

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

PRINTED: 06/16/2010
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 _____	RECEIVED JUN 2010 OFFICE OF INSPECTION & SURVEILLANCE 1-1234567890 1192021222324 2526	(X3) DATE SURVEY COMPLETED 06/04/2010
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 AMENDED An annual survey was conducted 06/02-04/10 and a Life Safety Code Survey was conducted on 06/02/10 to determine the facility's compliance with Federal Regulatory Requirements. Deficiencies were identified with the highest S/S being a "D".	F 000	This plan of correction is submitted as the facility's credible allegation of compliance.	06-24-10	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to meet professional standards of quality for one resident (#22) in the selected sample of 25. Resident #22 received a physician's order for Macrobid (an antibiotic). The resident had a documented allergy to Macrobid. The nurse transcribing the order failed to identify the resident's listed allergies and the facility administered the medication to Resident #22, without noted adverse side effects. Findings include: A record review revealed Resident #22 was admitted to the facility with diagnoses to include Status Post Gangrenous Appendectomy, Urinary Retention and Chronic Urinary Tract Infections. A review of a physician's order, dated 06/02/10, revealed an order for Macrobid 100 milligrams (mg) by mouth (po) twice a day (bid) for 10 days for a Urinary Tract Infection (UTI).	F 281	1. The corrective action accomplished for resident # 22 found to be affected by the deficient practice: a. Physician was notified during survey for clarification of allergies. b. Incident report completed. c. Family notified. d. Physician orders received. e. Allergy list updated. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. All residents who reside in the facility had the potential to be affected by the deficient practice. 3. Measures and systemic changes to ensure that the deficient practice will not recur:		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Sandra J Dick

TITLE

Administrator

(X6) DATE

06-17-10

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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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071	
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F 281	<p>Continued From page 1</p> <p>A review of the Medication Administration Record (MAR), dated 06/02/10, revealed the order for the Macrobid was written to be administered twice a day for 10 days and the facility had given the resident five doses.</p> <p>A review of the clinical record revealed Resident #22's chart was flagged with a red allergy sticker, which noted the resident had an allergy to Macrobid. Additionally, the resident's allergy to Macrobid was documented on the "Patient Continuity of Care" form submitted by the discharging hospital and the "Admission Report", both dated 05/20/10.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 06/04/10 at 9:20 AM, revealed she had written the order for the Macrobid and did not check the resident's chart for medication allergies.</p> <p>An interview with LPN #1, on 06/04/10 at 9:25 AM, revealed she had taken the order from the physician's office for the Macrobid and did not check the resident's chart for medication allergies.</p> <p>An interview with LPN #3, on 06/04/10 at 9:50 AM, revealed Macrobid should have been removed from the chart as a medication allergy, due to the fact Resident #22 had taken Macrobid in the past and the physician's office had mistakenly identified Macrobid as an allergy for Resident #22.</p> <p>An interview with the Director of Nursing (DON), on 06/04/10 at 2:20 PM, revealed she expected the licensed staff receiving or witting the</p>	F 281	<p>a. Licensed nursing staff has been in-serviced regarding adherence to medication administration policy to confirm residents list of allergies.</p> <p>b. All charts were audited for drug/allergy confirmation.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. Weekly audits will be conducted by Nursing Administration for adherence to allergy verification.</p> <p>b. Weekly results will be given to Nursing Director.</p> <p>c. Results of findings will be reported at quarterly Quality Improvement Committee meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>"COMPLETION DATE"</p> <p>5. The facility declares compliance with F281 deficiency effective 06/24/2010</p>	06/24/2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2010
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 281	Continued From page 2 physician's orders to verify medication allergies at that time. A review of the policy for "Medication Administration", dated 7/02 and revised 12/04, revealed staff were supposed to confirm the resident's list of allergies.	F 281			

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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 06/02/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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