STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185313	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekwood Nursing & Rehabilitation	107 Boyles Drive Russellville, KY 42276

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 37031 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for one of one residents (Resident (R) 81) reviewed who received tube feeding. Observation and interview on 10/30/2024 at 3:02 PM revealed Certified Nurse Aide (CNA) 2 had detached and placed R81's feeding pump on hold while she gave resident care which was not within her job description. The findings include: Review of the facility policy, Care and Treatment of Feeding Tubes, revised 05/31/2023, revealed It was a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Review of the Certified Nursing Assistant Job Description, dated 2018 revealed a commitment to promoting wellness, healing, and independence for all the lives a CNA touches. The summary included to perform direct resident care duties under the supervision of licensed nursing personnel. Review of essential duties and responsibilities revealed the CNA was to assist nursing staff with the basics of aseptic and sterile techniques to avoid infection of residents. Further review revealed the CNA's responsibilities did not include detaching and/or placing on hold a resident's feeding tube/pump. Review of the CNA 2's current learning/education list revealed no education on the use of feeding tube pumps or with resident tube feedings. Review of R81's medical record revealed the facility admitted the resident on 08/28/2024 with diagnoses which included cerebral ischemia (stroke), acute respiratory failure, persistent vegetative state after a traumatic brain injury from a motor vehicle accident, and gastrostomy (feeding tube) status. Review of the Admission Minimum Data Set (MDS) with Assessment Reference Date of 09/01/2024 revealed the resident was of a persistent vegetative state. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER: Creekwood Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 107 Boyles Drive Russellville, KY 42276	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/2024 at 3:02 PM, CNA2 and CNA12 were observed performing incontinent care for R81. The resident was in a supine position with the head of bed flat. The resident's gastrostomy tube (G-tube) was detached from the resident. Observation revealed the tubing was coiled on top the feeding tube pump with no cap in place at the end of the tubing and the pump was set on hold. CNA2 stated the nurse had unhooked the feeding tube. As the pump started to alarm, CNA2 stated it would alarm until the nurse hooked the pump tubing back up to the resident. During an interview on 10/30/2024 at 3:06 PM with Registered Nurse (RN) 1 at the nurses station, she stated she did not detach R81's gastrostomy tube and she was the only nurse working this unit. She also stated when she detaches a gastrostomy tube, she caps the end of the tubing so it stays clean. During an interview 10/30/2024 at 3:12 PM, CNA2 stated she had unhooked R81's feeding tube. CNA2 stated she knew the nurse was busy and did not want to bother her so she unhooked it herself. She further stated she had not been educated on unhooking the tube feeding or on the use of the feeding tube. CNA2 stated she knew she was not supposed to detach the tube or place the pump on hold. During an interview on 10/31/24 at 12:30 PM, Licensed Practical Nurse (LPN) Staff Development Coordinator (SDC) stated she had been working as the SDC since the end of August 2024. She stated the orientation packet for CNAs did not include anything about gastrostomy tube care because CNAs are unable to care for the gastrostomy tubes. LPN/SDC further stated she verbally told them during orientation that residents with G-Tubes (Gastrostomy tubes) were to have their head of bed (HOB) elevated 30 to 45 degrees and if there was any concern about the tube to tell their nurse. She stated her expectations was for the CNA to keep the resident's HOB elevated and to watch for any complications of the tube; however, CNAs are not to touch the tube. During an interview with the Director of Nursing (DON) on 10/31/2024 at 2:48 PM, she stated she expected the CNAs to follow the facility policy and the CNA job description which does not include the care of gastrostomy tubes. She further stated only nurses could change, continue, or terminate feedings. Per the DON, staff receive inservices and orientation regarding management of feeding tubes. The DON stated CNAs were educated to not touch the tube or turn it off/on. During an interview on 10/31/24 at 3:57 PM, the Administrator stated CNAs should not touch or turn off a feeding tube per the facility policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37031 Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure an account of all controlled drugs was maintained and reconciled for two of 14 residents (Residents (R) 3 and R41) who received narcotic medications in the facility. The findings include: Review of the facility policy, Medication Administration revised 02/20/2024, revealed medications were administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy further revealed that if the medication were a controlled substance, staff were to sign the narcotic book. Per the policy, staff were to correct any discrepancies and report to the nurse manager. Review of the facility policy, Disposal of Medications and Medication-Related Supplies revealed Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations. The Director of Nursing, in collaboration with the consultant pharmacist is responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. When a dose of a controlled medication was removed from the container for administration but refused by the resident or not given for any reason, it was not placed back in the container. The medication would be destroyed in the presence of a licensed nurse and disposal was documented on the accountability record/book on the line representing that dose. Review of R41's facility face sheet revealed the resident was admitted on [DATE] with diagnoses which included, chronic obstructive pulmonary disease, rheumatoid arthritis and traumatic subdural hemorrhage. Review of the physician order with a start date of 08/27/2024 revealed an order for Tramadol 50 milligrams (a schedule IV narcotic) to be taken every six hours as needed for pain. Review of the Medication Administration Record (MAR) for R41 revealed the Tramadol 50 milligrams was administered to R41 at 9:00 PM on 10/29/2024. On 10/30/2024 at 3:18 PM an observation with Kentucky Medical Assistant (KMA) 4 with medication cart 300 B (the 300 unit had 2 medication carts. A and B) revealed a discrepancy with the narcotic count for R41. The count of the Tramadol 50 milligrams was twenty-two tablets; however, the count sheet or sign out record showed there were twenty-three available. KMA4 stated she must have overlooked that count at 2:00 PM today when she and KMA1 counted. