

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

PRINTED: 08/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
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F 000	INITIAL COMMENTS	F 000			
F 280 SS=D	<p>A standard health survey was initiated on 07/30/13 and concluded on 08/01/13 and a Life Safety Code survey was conducted on 07/31/13 with deficiencies cited at the highest scope and severity of an "F", with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy titled Completion of the Resident Assessment Instrument (RAI) Process,</p>	F 280	F 280		
			<p>1. Care plans for Residents #1, #7 and #9 have been reviewed and revised to reflect their current care needs.</p> <p>2. All residents have the potential to have items in their care plans updated or removed.</p> <p>3. An interdisciplinary team to include the Director of Nursing, Unit Managers, MDS Nurse, Staff Development Director, Social Services Director and Therapy Director will review all care plans for accuracy by August 30, 2013. All nurses will be in-serviced on updating care plans by the Director of Nursing and Staff Development Coord. on September 3, 4 and 5, 2013.</p>		

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

TITLE

(X6) DATE

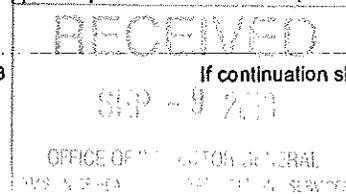
Lustig Butterfield

Administrator

9-05-2013

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.

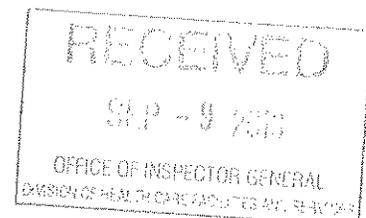
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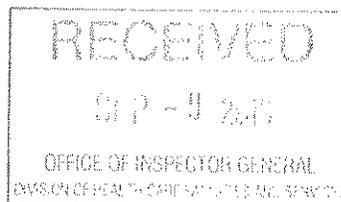
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F 280	<p>Continued From page 1</p> <p>it was determined the facility failed to revise the care plans for three (3) of fifteen (15) sampled residents, Residents #1, #7 and #9. The facility did not have a falls program; however the facility used this as an intervention on Residents #1 and #7 careplans. The facility failed to revise Resident #9's care plan to reflect the physician's ordered medication changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Completion of the RAI Process, reviewed November 1, 2011, revealed the care plan would be reviewed for accuracy quarterly and as needed prior to the Assessment Reference Date (ARD).</p> <p>1. Record review for Resident #1 revealed the facility admitted the resident on 12/13/11 with diagnoses of Dementia, Congestive Heart Failure, Pseudobulbar Affect, Urinary Tract Infection and Bronchitis. On 06/17/13, the facility assessed the resident to have cognitive impairment using the Brief Interview for Mental Status (BIMS) where on a scale of zero (0) to fifteen (15) the resident scored a zero (0). The facility assessed Resident #1 as utilizing a wheelchair for his/her mode of locomotion and was assessed as unsteady and did not walk.</p> <p>Review of the care plan for Resident #1 revealed an identified problem dated 12/29/11 related to falls. The care plan had listed eighteen (18) falls since 01/01/2012. The facility developed approaches that included placing the resident in a falls prevention program. The next scheduled review date was 09/13/13.</p> <p>Observation, on 07/30/13 at 11:10 AM, revealed</p>	F 280	<p>F 280 cont.</p> <p>4. The Director of Nursing and / or Staff Development Coord. will oversee the review of 5 care plans a week for 3 months and will report their findings to the QA committee for analysis.</p>	9-6-2013



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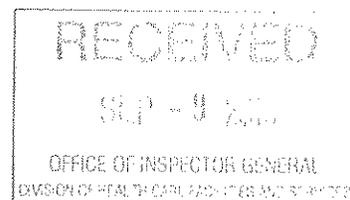
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F 280	<p>Continued From page 2</p> <p>Resident #1 sitting in a wheelchair in his/her room with his/her spouse. The wheelchair had a high back and tippers placed on the back of the chair. Continued observations at 12:40 PM revealed the resident sitting in the wheelchair at the dining room table. At 2:04 PM the resident was observed sleeping in his/her bed. On 07/31/13 at 7:13 AM Resident #1 was in his/her room sitting in a wheelchair.</p> <p>2. Record review for Resident #7 revealed the facility admitted the resident on 04/06/12 with a readmit date of 11/26/12. The diagnoses listed for Resident #7 included, Altered Mental Status, Dementia with Lewy Bodies, Dementia with behaviors and Aftercare for a Fractured hip. The facility assessed the resident to have a BIMS score of three (3) on 07/15/13, indicating cognitive impairment. The resident did not walk during the last assessment period for the Minimum Data Set (MDS) and it was noted Resident #7 used a wheelchair for locomotion.</p> <p>Review of the care plan for Resident #7 revealed an identified problem dated 04/25/12 related to falls. On 10/18/12 the resident fell and broke his/her hip, requiring hospitalization. The care plan had listed Resident #7 as having had a fall on the following dates in 2013: 2/8, 3/3, 3/23, 4/10, 4/21, 5/5, 5/13, 5/30, 6/25, 6/27 and 7/25. Included in the approaches to the problem were to place the resident in a falls prevention program dated 04/25/12. The target date for the goal on the current care plan for the problem of falls was 04/24/13. The goal of the resident remaining free from injury had remained on the care plan and was not updated since it was first written on the care plan on 09/15/12.</p>	F 280	



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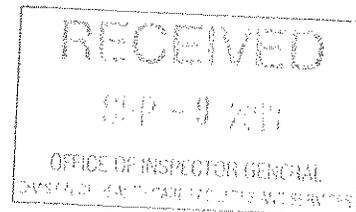
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F 280	<p>Continued From page 3</p> <p>Observation, on 07/30/13 at 11:13 AM, revealed Resident #7 sitting in a wheelchair outside the door to her room with a lap buddy on his/her chair. At 12:04 PM the resident was in his/her wheelchair in the dining room. At 2:05 PM Resident #7 was sitting in the wheelchair outside his/her room in the wheelchair with the lap buddy in place. At 2:04 PM, Resident #7 was taking a nap in bed.</p> <p>Interview, on 08/01/13 at 1:05 PM, with Licensed Practical Nurse (LPN) #1 revealed she did not update care plans. She stated her opinion would be concerning the status of the resident, but she did not update care plans.</p> <p>Interview, on 08/01/13 at 1:17 PM, with LPN #2 revealed she gave verbal input to the Unit Manager related to transfers, toileting or whatever the issue with the resident may be, but she did not physically go in and change a care plan herself.</p> <p>Interview, on 08/01/13 at 4:15 PM, with the Director of Nursing (DON) revealed the facility had identified a problem with falls. She also stated there was not a falls prevention program. She stated a resident who experienced a fall would be reviewed the following day by a multi-disciplinary team. However, the written care plan was not present during the review. She stated the Unit Managers usually go back to the unit and make the changes on the care plan. She stated anyone could update the care plan. However, interviews with staff nurses revealed they did not update the care plans.</p> <p>Interview, on 08/01/13 at 5:12 PM, with the North Unit Manager revealed there was not a falls</p>	F 280			



