's policy regarding Reordering, Changing and Discontinuing Medication Orders, dated 08/01/02, revealed the Center would communicate any medication reorders, changes or discontinuation to the pharmacy in accordance with pharmacy guidelines and state/federal regulations.</p>	F 329	<p>completed on 2/26/15 by the Director of Nursing on all residents with a pharmacy recommendation for gradual dose reduction for January 2015 to determine if all recommendations had been considered by the residents' attending physician and transcribed if indicated. No other areas of concern were identified.</p> <p>3. Licensed nurses will be re-educated by the Director of Nursing and/or the Nurse Practice Educator by 4/3/15 to review all pharmacy recommendations for gradual dose reduction have been reviewed by the physician and transcribed per physician order. A post-test will be administered at the time of re-education to validate understanding. Staff not available during this time frame will be provided re-education including completion of post-test by the Director of Nursing or Nurse Practice Educator upon return to work.</p> <p>4. The Director of Nursing will audit pharmacy recommendations monthly ongoing to determine the residents' attending physician has reviewed and verify the orders have been transcribed. Areas of concern will be corrected immediately when identified. The results of the audit will be submitted by the Director of Nursing to the monthly PI Committee for any additional follow up or re-education needs.</p>	
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F 329	<p>Continued From page 15</p> <p>Review of the job description for the Registered Nurse, with a revision date of 10/22/12, revealed the Registered Nurse was responsible for coordinating and delegating care as appropriate, verifying the medical orders were accurately transcribed and collaborating with physicians in rounds and examination of patients as needed.</p> <p>Review of the Clinical record for Resident #3 revealed the facility admitted the resident on 01/23/13 with diagnoses of Dementia, Unspecified Episodic Mood Disorder, Anxiety State and Depressive Disorder. Review of the Plan of Care (POC) revealed a focused area that stated the resident was at risk for complications due to psychotropic drugs with a goal for the resident to have the smallest most effective dose without side effect.</p> <p>Continued review of the clinical record revealed a signed Physician order, dated 01/28/15, to decrease Ativan one (1) milligram (mg) twice a day to Ativan one-half (1/2) mg three times a day per the Pharmacist drug regimen review. Review of the February MAR revealed Resident #3 was still receiving Ativan one mg twice a day and there was no evidence the order had been changed.</p> <p>Interview with the Registered Nurse Unit Manager on 02/26/15 at 3:04 PM revealed when the Physicians to do rounds a nurse has to be consistently with them. The Physician will usually leave the chart open to the page the order was written, and the nurse will take the order off when the Physician leaves.</p> <p>Interview with the Administrator on 02/26/15 at 5:00 PM revealed his expectation was that the nurse take off the Physician's orders, he stated</p>	F 329		



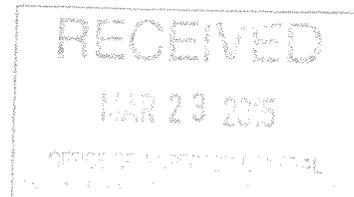
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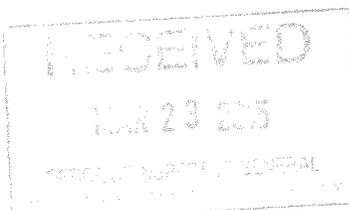
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F 329 F 332 SS=E	<p>Continued From page 16 the nurses would be re-educated.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure it was free of medication error rates of five percent or greater. Medication pass observations conducted on the morning of 02/25/15 resulted in the assessment of three (3) medication errors out of thirty-eight (38) opportunities, reflecting a medication error rate of 7.9 percent.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation during the morning medication pass on the 300 Unit, on 02/25/15 at 8:20 AM, for Unsamped Resident A with diagnoses of Hypertension recieved six medications which included the antihypertensive medication, Lisinopril with HCTZ. Immediately following the observation of the administration of the six medications, a review of Unsamped Resident A's Medication Administration Record (MAR) revealed the resident should have also received a seventh medication, the antihypertensive medication, Amlodipine 10 mg. RN #1 stated she was sure she administered the medication (i.e., Amlodipine); it was the second packet she removed from the resident's drawer. 	F 329 F 332	<p>F332</p> <ol style="list-style-type: none"> 1. The attending physician and Responsible Party for unsampled Residents A were notified on 3/17/15 by the licensed nurse of the missed medication. The physician gave no new orders. Unsamped Residents B no longer resides at the facility. 2. All residents in the facility had the potential to be affected. Medication administration observations were conducted by the Director of Nursing , Nurse Practice Educator on 3/20/15 to determine residents received medications as prescribed, including pre-flushing the feeding tube prior to administering crushed medications and the need to follow manufacturer's specification for appropriate administration of medications not to be crushed. No other areas of concern were identified. 3. The Director of Nursing and/or Nurse Practice Educator will re-educate licensed nurses by 4/3/15 to the facility policy on proper medication administration, including the need to administer all medications as ordered, to pre-flush feeding tube prior to administering crushed medications and the need to follow manufacturer's specification for appropriate administration of medication not to be crushed. A post-test will be 	4/07/15



