

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

PRINTED: 10/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185046</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/31/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALEM SPRINGLAKE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>509 NORTH HAYDEN AVE.</b> <b>SALEM, KY 42078</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  Based on implementation of the acceptable POC, the facility was deemed to be in compliance 10/31/15, as alleged.	{F 000}			

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

TITLE

(X6) DATE

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185046	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/31/2015
Name of Facility SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	Street Address, City, State, Zip Code 509 NORTH HAYDEN AVE. SALEM, KY 42078	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0160</u> Reg. # <u>483.10(c)(6)</u> LSC _____	Correction Completed 10/31/2015	ID Prefix <u>F0371</u> Reg. # <u>483.35(l)</u> LSC _____	Correction Completed 10/31/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>PH</u>	Date: <u>10/27/15</u>	Signature of Surveyor: <u>Debra L. Hedden, RLS, DR</u>	Date: <u>10/27/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 10/1/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  18504G	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/01/2015
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NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Submission of this Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and Federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition of participation in Title 18 and Title 19 programs. The submission of the plan of Correction within this time frame should in no way be construed or considered as an agreement with the	10/24/15
F 160 SS-B	<p>A Recertification Survey was conducted on 09/29/15 through 10/01/15 with deficiencies cited at the highest Scope and Severity of a "F".</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview and facility policy review, it was determined the facility failed to ensure residents, who had money in Resident Accounts, had their money transferred to the resident's estate within thirty (30) days after the death of the resident, for two (2) residents (Resident A and B) out of five (5) residents.</p> <p>The findings include:</p> <p>Review of the facility policy "Resident Trust Fund Overview", dated 09/23/14, revealed within thirty (30) days of a resident's death, the nursing facility shall transfer the funds of the resident's account and a final account of those funds, to the Administrator or Executor of the estate, or to the person who has filed an application for release from administration.</p> <p>1. Resident A expired on 07/07/15 and the account was not closed until 09/25/15.</p>	F 160		

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

TITLE

Administrator

(X6) DATE

10/22/15

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/01/2015
NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078	
(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(5) COMPLETION DATE
F 160	Continued From page 1  2. Resident B expired on 07/17/15 and the account was not closed until 09/28/15.  Interview with the Business Office Manager (BOM), on 10/10/15 at 10:15 AM, revealed she was aware the account needed to be closed within thirty (30) days, and this was the facility policy to do this, but Resident A had issues with the estate and an outstanding debt owed to the facility. Resident B was "just missed" as the BOM was late in closing the account.  Interview with the Administrator, on 10/01/15 at 10:15 AM, revealed the facility had been in transition with staff members and these accounts were overlooked.	F 160	allegations of noncompliance or admissions by the facility. This Plan of Correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.  F160	
F 371 SS=F	483.35(f) 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 facility policy review it was determined the facility failed to store, prepare, distribute and serve food under	F 371	1. Resident A and B's funds were disbursed by the Business Office Manager on 9/29/15 and the accounts closed 2. All accounts from deceased residents for the past six (6) months were audited on 10/21/15 by the Business Office Manager. No further issues related to the disbursement of funds upon the death of a resident have been identified. 3. The Business Office Manager was inserviced by the Administrator on 10/16/15 related to the requirement to disburse funds and close the resident account within thirty (30) days of the death of the resident.	10/30/15 e