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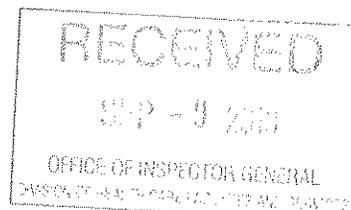
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F 280	<p>Continued From page 4</p> <p>prevention program and that should not have been on the resident's care plans. She revealed approaches on the care plan for Resident #7 were out of date and the same applied to Resident #1. The North Unit Manager revealed she did update the care plans and also met with the MDS nurse and Social Services for updates. However, she did not state how often they met and did not say if all approaches were reviewed for appropriateness.</p> <p>Interview, on 08/01/13 at 6:47 PM, with the MDS Coordinator revealed the care plans were reviewed quarterly with MDS assessments. In between assessments, the Unit Managers were to update the care plan with changes that occurred with the resident. Continued interview revealed approaches on the care plans that were not current were not removed and new approaches were just added.</p> <p>3. Clinical record review for Resident #9 revealed the facility admitted the resident on 02/16/11 with diagnoses of Essential Hypertension, Atrial Fibrillation and Dementia. Review of the current care plan provided by the facility revealed the problem onset of Hypertension requiring medication was dated 03/16/11 with continued updated goal target dates. An intervention on the care plan was to administer medication, Lopressor and Lisinopril and to evaluate, record, and report the effectiveness and any adverse side effects.</p> <p>Interview with LPN #7, on 08/01/13 at 3:08 PM, stated once the Doctor or Nurse Practitioner writes the order, then who ever takes the order off writes a real brief note in the nurses notes of what occurred and what was to be done, such as if a medication was ordered, discontinued or a follow</p>	F 280			



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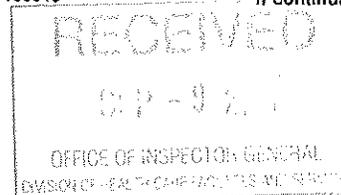
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F 280	Continued From page 5 up was needed. The supervisors come through and update the care plan. She stated she could update the care plan, but have not in a while. She stated the purpose of the care plan was a review of the resident care and the needs to take care of the resident. She stated it was important to change the information on the care plan. She reported she was unable to determine when the Lopressor and the Lisinopril were discontinued for Resident #9. Interview with the Minimum Data Set (MDS) Coordinator #5, on 08/01/13 at 5:35 PM, revealed the care plan review process was for the unit manager, interdisciplinary team and MDS to review the care plan for changes and updates. She stated Trental was also given for the blood pressure and was last changed on 08/30/11. She reported she was unable to determine when the Lopressor and the Lisinopril was discontinued for Resident #9, unless it was done at the time the Trental was added. She stated she was responsible for the changes on the care plan at each review interval such as quarterly and annual reviews at which time the medication change should have been caught and the care plan updated.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		



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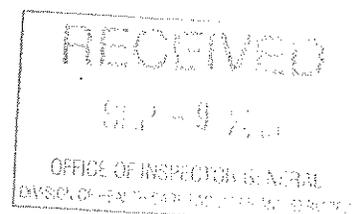
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F 315	<p>Continued From page 6</p> <p>infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to prevent urinary tract infections for one (1) of fifteen (15) residents, Resident #4. The facility staff failed to ensure a Coude Catheter was available and inserted per physician's order for Resident #4 when a positive urine culture was reported to the staff.</p> <p>The findings include:</p> <p>Review of the facility's Infection Control Manual, Prevention and Management of Urinary Tract Infections and Definition of Nosocomial Infection, revised 12/01/07, revealed an infection was a condition in which bacteria invaded a body site and multiplied causing clinical manifestations of a disease. The Prevention and Management of Urinary Tract Infections policy did not include preventive measures. Infections were usually confirmed through positive cultures from urine with a colony count of >100,000.</p> <p>Clinical record review for Resident #4 revealed the facility admitted the resident on 12/07/12, with a readmission date of 04/17/13, and diagnoses of Urinary Retention, Chronic Kidney Disease, Paraplegia, Colostomy, Congestive Heart Failure, Urinary Tract Infection, Disorders of the Skin and Subcutaneous Tissue. The resident had an indwelling urinary catheter for the Urinary Retention on admission. The facility collected a</p>	F 315	<p>F 315</p> <ol style="list-style-type: none"> 1. Resident #4 has a catheter as ordered by the physician. 2. Any resident needing a catheter could be affected by this same situation. 3. Any resident with a catheter will have their catheter care reviewed by Aug. 30, 2013 and then weekly by our D.O.N. to ensure that the correct catheter is being used and care is being provided as ordered by the physician. The Director of Nurses and / or Staff Development Coord. will provide education, on Sept. 3, 4 and 5, 2013, on catheter and colostomy care and procedures to follow if a catheter that is ordered is not available. The Director of Nurses will also ensure that the most common catheters are in stock. 	