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F 332	<p>Continued From page 17</p> <p>Following the observation, review of Unsampled Resident A's medication orders revealed the resident's order for the Amlodipine 10 mg. had been initiated on 01/18/15.</p> <p>Observation, at 2:50 PM on 02/25/15, during inspection of the medication cart for Unit 300 revealed Resident A's medication supply included a blister pack of Amlodipine 10 mg., designated as Rx 82471287, dated 02/18/15 and which had originally contained a total of 30 tablets. Further inspection of the pack revealed seven (7) tablets had thusfar been removed from the pack. However, further review of the resident's MAR revealed eight (8) tablets were charted as having been administered (i.e., one tablet each day from 02/18/15 through 02/25/15). An additional interview with RN #1 at that time pertaining to the additional findings revealed the nurse continued to insist that the Amlodipine had been administered to the resident that day during the morning medication pass. As a result of the findings, one medication error was assessed.</p> <p>2. Observation during the morning medication pass, on 02/25/15 at 9:00 AM, on the 100 Unit for a second unsampled resident (Unsampled Resident B) diagnosed with Dysphagia and Gastroesophageal Reflux Disease revealed the nurse was observed administering seven (7) medications at 9:00 AM. The resident currently had an order of "NPO" (i.e., nothing by mouth). Each medication was prepared individually to be administered via the resident's feeding tube. All medications were tablet formulations, were separately crushed, were each mixed in approximately 5-10 milliliters of water, and then individually administered via the feeding tube. Prior to administration, RN #3 checked the tube's</p>	F 332	<p>administered at the time of re-education to validate understanding. Staff not available during this time frame will be provided re-education including completion of post-test by the Director of Nursing or Nurse Practice Educator upon return to work.</p> <p>4. The Director of Nursing and/or Nurse Practice Educator will conduct medication administration observations across all shifts daily five times a week for two weeks, three times a week for two weeks, weekly times two months, then as determined by the monthly Performance Improvement Committee to determine medications are administered per medication administration policy. Areas of concern will be corrected when identified. The results of the observations will be submitted by the Director of Nursing to the monthly PI Committee for any additional follow up or re-education needs.</p>	