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NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078	
(X4) ID PREFIX TAG	SLIMINARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 2</p> <p>sanitary condilions. Observallons of the kitchen revealed the thermometers were not properly calibrated; food temperatures were not recorded; foods were left in the steamer, sometimes an hour prior to meals being served; thermometers were not available in the walk-in-freezer on two (2)observallons; there was no soap available at the hand wash sink and no step-on-trash can and there was multiple complaints from group and resident interviews regarding cold and "mushy" food served at the facility.</p> <p>Review of the facility's Census and Condition, dated 09/29/15, revealed there were fifty (50) residents in the facility; and, one (1) of these residents was tube fed and did not consume food items prepared in the kitchen.</p> <p>The findings include:</p> <p>Review of the facility policy, "Food Safety For Cooks," dated September 2010, revealed the thermometer should read 32 degrees Farenheit (F) in ice water and if it did not, the nut below the face of the thermometer should have been adjusted to read 32 degrees F. Thermometers shall be in all refrigerators, freezers and storage areas. Hands should be washed with soap and rinsed thoroughly, wiped dry and the paper towel placed into a hands free garbage can, that has a foot pedal, where the lid raises when pressure is applied by the staff members foot. Interview with the Interim Dietary Manager, on 10/01/15 at 9:25 AM, revealed there was no policy on how long food could be held in the steamer.</p> <p>1. Observation of the kitchen, on 09/29/15 at 11:30 AM, revealed the staff were first using a thermometer with recordings for food</p>	F 371	<p>4. The Business Office Manager will audit all accounts of residents who have been deceased within the past thirty (30) days to ensure that funds have been disbursed and the account closed timely. This audit will occur monthly for three (3) months. Any identified issues will be corrected immediately. The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. The Quality Assurance Committee will review any identified issues and make recommendations to correct identified issues. The Quality Assurance Committee meets monthly with the Medical Director attending at least quarterly. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Social Services Director, MDS Coordinator, Maintenance Director, Housekeeping Director and the Medical Director.</p>	

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NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078	

(X4) IC PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 3</p> <p>temperatures of minus (-) 40 degrees F up to 160 degrees F and were unaware of how to properly register temperatures and calibrate the thermometers.</p> <p>2. Observation of the lunch meal, on 09/28/15 and 09/29/15 at approximately 11:30 AM, revealed the steam table with dry water wells and green beans and mixed vegetables with a mushy and dull green, yellow and orange colors.</p> <p>Observation of the noon meal, on 09/30/15 at 12:30 PM, revealed although food had not been placed in the dry wells of the steam table until 11:15 AM, food items had been kept in the steamer since 10:30 AM.</p> <p>Interviews with residents attending the Group Meeting on 09/29/15 at 2:00 PM, revealed three (3) of three residents complained of food being cold and overcooked or "mushy." Interviews with several residents during the Initial Tour of the facility, on 09/29/15 from 10:20 AM until 12:10 PM, revealed the same concerns.</p> <p>3. Observations of the walk-in freezer, on 09/29/15 at 11:18 AM and 09/30/15 at 11:30 AM, revealed there was no thermometer in the freezer.</p> <p>4. Observations of the hand sink near the three compartment sink on 09/28/15 and 09/29/15 revealed there was no soap available and a second hand sink, near the dishwasher, had no step-on-waste can.</p> <p>Interview with Cook #1 and Dietary Aide #1, on 09/29/15 at 12:30 PM, revealed both had been hired in April 2015 and had been through three (3)</p>	F 371	<p>F371</p> <ol style="list-style-type: none"> <li>The Regional Dietitian observed kitchen staff on October 15, 2015 properly register temperatures and calibrate the thermometers. The Regional Dietitian observed vegetable preparation on October 15, 2015. Vegetables were not heated an excessive amount of time in advance of serving and were served with proper palliative texture and color. The Regional Dietitian observed on October 15, 2015 a thermometer properly placed in the freezer. The Regional Dietitian observed on October 15, 2015 that all soap dispensers in the kitchen had soap available in the dispensers and a step-on waste can near the dishwasher.</li> <li>The Regional Dietitian observed kitchen staff on October 15, 2015 properly register temperatures and calibrate the thermometers. The Regional Dietitian observed vegetable</li> </ol>	10/30/15 e