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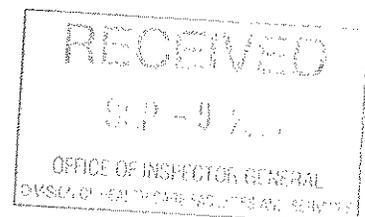
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F 315	<p>Continued From page 7</p> <p>urine specimen on 07/19/13. The cultured revealed >100,000 CFU/ml Escherichia Coli and Proteus Mirabills on 07/21/13. The facility collected a second urine specimen on 07/28/13 and on 07/31/13 the culture revealed a growth of Proteus Mirabilis.</p> <p>Review of the comprehensive care plan, dated 12/27/12, revealed an intervention to change the catheter per physician orders and the catheter bag every month. In addition, catheter care was to be provided every shift and as needed.</p> <p>On 07/27/13, the physician ordered for the catheter to be changed using a Coude Catheter.</p> <p>Interview with LPN #6, on 07/31/13 at 4:30 PM, revealed she did not know how long the catheter had been placed. She stated she had received an order from the urologist on 07/27/13 to change the catheter. She stated she spoke with the manager about the Coude Catheter; however, the facility did not have that type in stock and would have to order it.</p> <p>Observation of the indwelling catheter change with LPN #6, on 07/31/13 at 4:30 PM, revealed the Coude Catheter available for use did not have a balloon to anchor inside the bladder. LPN #6 attempted to insert the same catheter twice. At that time, the Unit Manager came into the room and said the Coude was the wrong type. The Coude Catheter was removed from the resident's bladder and a regular catheter, 16 French indwelling catheter, was placed.</p> <p>Interview with the Nurse Practitioner, on 08/01/13 at 6:30 PM, revealed she knew the catheter had been placed for urinary retention and had not</p>	F 315	<p>F 315 cont.</p> <p>4. The Director of Nursing and / or Staff Development Coord. will review every new catheter order, weekly, to ensure that catheters are being used and cared for as ordered by the attending physician. Also every other week, for 12 weeks, an inventory of catheters will be taken to ensure that catheters commonly used are in stock. A report will be presented to the Standards of Care committee and to the QA committee meeting who will determine future QA requirements.</p>	9-6-2013



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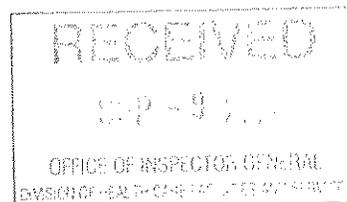
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F 315	Continued From page 8 been changed since around 03/2013. She stated she placed an order for the catheter not to be changed. She stated previously the catheter was not to be changed; however, a recent visit to the urologist for an evaluation related to a large opening of the penis. indicated the need to change the catheter. The urologist ordered for the catheter to be changed on 07/27/13. In addition, observation during the catheter change on 07/31/13 revealed the colostomy bag was leaking around the ostomy site onto the catheter. Interview with Resident #4, on 07/01/13 at 2:30 PM, revealed the catheter had been in for a long while, but did not remember when it was last changed.	F 315	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. 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 failed to maintain an error rate of less than five (5) percent during a medication pass. There were two (2) errors out of twenty-six (26) opportunities, resulting in a 7.69% medication error rate. The findings include:	F 332	F 332 1. Nursing staff involved were in-serviced regarding accurate med passes. Residents A and resident B are receiving eye drops as ordered by the physician. Residents A and B had no adverse effects due to eye drop errors. 2. All residents receive medications and therefore all residents could be affected by the deficient practice.



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F 332	<p>Continued From page 9</p> <p>Review of the Eye Drop Administration policy, undated, revealed equipment required to administer eye drops included the Medication Administration Record (MAR).</p> <p>1. Record review for Unsampled Resident A revealed a physician's order for Combigan eye-drops, one (1) drop in the left eye twice a day.</p> <p>Observation, on 07/31/13 at 9:10 AM, revealed Licensed Practical Nurse (LPN) #1 instilled one (1) eye drop in both the right eye and the left eye of Unsampled Resident A. The physician had ordered the eye drop for the left eye only.</p> <p>Interview, on 08/01/13 at 1:05 PM, with LPN #1 revealed she had made the drug error because she was nervous while being observed during the medication pass. She stated she had been in-serviced on how to administer medications. LPN #1 revealed to administer the wrong medication may have had an adverse affect on the resident, depending on the type of medication it was.</p> <p>2. Record review for Unsampled Resident B revealed a physician's order for Refresh Dry Eye Therapy 1-1%, two (2) drops both eyes twice a day.</p> <p>Observation, on 07/31/13 at 7:30 AM, revealed LPN #3 instilled one (1) drop to each eye of Unsampled Resident B when the physician had ordered two drops to be instilled in each eye.</p> <p>Interview, on 07/31/13 at 8:41 AM, with LPN #3 revealed she made the error because she was nervous. She stated she knew the resident was</p>	F 332	<p>F 332 cont.</p> <p>3. All nursing staff will be in-serviced regarding accurate med pass procedures on September 3, 4 and 5, 2013 by the Director of Nursing and / or Staff Development Coordinator.</p> <p>4. The Director of Nursing and / or Staff Development Coordinator will observe two med passes a week for 4 weeks and then one med pass per week for 8 weeks. We will ask our pharmacy consultant to monitor one med pass a month for three months. The Director of nursing and the pharmacy consultant will report findings to the monthly Standards of Care meetings and the QA committee meeting. The QA committee will determine further med pass observations based on report findings.</p>	9-6-2013	



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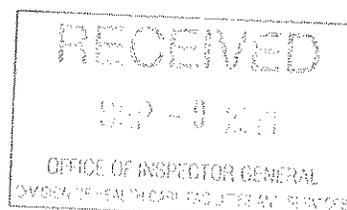
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F 332	Continued From page 10 to receive two (2) eye drops in each eye. She revealed she had been in-serviced on medication administration.	F 332			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to serve food in a sanitary manner. The Dietary staff touched multiple surfaces and continued to serve food to the residents. The findings include: Review of the facility's policy regarding Hand Washing Technique, Revised 12/03/07, revealed the objective in washing hands was to prevent the spread of infection. The policy did not note when it was indicated to wash hands. Review of the facility's Infection Control Manual, Standard Precautions, revised 11/03/07, revealed the section on handwashing was the policy and directed the staff to wash their hands after touching contaminated items whether or not	F 371	F 371 1. The staff member involved was immediately counseled on proper hand washing between glove changes and food is being served in a sanitary manner. 2. All residents have the potential to be affected by the deficient practice. 3. Our Dietary Consultant will provide another in-service to all food service employees on proper hand hygiene while working in the kitchen on August 20, 2013. Every 6 months our Food Service Director will provide an in-service on kitchen sanitation, to include hand washing and the wearing of gloves. Hand washing competency audits will be completed every three months for one year.		