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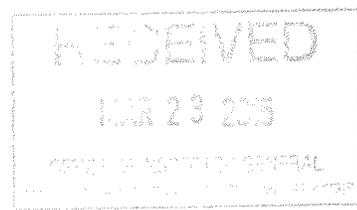
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F 332	<p>Continued From page 18</p> <p>placement and residual. However, there was no effort made to pre-flush the tube prior to administering the medications. Subsequently, the nurse's attempt to administer the first medication revealed the resident's tube was significantly clogged. After continued efforts by the nurse to unclog the tube (resulting in some slight spillage of medication), the tube became unclogged, resulting in no further problems with the flow of the medication. RN #3 proceeded to administer each medication separately, flushed the tube between each medication, and concluded the administration with a post-flush. Immediately following the observation, RN #3 was interviewed and acknowledged the pre-flush should have been performed with the resident's feeding tube. However, because RN #3 failed to perform the tube pre-flush, a second medication error was assessed.</p> <p>Following the observation of Unsampled Resident B's morning medication administration, review of the medication orders revealed that one of Resident B's medications (Prevacid Solutab 30 mg.) stated to be given "by mouth". Moreover, the package as received from the pharmacy (Rx 18871506) dated 02/19/15 also stated to be given "by mouth". The package contained no additional instructions from pharmacy regarding the proper methods to use when administering by mouth (e.g., warnings not to chew, split, or crush the tablet), nor any instructions regarding the proper method for administering the medication via a feeding tube.</p> <p>Review of the manufacturer's literature regarding administration of the Prevacid Solutab revealed the tablet could be administered via a feeding tube if mixed in a small amount of water</p>	F 332		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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F 332	<p>Continued From page 19 (approximately 10 milliliters), and then infusing through the tube within 15 minutes. The manufacturer specified the tablet should not be chewed, cut, or crushed.</p> <p>Interview at about 12 noon on 02/25/15, with RN #3 regarding the discrepancy regarding the Prevacid Solutab revealed the nurse expressed being unaware the solutab should not be crushed prior to administering via Unsamled Resident B's feeding tube. The manufacturer's specification regarding administering the medication via a feeding tube was explained to the nurse, and it was further suggested the facility check with its pharmacy provider for further clarification.</p> <p>Interview, at 9:00 AM on 02/26/15, with RN #4 regarding administration of Unsamled Resident B's medications via the feeding tube revealed the administration of the Prevacid Solutab, the nurse explained they mixed the tablet in a small amount of water and give that through the tube. They know it's not supposed to be crushed. Thus, because the Prevacid Solutab was observed not being administered via the resident's feeding tube in accordance with manufacturer specifications, a third medication error was assessed.</p>	F 332		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 04/07/2015
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 04/07/15 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185409	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1992, (2014 Rehab. Addition)</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected.</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 50 KW generator, fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 02/26/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crestview Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	

ORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X <i>[Signature]</i>	TITLE X Administrator X	(X6) DATE 3/20/15
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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K 000 Continued From page 1
Deficiencies were cited with the highest deficiency identified at D level.
K 022 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain exits in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has fifty-eight (58) certified beds and the census was fifty-one (51) on the day of the survey.

The findings include:

Observation, on 02/26/15 at 9:57 AM, with the Administrator and the Maintenance Director revealed the pair of exterior doors leading to an enclosed courtyard from the Dining Area, could be confused as an exit, as the door was not marked as "No Exit".

K 000

K 022

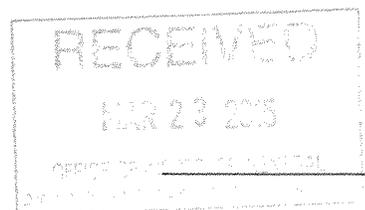
K022
1. A temporary "No Exit" sign was immediately placed on the identified door. A permanent sign was ordered by the Maintenance Director on 3/20/15.

2. A walkthrough observation audit of all doors leading to the outside was completed by the Maintenance Director on 2/26/15. No other concerns were identified.

3. The Maintenance Director was re-educated by the Administrator on 2/27/15 on the NFPA 101 LSC 7.10.1.4 and 7.10.8.1 regarding maintaining exits per NFPA standards, including all egress doors that are not considered an exit will be identified as such.

4. The Maintenance Director will audit all outside egress doors to determine appropriate signage is visible monthly for six months. The result of the audit will be submitted by the Maintenance Director to the monthly PI Committee for any additional follow up or re-education needs.

4/07/15



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NAME OF PROVIDER OR SUPPLIER CRESTVIEW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1871 MIDLAND TRAIL SHELBYVILLE, KY 40065
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K 022 Continued From page 2

Interview, on 02/26/15 at 9:59 AM, with the Administrator and the Maintenance Director revealed they were unaware of the pair of exterior doors not being marked in accordance with NFPA standards.

Reference: NFPA 101 Life Safety Code (2000 Edition).

7.10.8.1 * No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:

NO
EXIT

Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.

Exception: This requirement shall not apply to approve existing signs.

K 022