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NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 4 DMs since that time and were doing their best to ensure the residents had good food to eat and the dietary work was completed on time.  Further interview with the Interim Dietary Manager (DM), on 10/01/15 at 9:25 AM, revealed she was helping out three to four hours a day, since the last DM quit on 09/18/15 and until the next full time manager was to be hired on 10/12/15. She stated she was unaware how much training the current staff had acquired, as the inservice records could not be found and two (2) staff were hired in April and the most recent had been hired two (2) days ago. The DM stated the dietary staff were responsible to let her know when they were running out of supplies, like hand soap and food items, so she could re-order. She also stated she was unaware the food was held in the steamer, to keep warm, prior to meals and stated she had been working back and forth at a sister facility for twenty (20) years and the steam table had always been utilized with dry wells and the manufacturing instructions stated this could be used with water or dry. However, she stated the food should not have been kept in the steamer for long periods.	F 371	preparation on October 15, 2015. Vegetables were not heated an excessive amount of time in advance of serving and were served with proper palliative texture and color. The Regional Dietitian observed on October 15, 2015 a thermometer properly placed in the freezer. The Regional Dietitian observed on October 15, 2015 that all soap dispensers in the kitchen had soap available in the dispensers and a step-on waste can was located near the dishwasher.  3. All Dietary staff and the new Dietary Manager were inserviced by the Administrator by 10/29/15 related to properly registering food temperatures and calibrating the thermometers, preparing vegetables in a proper time period such that proper palliative texture and color was preserved, ensuring that a thermometer was placed in the freezer, that soap dispensers	

contained soap and that a step-on waste can was located near the dishwasher. No Dietary staff will work past 10/29/15 without receiving this training.

4. The Dietary Manager will audit weekly for three (3) months for the proper registering of food temperatures and calibrating

thermometers, the preparation of vegetables in a proper time period to ensure that proper palliative texture and color was preserved, ensuring that a thermometer is placed in the freezer, soap dispensers contain soap and that a step-on waste can is located near the dishwasher. All identified issues will be corrected immediately. The results of the audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. The Quality Assurance Committee will review any identified issues and make recommendations for correction. The Quality Assurance Committee meets monthly with the Medical Director attending at least quarterly. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Social Services Director, MDS Coordinator, Maintenance Director, Housekeeping Director and the Medical Director.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  R 10/31/2015
NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS  Based on implementation of the acceptable POC, the facility was deemed to be in compliance 10/31/15, as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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(Y1) Provider / Supplier / CLIA / Identification Number 185046	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 10/31/2015
Name of Facility SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	Street Address, City, State, Zip Code 509 NORTH HAYDEN AVE. SALEM, KY 42078	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0045	Correction Completed 10/31/2015	ID Prefix _____ Reg. # NFPA 101 LSC K0147	Correction Completed 10/31/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <i>OH</i>	Date: <i>10/27/15</i>	Signature of Surveyor: <i>Debrah Anderson, NCH, QC</i>	Date: <i>10/27/15</i>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on:  
9/30/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078	

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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1996.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1996 with forty-six (46) smoke detectors and three (3) heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1996.</p> <p>GENERATOR: Type II generator installed in 1996. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 09/30/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-five (75) beds with a census of fifty (50) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>Submission of this Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under State and Federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition of participation in Title 18 and Title 19 programs. The submission of the plan of Correction within this time frame should in no way be construed or considered as an agreement with the</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator DATE 10/22/15