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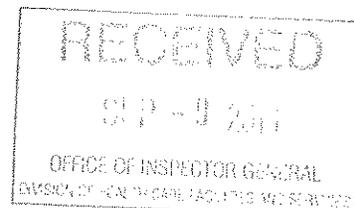
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F 371	<p>Continued From page 11</p> <p>gloves were worn. Gloves were to be changed between task and procedures on the same resident after contact with material that may contain a high concentration of micro-organisms. The staff was to wash hands after removal of gloves.</p> <p>Observation of Dietary Aide #15, on 07/31/13 at 12:12 PM, revealed she entered the walk in refrigerator and obtained the rolling cart with partially filled trays while wearing gloves. She pulled the cart from the refrigerator and pushed the the cart with gloved hands holding the metal bars on the corners. She continued wearing the same gloves and continued with the meal service. She touched the inside of the plates with her left thumb as she grasp the plate for service. She held the cart corners as she slide the next tray into line. She continued with the meal services. She removed her gloves and entered into the dish wash room. As she passed the trash container, she lifted the lid and placed the soiled gloves into the trash container and proceeded into the area. She did not wash her hands after contact with the trash lid. She obtained plate guards and returned to the service line. She did not wash her hands. She donned another set of gloves and continued with meal service.</p> <p>Review of the facility's handwashing in-service attendance record, dated 04/25/13, revealed Dietary Aide #15 attended the in-service.</p> <p>Interview with Dietary Aide #15, on 08/01/13 at 6:03 PM, revealed it was ok to change gloves between job while in the kitchen. She stated she was suppose to wash her hands when she left the kitchen and came back into the kitchen area. She stated she did wash her hands when coming</p>	F 371	<p>F371 cont.</p> <p>4. Our Dietary Consultant will monitor one meal a week for one month to ensure in-services have been effective. Reports will be provided to our Standards of Care meeting and our QA Committee. Our Food Service Director or Clinical Dietary Manager will observe one meal a week for 3 months and thereafter as directed by the QA committee.</p>	9-6-2013	



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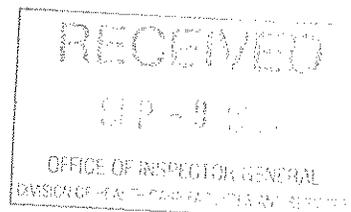
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F 371	Continued From page 12 into the kitchen area. She stated she was trained on hand washing in the kitchen. She stated the purposes of washing hands was to keep the residents from getting sick. Interview with the Food Service Manager, on 08/01/13 at 6:15 PM, revealed the staff were trained on hand washing. She stated the staff were trained to wash their hands upon entering the kitchen area. Hand washing was determined by the location in the kitchen area as to when to wash and when to change gloves and what you could touch with the gloves. She reported the staff should wash hands when gloves were changed and they changed to a dirty area. It was ok for them to change gloves without washing their hands while in the kitchen when in the same area.	F 371			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425	F 425 1. The EDK med box has been replaced and nurses will be in-serviced on September 3, 4 or 5, 2013 regarding correct procedures of when and how to use to EDK box for medications that are needed and what documentation is required when removing medications from the EDK box.		



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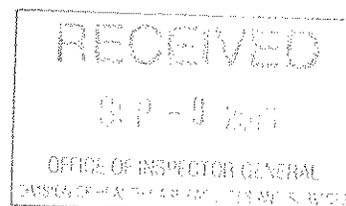
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F 425	<p>Continued From page 13 services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies for Emergency Pharmacy Service and Emergency Kits, and Ordering and Receiving Medications from the Dispensing Pharmacy, it was determined the facility failed to ensure the pharmacy provided an Emergency Drug Kit (EDK) that was complete and that scheduled medications were available for administration for two (2) of twenty-eight (28) medications and the EDK box revealed one (1) of the medications was listed on the par level; however, it was not in the EDK box and not available.</p> <p>The findings include:</p> <p>Review of the facility policy's Emergency Pharmacy Service and Emergency Kits, undated, revealed the facility nurse who removed a medication from the EDK was responsible to have notified the pharmacy in order for the pharmacy to have exchanged the opened EDK for a complete EDK. The policy stated the EDK was inventoried once a month by the consultant pharmacist or the provider pharmacy.</p> <p>Review of the facility's policy titled Ordering and Receiving Medications from the Dispensing Pharmacy, undated, revealed medications that were not automatic refills were to be ordered three (3) to four (4) days in advance of need to assure an adequate supply was on hand. In</p>	F 425	<p>F 425 cont.</p> <p>2. All residents medications are provided from a pharmacy and then provided to residents by our nursing staff. Therefore all residents could be affected by this deficient practice.</p> <p>3. Pharmacy will provide us a new procedure to ensure that all medications listed as being in the EDK box are in fact in the EDK box. The Director of Nursing will also provide an in-service regarding using the EDK box to supply medications needed but not yet present in the med cart. In-service will also include training on procedures for removing meds from the EDK box and the documentation needed to ensure the pharmacy knows the EDK box has been used. D.O.N. will provide in-services will be held on Sept. 3, 4 and 5, 2013.</p>	



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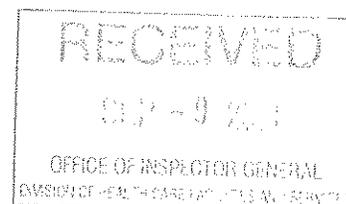
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F 425	<p>Continued From page 14</p> <p>addition, it was stated timely delivery of a new order was required so that medication administration was not delayed. The EDK was used when the resident needed a medication prior to pharmacy delivery.</p> <p>Observation, on 07/31/13 at 7:30 AM, revealed LPN #3 did not have the following medications available in the medication cart to administer, Senna Laxative 8.6 mg tablet for Resident C and Multi-vits Liquid 9 mg/15 ml for Resident B as ordered by the physician.</p> <p>Interview, on 07/31/13 at 1:15 PM, with LPN #3 revealed the medications unavailable during the observed morning medication pass were called to the pharmacy for delivery and had not yet arrived at the facility. She stated if a medication was delayed in delivery from pharmacy a second call will bring them right out. She stated the process to be followed when a medication was not available was to go to the EDK, and if available in the EDK, give that medication until the resident's medication arrived from the pharmacy. However, she had not used the EDK for a source during the medication pass when the ordered medication was not available. Review of the EDK content list revealed the medication was listed. However, the medication was not present in the EDK. The EDK was not a complete kit. The staff was not aware of who had opened the EDK and used the medication.</p> <p>Interview, on 07/31/13 at 3:05 PM, with LPN #5 revealed there was only one EDK in the facility. The missing medication during the medication pass, Senna, was listed on the contents of the EDK; however, when the EDK was checked for the medication, it was missing. She revealed the</p>	F 425	<p>F 425 cont.</p> <p>4. The Director of Nursing and / or Staff Development Coordinator will observe two med passes a week for 4 weeks and then one med pass per week for 8 weeks. We will ask our pharmacy consultant to monitor 1 med passes a month for three months. The Director of Nursing and the Pharmacy consultant will observe the need to use EDK box and will observe whether the EDK box was filled correctly and used by the nurses appropriately. The Director of nursing and the pharmacy consultant will report findings to our monthly Standards of Care meetings and our QA committee meeting. The QA committee will determine further med pass observations based on report findings.</p>	9-6-2013	



