

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

PRINTED: 06/26/2013
FORM APPROVED
OMB NO. 0938-0391

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 C 06/13/2013
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 000	INITIAL COMMENTS An abbreviated survey (KY #20231) was conducted on 06/11/13 through 06/13/13 to determine the facility's compliance with Federal requirements. KY #20231 was substantiated with a deficiency cited.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to accommodate the needs of one (1) resident (#1), in the selected sample of three (3) residents, related to staff failing to remove the resident from the bedpan for approximately one and one-half hours. Findings include: A review of the facility's policy and procedure for "Bedpan or Urinal, Assisting the Resident to Use", last revised 08/2010, revealed staff should allow the resident to be alone after placing the resident on the bedpan but should monitor status.	F 246	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 1. The corrective action accomplished for resident #1 found to have been affected by the deficient practice. a. Resident #1 was removed from bedpan immediately when found. b. A skin assessment was completed by the licensed nurse. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. Measures and systemic changes to ensure that the deficient practice will not recur: a. The facility's policy and procedure for "bedpan or urinal, assisting the resident to use" was	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra J Dick TITLE: Administrator (X6) DATE: 07-01-2013

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

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F 246	<p>Continued From page 1</p> <p>A record review revealed Resident #1 was admitted to the facility on 03/06/13 with a diagnosis of Acute Vertebral Compression Fracture at L3 for rehabilitation.</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 03/12/13, revealed the facility assessed Resident #1's cognition as moderately impaired and required extensive assistance of one staff for toileting.</p> <p>A review of the Comprehensive Care Plan for self care deficit, dated 03/18/13, revealed an intervention to offer and assist with toileting every two hours. A review of the Certified Nurse Aide (CNA) Care Record, dated 03/06/13, revealed for one staff to assist with bedpan for elimination.</p> <p>Interview with Resident #1's family member, on 06/11/13 at 8:15 AM, revealed the facility notified her that Resident #1 was left on the bedpan for two hours. She stated the nurse told her the CNA placed the resident on the bedpan before the end of the shift and failed to notify the oncoming CNA the resident was still on the bedpan.</p> <p>Interview with CNA #1, on 06/11/13 at 3:50 PM, revealed her and LPN #1 checked on Resident #1 prior to the end of their shift, on 03/24/13 at approximately 6:30 PM, and the resident was having a problem having a bowel movement. The resident asked to be left on the bedpan so he/she could try to have a bowel movement. The CNA stated she left the resident on the bedpan but she did not report it to the oncoming CNA because Resident #1 was not her resident, she had just answered the call light. The CNA</p>	F 246	<p>reviewed and revised.</p> <p>b. The facility has in-serviced staff on updated policy and procedure.</p> <p>c. The facility has in-serviced nursing staff regarding hand off reporting communication.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Unit Coordinator will perform weekly audits to ensure hand off reporting communication is being followed.</p> <p>b. Audits will be submitted to the Director of Nursing weekly.</p> <p>c. The Unit Coordinator will report results of findings and corrective actions at the quarterly Quality Assurance Committee Meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with F246 deficiency effective 7/05/2013</p>	7/05/2013	

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F 246	<p>Continued From page 2</p> <p>revealed she heard LPN #1 report to the oncoming nurse (LPN #2) that Resident #1 was on the bedpan.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/11/13 at 3:30 PM, revealed her and CNA #1 checked on Resident #1 prior to the end of their shift, on 03/24/13 at approximately 6:45 PM, and the resident wanted to be left on the bedpan so he/she could try to have a bowel movement. The LPN stated she left the room but reported the resident was on the bedpan to the oncoming nurse.</p> <p>Interview with LPN #2, on 06/11/13 at 3:20 PM, revealed she was passing medications to Resident #1 and his/her roommate, on 03/24/13 at approximately 8:00 PM, when she noticed Resident #1 had on a purple latex glove. The LPN stated she asked the resident what he/she was doing and the resident stated he/she was trying to use the restroom. The LPN revealed the resident stated she was uncomfortable because he/she had been on the bedpan for two hours. The LPN stated she removed the bedpan and noted the resident had a red ring around his/her buttocks and an indentation on the right buttock from the rim of the bedpan.</p> <p>A review of a skin assessment, dated 03/24/13, revealed Resident #1 had erythema (redness) and an indentation from bedpan. Written in comment section of assessment was "been on bedpan for two hours".</p> <p>An interview with the Director of Nursing, on 06/11/13 at 4:05 PM, revealed the staff should have ensure Resident #1 was not left on the</p>	F 246			

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