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  09/30/2015
NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000	allegations of noncompliance or admissions by the facility. This Plan of Correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
K 045 SS=E	<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 egress was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of four (4) smoke compartments, staff and approximately twenty-eight (28) residents. The facility has the capacity for seventy-five (75) beds and at the time of the survey, the census was fifty (50).</p> <p>The findings include:</p> <p>Observation, on 09/30/15 at 9:55 AM with the Maintenance Supervisor, revealed the outside light fixture at the 500 hall exit was observed to be a single bulb lighting fixture. An exterior exit light fixture is required to have more than one (1) bulb in case one bulb burns out the fixture will not leave the area in darkness.</p> <p>During the survey the 200 hall exit was also observed to have a single bulb outside light</p>	K 045 K045	<ol style="list-style-type: none"> <li>1. The Maintenance Director replaced the one (1) bulb fixture on the 200 hall exit and the 500 hall exit with a two (2) bulb fixture on 10/29/15. The sidewalk from the 200 hall exit leading to the parking lot was illuminated on 10/29/15 by adding two (2) flood lights by an Electrical Contractor.</li> <li>2. All other exits were observed by the Maintenance Director to have either two (2) light fixtures or a two (2) bulb fixture on 10/20/15.</li> <li>3. The Maintenance Director was inserviced by the Administrator on 10/21/15 on the requirement to have all exits illuminated by two (2) light fixtures or a two (2) bulb fixture.</li> </ol>	10/29/15 e

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NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 2 fixture. The 200 hall exit also had a sidewalk to the parking lot with no apparent means of illuminating this area. Lighting must be maintained to the public way under all conditions.  Interview, on 09/30/15 at 10:10 AM, with the Maintenance Supervisor, revealed he was not aware the sidewalk to the parking lot was required to be illuminated.  The census of fifty (50) was verified by the Administrator on 09/30/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 09/30/15.  Reference: NFPA 101 2000 edition  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.	K 045	4. The Maintenance Director will observe all exits for illumination by two (2) light fixtures or a two (2) bulb fixture weekly for three (3) months. Any identified issues will be immediately corrected. The results of the observations will be reviewed by the Quality Assurance Committee monthly for three (3) months. The Quality Assurance Committee will review any identified issues and make recommendations to correct the identified issues. The Quality Assurance Committee meets monthly with the Medical Director attending at least quarterly. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Social Services Director, MDS Coordinator, Maintenance Director, Housekeeping Director and the Medical Director.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2	K 147	K147  1. The exposed wiring protruding	10/30/15 e

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NAME OF PROVIDER OR SUPPLIER  SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078	
(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 3</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 National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, staff and other occupants of the building. The facility has the capacity for seventy-five (75) beds and at the time of the survey, the census was fifty (50).</p> <p>The findings include:</p> <p>Observation, on 09/30/2015 at 9:40 AM with the Maintenance Supervisor, revealed exposed wiring protruding from a junction box located at the garbage disposal sink located in the kitchen washroom.</p> <p>Interview on 09/30/2015 at 9:41 AM with the Maintenance Supervisor, revealed he was not aware the wiring was not secure in the junction box under the garbage disposal sink.</p> <p>Electrical wiring must be maintained for fire/safety reasons.</p> <p>The census of fifty (50) was verified by the Administrator on 09/30/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 09/30/2015.</p> <p>Actual NFPA Standard:</p>	K 147	<p>from the junction box located at the garbage disposal sink located in the kitchen washroom has been repaired on 10/29/15 by the Maintenance Director.</p> <ol style="list-style-type: none"> <li>All other pull boxes, junction boxes and conduit bodies were observed by the Maintenance Director to have covers compatible with the box and conduit body construction with no exposed wiring on 10/20/15.</li> <li>The Maintenance Director was inserviced on 10/21/15 by the Administrator on the requirement that pull boxes, junction boxes and conduit bodies have covers compatible with the box and body construction with no exposed wiring.</li> <li>The Maintenance Director will observe all pull boxes, junction boxes and conduit bodies for proper covers and no exposed wiring weekly for three (3)</li> </ol>	

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K 147	Continued From page 4  NFPA 70 1999 edition  370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	months. Any identified issues will be immediately corrected. The results of the observations will be reviewed by the Quality Assurance Committee monthly for three (3) months. The Quality Assurance Committee will review any issues and make recommendations to correct the identified issues. The Quality Assurance Committee meets monthly with the Medical Director attending at least quarterly. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Social Services Director, MDS Coordinator, Maintenance Director, Housekeeping Director and the Medical Director.		