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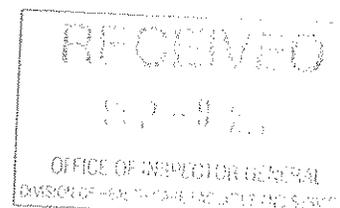
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F 425	<p>Continued From page 15</p> <p>EDK was used for medications unavailable on the medication cart or the pharmacy was called to deliver the medications which were unavailable for resident administration. She revealed a drug needed urgently (STAT) would take two (2) to (4) hours for delivery and a regular order for a medication would come in the next day. She revealed current ordered prescribed medications were sometimes not refilled by pharmacy when the fax did not go through or the resident did not have insurance or whatever the malfunction may be. She explained when those things happened, she would not know a medication was not available for administration until she went to remove the medication from her medication cart.</p> <p>Interview, on 08/01/13 at 1:05 PM, with Licensed Practical Nurse (LPN) #1 revealed there were times when medications that were listed as contained in the EDK were not available in the EDK and pharmacy would be called to deliver the medication and usually the pharmacy would bring the medication on the next shift. She revealed the seriousness of the drug may have something to do with the delivery time.</p> <p>Interview, on 08/01/13 at 1:23 PM, with LPN #2 revealed every once and a while there would be a mix up with pharmacy and medications would not be available. For those times she stated pharmacy would be called and they would have the medication delivered by the next shift at least.</p> <p>Interview, on 08/01/13 at 5:12 PM, with the North Unit Manager revealed sometimes the facility had a problem with the regularly scheduled medications being available and delivered by pharmacy. She revealed medications were on a</p>	F 425			



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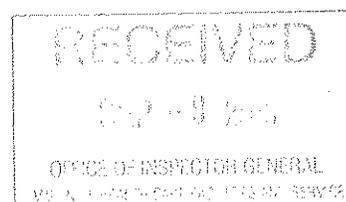
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F 425	Continued From page 16 schedule for renewal and they would not show up. She revealed her understanding of the EDK was it would be replaced daily by pharmacy. She stated papers were to be filled out for the medications removed from the EDK and faxed to pharmacy. The completed paper would inform pharmacy what was removed from the EDK and what was needed to be replaced. However, the medication unavailable from the EDK revealed the process of filling out the document had not been followed and the medication was not replaced. Interview, on 08/01/13 at 6:47 PM, with the Director of Nursing revealed pharmacy maintained the EDK. She revealed she had not been made aware of any concerns about the lack of availability of medications.	F 425			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	F 431 1. The two unlabeled vials of medication, the two bottles of isopropyl alcohol and the one bottle of betadine that were opened but not dated were immediately discarded from the South Medication room. The heparin flush syringe was also discarded. 2. Although no residents were known to have been affected by the deficient practice, all residents have the potential to be affected.		



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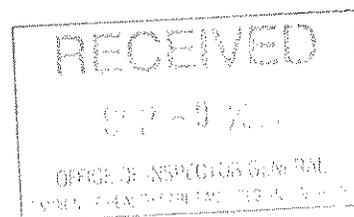
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F 431	<p>Continued From page 17</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy Storage of Medications and Biologicals, it was determined the facility failed to ensure medications and biologicals were appropriately labeled and dated when opened in one (1) of two (2) medication rooms. In the South Medication Room two (2) opened vials of medication were found to have labels which did not contain the name of the medication. In addition, there were two (2) bottles of isopropyl alcohol opened and undated, stored with dressing supplies and a bottle of prep solution (Betadine) opened and not dated. There was a pre-filled heparin flush syringe with an expiration date of 06/11 also found in the South Medication Room.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Storage of Medications and Biologicals, undated, revealed</p>	F 431	<p>F 431 cont.</p> <p>3. A new policy will be written regarding the inspection of the Medication rooms to include the dating of medications or biologicals once they are opened. Unit managers will inspect the Medication rooms biweekly, for undated, unlabeled or out dated medical supplies.</p> <p>4. The Director of Nursing will monitor the Medication rooms monthly to verify that the weekly checks are sufficient to correct the situation. The pharmacy consultant will also monitor the Medication rooms monthly for proper storage of medications, biological and medical supplies. Reports will be given to our monthly Standards of Care meetings and presented to our QA committee meetings.</p>	9-6-2013	



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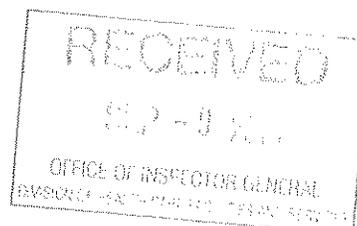
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F 431	<p>Continued From page 18</p> <p>medications were to be stored safely, securely and properly. The policy stated outdated medications would be immediately removed from stock. In addition, the policy stated medication storage conditions were monitored on a monthly basis and corrective action taken if problems were identified. The policy did not address the dating of medications or biologicals once they were opened.</p> <p>Observation, on 07/31/13 at 1:25 PM, of the South Medication Room revealed two (2) opened vials of medication labeled without the name of the medication. The same two (2) vials were not dated when opened. There were two (2) bottles of isopropyl alcohol opened and undated, in addition to a bottle of prep solution (Betadine) opened and not dated. Continued observation revealed a pre-filled heparin flush syringe with an expiration date of 06/11.</p> <p>Interview, on 07/31/13 at 1:25 PM, with Licensed Practical Nurse (LPN) #4 revealed it was standard nursing practice to date a medication vial when opened. She revealed the purpose to date a medication when opened was to know when the medication was to expire.</p> <p>Interview, on 07/31/13 at 1:35 PM, with the South Unit Manager revealed the nursing staff was responsible to monitor the medication room for expired medications and undated labels. She stated the heparin syringe should have been removed from the room. The South Unit Manager revealed multi dose vials were to be dated when opened so you would know how long it had been open. She stated there have been in-services on dating things such as eye drops, liquids in carts, insulin vials and multi dose vials.</p>	F 431			