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During further interview, KMA4 stated when she did the count at 2:00 PM on 10/30/2024 with KMA1, she should have noted the discrepancy. She stated she was looking at the medications and KMA1 was reviewing the sign out records for the narcotics. She stated it was hard to see the tablets in the medication card especially when the medication was the same color as the card and when the tablets were small. During an interview on 10/31/2024 at 9:40 AM, KMA1 stated she counted narcotics with RN2 at 6:00 AM on 10/30/2024; however, she did not notice the discrepancy at that time. She further revealed she counted with KMA6 at 2:00 PM when she left the facility and neither of them noted the discrepancy. Review of R3's medical record revealed the facility admitted the resident on 04/25/2022 with diagnoses which included, schizophrenia, osteoarthritis, and lumbosacral pain. Further review revealed the resident was presently receiving palliative care. Review of R3's physician orders revealed an order for Ativan (lorazepam a Schedule IV drug) 0.5 milligrams per tablet, one tablet three times a day for anxiety. During the observation of Medication cart 300 B with KMA4, the lorazepam 0.5 milligram tablet count was incorrect. The count of tablets were four (4); however, the narcotic count sheet showed there were five (5) tablets available. KMA4 stated, Oh, I wasted one earlier when I dropped it on the floor, headed to the resident's room and I haven't signed it out yet. The surveyor asked whom she wasted it with, she stated, I just picked it up and automatically threw it in the sharps box. She stated she was supposed to waste it with a licensed nurse; however, she just planned to have one sign it later. During an interview on 10/30/2024 at 3:24 PM, the Director of Nursing (DON) stated she expected the staff administering the medication to sign out the medication as the medication was given. She also stated during the narcotic counts, she expected staff to ensure the count and the medication monitoring/control record have the same count. The DON further stated she expected all nursing staff giving narcotic medications to follow the narcotic waste policy as written and to ensure a licensed nurse was used to waste and cosign the narcotic count sheet. During an interview with the Administrator on 10/31/2024 at 3:24 PM, she stated she expected all nursing personnel counting narcotics to ensure the counts match the sign out sheets and if there is a discrepancy, to notify the DON immediately. She further stated she expected nursing staff administering narcotics to follow the facility policy for wasting narcotics as written.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45914 Based on observation, interview, and review of the facility's policy, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, which had the potential to affect 85 of the facility's 86 residents who consumed food from the kitchen. Observation of the walk-in freezer revealed multiple food items in their original containers but were not sealed or dated when opened. The findings include: Review of facility's undated policy titled, Food Receiving and Storage, revealed foods should be received and stored in a manner that complies with safe food handling practices. Further review revealed all foods stored in the refrigerator or freezer would be covered, labeled, and dated (use-by date). Continued review revealed wrappers of frozen foods must remain intact until thawing. Observation of the kitchen, on 10/29/2024 at 11:20 AM, with the Dietary Manager (DM) of the walk-in freezer revealed the food items were in the original boxes and packaged inside large plastic bags. However, the boxes and packages had been opened but were not sealed or dated when opened. These opened items included bulk foods of cookie dough, broccoli, western style beef patties, and mixed vegetables (which had a scoop lying inside the box on top of the vegetables). Further observation revealed multiple bags of tater tots in its original container with one package that had been opened and half of the bag used, but was not sealed or dated when opened replaced into the original container. During an interview on 10/29/2024 at 11:50 AM, the DM stated he was aware that food items were to be labeled, dated, and sealed to ensure there was no contamination. He further stated that residents could get sick from exposed food items and could be worse for residents who had compromised immune systems. The DM stated he would use the situation as a teachable moment for all dietary staff to ensure they were educated on the facility's policy and procedure related to proper food storage and how resident's health could be affected if those policies were not followed. During an interview on 10/31/2024 at 11:30 AM with [NAME] (C) 2, she stated she worked in the facility in the dietary department for eight years. She stated when foods were stored in the freezer and the open boxes should include the opened date and use-by-date. C2 stated if the box contained individually sealed packages. those opened packages were resealed and dated when opened as well as sealing the box. She further stated when bulk items were opened and stored back in the freezer, the plastic bag and the box were both resealed. Per C2, she was aware that if staff were not following the facility's policy on food storage that resident's could get sick. She further stated food could be freezer burned and residents had complained before about food not tasting good. She stated she did not want to provide food that the residents did not like. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/31/2024 at 11:40 AM, C3 stated she had been a cook at the facility for four years. She stated all open boxes should be sealed and dated when the boxes/packages were opened. She stated the staff had used scoops to get the amount needed but staff should never leave a scoop in with the food to prevent potential cross contamination. She stated all food items were to be rotated which was why the dates were important to ensure they were serving quality meals. She stated resident could get sick if staff had not followed the facility's policy and procedures related to food storage and the resident would be unhappy with food that had been freezer burned. She stated the facility had wanted to serve residents the best food and ensure any concerns with their meals were resolved because it was all about the residents receiving the best quality care. During a second interview with DM, on 10/31/2024 at 11:50 AM, he stated his expectations was for staff to ensure the boxes that were opened had been properly sealed and dated when opened. He further stated that moving forward he would ensure the staff understood the importance of residents receiving quality food service. In an interview with the Administrator, on 10/31/2024 at 4:05 PM, she stated her expectations for dietary staff would be to follow the protocols the facility had established for food safety.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37031 Based on observation, interview, record review and review of the facility policy, it was determined the facility failed to establish and maintain an infection prevention and control program to help prevent the development and transmission of infections for one of 18 sampled residents (Resident (R) 81). Observation and interview on 10/30/2024 revealed Certified Nurse Aide (CNA) 2 detached R81's tube feeding and placed the uncovered/uncapped end on top of the feeding tube pump. The findings include: Review of the facility policy titled Infection Prevention and Control Program, revised on 02/21/2024, revealed the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy explanations and compliance guidelines revealed all staff were responsible for following all policies and procedures related to the program. Staff included employees. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Per the policy, all staff shall receive training, relevant to their specific roles and responsibilities regarding the facility's infection prevention and control program, including policies and procedures related to their job function. Review of the Certified Nursing Assistant Job Description, dated 2018 revealed a commitment to promoting wellness, healing, and independence for all lives touched. The summary included that the CNA will perform direct resident care duties under the supervision of licensed nursing personnel. Review of essential duties and responsibilities revealed the CNA was to assist nursing staff with the basics of aseptic and sterile techniques to avoid infection of residents. Review of R81's medical record the facility admitted the resident on 08/28/2024 with diagnoses which included cerebral ischemia (stroke), acute respiratory failure, persistent vegetative state after a traumatic brain injury from a motor vehicle accident, gastrostomy (feeding tube) status. Review of R81's Admission Minimum Data Set (MDS) with Assessment Reference Date of 09/01/2024 revealed the resident was in a persistent vegetative state. On 10/30/2024 at 3:02 PM, CNA2 and CNA12 were observed performing incontinent care for R81. The resident was in a supine position with the head of bed flat. The resident's gastrostomy tube (G-tube) was detached from the resident. The tubing was coiled on top the feeding tube pump with no cap in place at the end of the tubing and the pump was set on hold. CNA2 stated the nurse had unhooked the feeding tube. During an interview on 10/30/2024 at 3:06 PM with Registered Nurse (RN) 1 at the nurses station, she stated she did not detach R81's gastrostomy tube and she was the only nurse working this unit. She also stated when she detaches a gastrostomy tube, she caps the end of the tubing so it stays clean. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second interview on 10/30/2024 at 3:12 PM, CNA2 stated she had unhooked R81's feeding tube. She stated she knew the nurse was busy and didn't want to bother her so she did it herself. Per CNA2, she had not been educated on use of the feeding tube. She further stated she did not know the tube was to be capped when detached. In an interview on 10/31/24 at 12:30 PM with Licensed Practical Nurse (LPN) Staff Development Coordinator (SDC) she stated she had been working as the SDC since the end of August 2024. She stated the orientation packet for CNAs did not include anything about gastrostomy tube care because CNAs are unable to care for the gastrostomy tubes. She stated she verbally told them during orientation that residents with G-Tubes were to have their head of bed (HOB) elevated 30 to 45 degrees and if there was any concern about the tube to tell their nurse. She stated her expectations was for the CNA to keep the resident's HOB elevated and to watch for any complications of the tube; however, CNAs are not to touch the tube. During an interview on 10/31/2024 at 2:48 PM, the Director of Nursing (DON) stated she expected the CNAs to follow the facility policy and the CNA job description which does not include the care of gastrostomy tubes. She also stated only nurses could change, continue, or terminate feedings. She further stated staff were provided in-services and orientation regarding management of feeding tubes. Per the DON, CNAs are educated to not touch the tube or turn it off and on. The DON stated she expected all nursing staff to cap the end of a gastrostomy tube when temporarily detaching the tubing. She stated this would ensure no contamination of the tubing. On 10/31/24 at 3:57 PM, an interview with the Administrator revealed CNAs should not touch or turn off a feeding tube per the facility policy and should follow the infection control policy as written.