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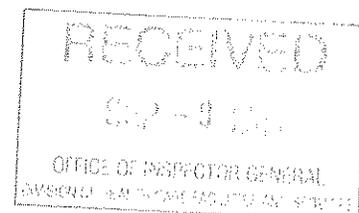
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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
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F 431	<p>Continued From page 19</p> <p>She stated the reason to not use an expired solution such as Betadine or isopropyl alcohol was the solution may cause harm if bacteria had set up in the solution.</p> <p>Interview, on 07/31/13 at 3:10 PM, with LPN #5 revealed when you opened a medication vial or biological you were to date, time and initial the container, that it was standard nursing practice. She stated this was done because these items have limits. She revealed medication vials or biologicals can harm the resident if expired, loose effectiveness and germs may grow.</p> <p>Interview, on 08/01/13 at 1:05 PM, with LPN #1 revealed when a medication vial was opened you were to initial and date the vial. She revealed the same was true for biologicals. LPN #1 revealed the dates of opened items was important because a drug may become less effective and liquid solutions may have bacteria which may harm the resident.</p> <p>Interview, on 08/01/13 at 1:23 PM, with LPN #2 revealed medication vials were to be dated and initialed when opened. She stated she had not been in-serviced on the storage of medications and biologicals. She revealed all the nurses were responsible to monitor the medication room.</p> <p>Interview, on 08/01/13 at 5:12 PM, with the North Unit Manager revealed medication vials were to be dated and initialed when opened. She stated the reason to do this was the medication may have lost its potency or bacteria may have grown in the vial.</p> <p>Interview, on 08/01/13 at 6:47 PM, with the Director of Nursing (DON) revealed the nursing</p>	F 431			



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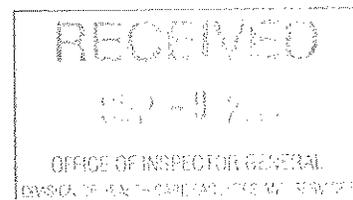
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F 431	Continued From page 20 staff had not been in-serviced on the storage of medications and biologicals. She revealed open medication vials and biologicals were to be dated and initialed when opened. She did not state who was responsible to monitor the medication rooms.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F 441 1. LPN #6 and #7, providing care to residents #4 and #7, were counseled on August 2, 2013 and nurses are currently providing care to Residents #4 and #7 using proper hand hygiene. 2. We acknowledge that all residents could be affected by this deficient practice. 3. Additional in-services, for all nurses, will be provided by the Director of Nursing and / or Staff Development Coordinator on September 3, 4 and 5, 2013. In-service to include proper hand hygiene and proper aseptic techniques.		



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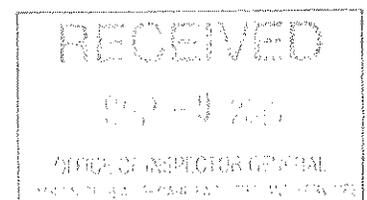
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F 441	<p>Continued From page 21</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policies Infection Control Program, Dressing Change, and Hand Washing Technique, it was determined the facility failed to implement their Infection Control Program to prevent transmission of infections or disease in regard to hand hygiene for two (2) of fifteen (15) sampled and three (3) unsampled residents. The nursing staff, during wound care for Resident #4 and Resident #7, failed to wash their hands after removal of soiled gloves and donning new gloves.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Infection Control Program, revised 11/03/07, revealed the facility had an infection control program that actively identified, controlled and prevented infections within the facility. In addition, it was revealed one of the facility functions was to observe direct care staff in the use of gloves and handwashing practices.</p> <p>Review of the facility's policy Dressing Change, effective 10/28/12, revealed with gloved hands soiled dressings were to be removed, then the gloves are removed, hands washed and new gloves donned prior to cleansing the wound and placing the dressing over the wound.</p>	F 441	<p>F 441 cont.</p> <p>4. Our Staff Development / Infection Control Coordinator will observe two treatments / dressing changes a week per wing for the next 12 weeks. She will report her finding to our Standards of Care meetings and also to our QA committee meeting. The QA committee based on her findings will determine the frequency of continued observations.</p>	9-6-2013	



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F 441	<p>Continued From page 22</p> <p>Review of the policy Hand Washing Technique, Revised 12/03/07, revealed the objective in washing hands was to prevent the spread of infection. The policy did not note when it was indicated to wash hands.</p> <p>1. Observation, on 07/31/13 at 3:20 PM, revealed Licensed Practical Nurse (LPN) #6 completing a dressing change to the right buttock of Resident #7. LPN #6 washed her hands prior to the dressing change. However, after LPN #7 removed the soiled dressing, she changed her gloves without washing her hands between the glove change. When the dressing change was completed, LPN #6 walked out of the resident's room with the soiled supplies, to the soiled utility room where she then washed her hands.</p> <p>2. Review of the facility's Infection Control Manual, Standard Precautions, revised 11/03/07, revealed standard precautions were to be used on all residents. In the section of handwashing the policy directed staff to wash their hands after touching blood, body fluids, secretions, excretions and contaminated items whether or not gloves were worn. Gloves were to be changed between task and procedures on the same resident after contact with material that may contain a high concentration of micro-organisms. Also, the staff was to wash hands after removal of gloves.</p> <p>Observation of LPN #6 during care provided to Resident #4, on 07/31/13 at 4:30 PM, revealed she cleaned the over the bed table and removed her gloves. She did not practice hand hygiene and reapplied gloves to her hands. She removed the colostomy bag, cleaned the stool from around the ostomy site, removed her gloves. LPN #6 donned gloves on both hands without hand hygiene between glove changes. She cleaned</p>	F 441			



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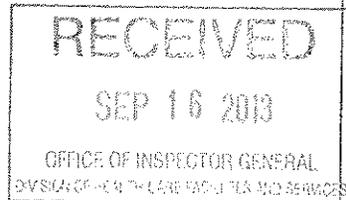
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F 441	<p>Continued From page 23</p> <p>the stoma site with normal saline and gauze. She proceeded to apply a skin prep to the skin around the stoma site. She reapplied the colostomy bag.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 12/07/12, with a readmission date of 04/17/13, and diagnoses of Chronic Kidney Disease, Paraplegia, Colostomy, Urinary Tract Infection, Disorders of the Skin and Subcutaneous Tissue. Review of the Quarterly MDS, dated 02/14/13 revealed the facility assessed the resident as a paraplegic and as requiring extensive assistance by staff with hygiene and bathing and was dependent on staff for care of the colostomy.</p> <p>Interview with LPN #6, on 08/01/13 at 5:05 PM, stated hand hygiene was to be done between every patient. She stated it was ok to change gloves during a procedure without hand hygiene as long as you were doing the same procedure. She stated you had to do hand hygiene when the nurse changed to a different procedure. She stated, she should have washed her hands when she changed gloves.</p> <p>Interview with the North Unit Manger, on 08/01/13 at 4:21 PM, revealed the staff were very conscientious when it came to hand hygiene. She stated some of the staff double gloved when care was provided to the residents. She stated the staff was supposed to do hand washing before resident care. She stated she would have to review the policy for the details.</p>	F 441			



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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: 1978, 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type III 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 (wet) sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is LP gas.</p> <p>A standard Life Safety Code survey was conducted on 07/31/13. Springhurst Health and Rehab 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> <p>Deficiencies were cited with the highest</p>	K 000			

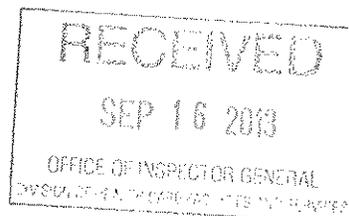


LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Leslie J. Butterfield* TITLE: Administrator (X6) DATE: 9-16-2013

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.

J A

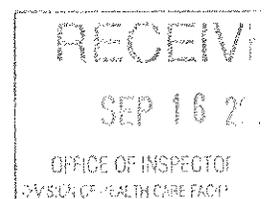
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 185305		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 07/31/2013	
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K 000	Continued From page 1 deficiency identified at F level. CFR: 42 CFR 483.70(a)			K 000			
K 045 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of the six (6) smoke compartments, residents, staff and visitors. The facility has ninety (90) certified beds and the census was seventy-two (72) on the day of the survey. The facility failed to provide the required illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observations, on 07/31/13 between 10:10 AM and 1:15 PM, with the Maintenance Supervisor revealed the exits located in the Main Dining Room, the Activities Room, the Sun Room, and the South-West Resident Hall did not have a light installed outside to provide the required illumination for exit discharge. The exits were equipped with a light fixture with only one bulb installed.</p>			K 045	<p>K 045</p> <p>1. No residents were affected by this cited deficiency. Dual bulb light fixtures were ordered and have been installed at the exits located in the main dining room, the activities room, the sun room and the south-west resident hall. Project was completed on September 03, 2013.</p> <p>2. A thorough inspection of all other exits found that all of the remaining exits had dual bulb light fixtures. Therefore no other residents were affected.</p> <p>3. Maintenance will monitor, monthly, all outside exit fixtures to ensure that all light fixtures are working and that all bulbs are working. The maintenance director will in-service all maintenance staff of the importance to make sure all outside lights are operating correctly. The in-service will take place on September 3, 2013.</p>		



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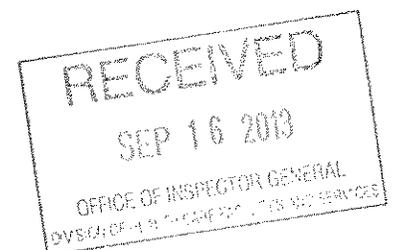
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K 045	Continued From page 2 Interviews, on 07/31/13 between 10:10 AM and 1:15 PM, with the Maintenance Supervisor revealed he was not aware the exits did not have the required illumination for egress lighting. Reference: NFPA 101 (2000 Edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation,	K 045	K 045 cont. 4. The Maintenance Director will provide a report to the administrator each month of their findings. The Administrator will visually inspect, each quarter, each exit lighting fixture to ensure monthly inspections by maintenance are accurate and meeting the Life Safety requirements. Administrator will report finding to the QA committee who will decide any further required actions.	9-6-2013	



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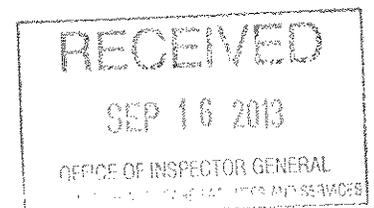
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K 045	Continued From page 3 the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045			
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to	K 047	K 047 1. No residents were affected by this cited deficiency. The exit sign in the therapy department was replaced with a new sign on August 02, 2013. 2. A thorough inspection of all other exit signs found that all of the remaining exit signs were working properly. Therefore no other residents were affected.		



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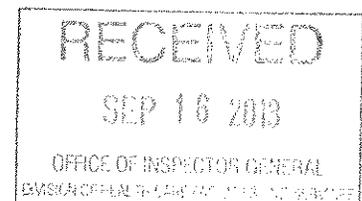
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K 047	Continued From page 4 affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility has ninety (90) certified beds and the census was seventy-two (72) on the day of the survey. The findings include: Observation, on 07/31/13 at 10:30 AM, with the Maintenance Supervisor revealed the exit from the Therapy Department to the exterior of the building had an exit sign with a battery powered emergency back-up light and exit sign that was not illuminated and did not function when tested. Interview, on 07/31/13 at 10:30 AM, with the Maintenance Supervisor revealed he was unaware the signage was not illuminated and not functioning properly. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	K 047 cont. 3. Maintenance will monitor, monthly, all exit signs to ensure that all exit sign fixtures are working and that all Backup batteries are working. The maintenance director will in-service all maintenance staff of the importance to make sure all exit lights are operating correctly. The in-service will take place on September 3, 2013. 4. The Maintenance Director will provide a report to the administrator each month of their findings. The Administrator will visually inspect, each quarter, each exit sign fixture to ensure monthly inspections by maintenance are accurate and meeting the Life Safety requirements. Administrator will report finding to the QA committee who will decide any further required actions.		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		9-6-2013	



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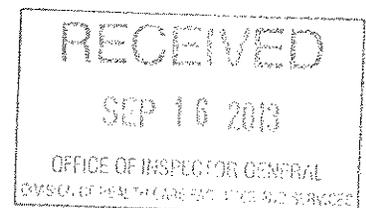
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K 062	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect each of the six (6) smoke compartments, all residents, staff and visitors. The facility has ninety (90) certified beds and the census was seventy-two (72) on the day of the survey. The facility failed to ensure items were not stored within eighteen (18) inches from any sprinkler heads and escutcheon plates were installed at all sprinkler heads. The findings include: 1. Observations, on 07/31/13 between 9:27 AM and 12:13 PM, with the Maintenance Supervisor revealed items were stored within eighteen (18) inches of the sprinkler head within the closets located in all of the Resident Rooms. Interviews, on 07/31/13 between 9:27 AM and 12:13 PM, with the Maintenance Supervisor revealed he was not aware of items being stored within eighteen (18) inches of the sprinklers heads located in the closets in all Resident Rooms. 2. Observation, on 07/31/13 at 12:25 PM, with the Maintenance Supervisor revealed there was an escutcheon plate missing on one (1) sprinkler head located in the Sun Room. Interview, on 07/31/13 at 12:25 PM, with the Maintenance Supervisor revealed he was	K 062	K 062 1. No residents were affected by this cited deficiency. Items on shelves in resident closets, 18 inches from the sprinkler heads, were removed on August 02, 2013. The escutcheon plate for a sprinkler head in the Sun Room was replaced on July 31, 2013. 2. All residents were identified as having the potential to be affected by this deficient practice. 3. Maintenance has begun to remove all shelves from all resident's closets. All shelves in all residents' closets were removed by September 3, 2013. The Maintenance Director will in-service all maintenance personnel for detection of missing escutcheon plates. In-service will occur on September 3, 2013. 4. Maintenance will inspect all resident closets once a month to ensure that no shelves, in resident rooms, have been reinstalled and that closets in all other areas do not have items within 18 inches of any sprinkler head.		



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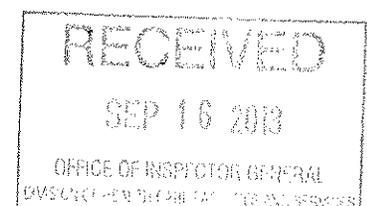
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K 062	Continued From page 6 unaware of the escutcheon plate missing at the sprinkler head located in the Sun Room. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062	K 062 cont. Maintenance will also monthly inspect all sprinkler heads to ensure that no escutcheon plates are missing. The Administrator will accompany maintenance once a quarter to ensure compliance with the Life Safety code. Maintenance will report finding monthly to the administrator and the administrator will report to the QA committee meeting. The Administrator will be responsible for compliance.		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential	K 076	K 076 1. No residents were affected by this cited deficiency. On August 23, 2013, oxygen was been moved to another dedicated closet where nothing else will be stored except for oxygen. 2. No other residents were harmed by this deficient practice. Only residents in the two smoke compartments had the potential to be affected.	9-6-2013	



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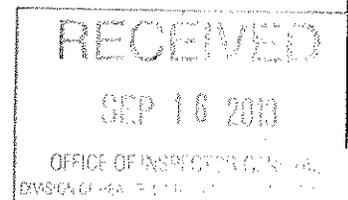
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K 076	<p>Continued From page 7</p> <p>to affect two (2) of six (6) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has ninety (90) certified beds and the census was seventy-two (72) on the day of the survey. The facility failed to ensure oxygen cylinders were stored a minimum of five (5) feet away from any combustibles items stored within the room.</p> <p>The findings include:</p> <p>Observation, on 07/31/13 at 9:12 AM, with the Maintenance Supervisor revealed the oxygen storage room located in the South Hall had oxygen cylinders stored within five (5) feet of boxed medical supplies on open shelves and under the wood constructed wall cabinets, also storing combustible items. Further observation at 1:27 PM with the Maintenance Supervisor revealed the oxygen storage room located in the North Hall had oxygen cylinders stored in the same manner as the South Hall.</p> <p>Interviews, on 07/31/13 at 9:12 AM and 1:27 PM, with the Maintenance Supervisor revealed he was unaware oxygen cylinders could not be stored within five (5) feet of combustible items and acknowledged the potential of a hazardous situation.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible</p>	K 076	<p>K 076 cont.</p> <p>3. Nursing will be re in-serviced on Life Safety codes for oxygen storage. The in-service will be provided by the Staff Development Director and / or the Administrator on September 3, 4 and 5, 2013.</p> <p>4. The Administrator will make weekly rounds for one month and then monthly rounds thereafter. He will be looking for proper storage of all oxygen tanks and that individual tanks are stored properly when not in use. He will report his finding to the QA committee who will ultimately determine if monthly rounds are sufficient.</p>	9-6-2013	



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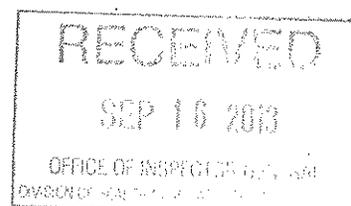
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K 076	Continued From page 8 construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076			
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147			



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K 147 SS=D	<p>Continued From page 9</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, approximately ten (10) residents, staff, and visitors. The facility has ninety (90) certified beds and the census was seventy-two (72) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/31/13 at 9:27 AM, with the Maintenance Supervisor revealed in Resident Room 164, medical equipment was plugged into a power strip.</p> <p>Interview, on 07/31/13 at 9:27 AM, with the Maintenance Supervisor revealed he was aware of the requirements for the usage of power strips; however, he was not aware of medical equipment being plugged into a power strip in the resident's room.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the</p>	K 147	<p>K 147</p> <ol style="list-style-type: none"> 1. No residents were affected by this cited deficiency. The power strip in room 164 was removed on July 31, 2013. 2. The day immediately following the survey a room to room inspection was completed and no extension cords were found and no other power strips with medical equipment plugged into them were found. 3. An in-service will be provided to maintenance, housekeeping and nursing staff regarding extension cords and the proper use of power strips. An in-service will be provided by the Administrator and the Director of Staff Development. In-services will occur on September 3, 4 and 5, 2013. 4. The Safety Committee will assign one person per week to inspect all rooms for extension cords and to ensure that no medical equipment is plugged into any power strip. 		



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K 147	Continued From page 10 intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	K 147 cont. The Administrator will make monthly rounds to determine if the weekly inspections are correcting the deficient practice. The Administrator will report to the QA committee his findings and the QA committee will determine any further actions.	9-6-2013	

