PRINTED: 04/17/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185336		C 04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD NURSING & REHABILITATION CENTER	420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069

(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 neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation.	
	An Abbreviated Survey investigating KY00021513 was initiated on 04/01/14 and concluded on 04/03/14. KY00021513 was substantiated with deficiencies cited.			
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	F 201		
	The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;		1. Resident #1 is no longer in the building.	
	The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;		2. The Director of Nursing and the Assistant Director of Nursing will assess all Discharge summaries before the resident is discharged to assure that all reasons, communications and pertinent facts are recorded on the Discharge Summary.	
	The safety of individuals in the facility is endangered;			
	The health of individuals in the facility would otherwise be endangered;			
	The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or		3. The Director of Nursing and Social Services Director were re-educated by the Administrator on 4/28/2014 to include in discharge and transfer documentation all discharge and transfer instructions including the	
	The facility ceases to operate.			
	This REQUIREMENT is not met as evidenced			

RECEIVED MAY 12 2014 BY:

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

ADMINISTRATOR 5-8-14

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

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F 201	Continued From page 1 by: Based on interview, record review and review of the facility's "Bill of Resident Rights", it was determined the facility failed to permit each resident to remain in the facility, and not be transferred or discharged from the facility unless it was for the resident's welfare or the facility could not meet the resident's needs for one (1) of six (6) sampled residents (Resident #1). Review of the facility's documentation revealed Resident #1 was discharged "home" two (2) days after admission due to a "criminal history". The findings include: Review of the facility's "Bill of Resident Rights", dated 07/01/09, revealed residents had the right to remain in the facility and not be transferred or discharged unless: the transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the center; the transfer or discharge was appropriate because the resident's health improved sufficiently and no longer needed the services provided by the center; the safety or health of individuals in the facility was endangered; failure to pay after appropriate notice; or the center ceased to operate. Review of the hospital Discharge Summary revealed Resident #1 was discharged to the facility on 03/18/14, after having a Left Leg Below the Knee Amputation (BKA) on 03/14/14. Review of Resident #1's medical record revealed the facility admitted the resident on 03/18/14, with diagnoses which included a Left Leg BKA, Hepatitis C (virus that infects the liver), Insulin Dependent Diabetes Mellitus and	F 201	reason for discharge/transfer, their right to appeal the discharge/transfer if it is not a planned discharge/transfer and the name and contact information of the local Ombudsman. The resident or family will verbalize understanding and this shall be documented in the medical record. 4. The Social Services Director and or Director of Nursing will audit all discharge/transfer records weekly to ensure the discharge/transfer record contains appropriate discharge/transfer instructions including the reason for discharge or transfer , the right to appeal the discharge if it is not a planned discharge and the name and contact information of the local Ombudsman. Documentation of resident	

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F 201	Continued From page 2 Methicillin-Resistant Staphylococcus Aureus (MRSA, an antibiotic resistant bacteria). Review of the Nursing Admission Assessment, dated 03/18/14, revealed Resident #1 to have thirty-four (34) staples to his/her left extremity stump. Continued record review revealed Resident #1 required wound dressing care and surgical site care to the left extremity stump, monitoring of fingerstick blood sugars with daily injections of insulin; Physical Therapy and Occupational Therapy. Record review revealed no documented evidence of behaviors while the resident was at the facility; and, no documented evidence Resident #1 was a safety risk to other residents. Review of the Social Service (SS) Note, dated 03/26/14 at 12:11 PM, revealed Resident #1 had gone to SS on 03/20/14, and reported he/she had a criminal history and also discussed this "issue" with the Administrator. Continued review of the SS Note revealed discharge plans were initiated with "BUS" transporting him/her "home". Further record review revealed no documented evidence Resident #1's discharge was necessary for the resident's welfare, the resident's needs could not be met in the center, the resident's health had improved sufficiently and he/she no longer needed the services provided by the center, or the safety or health of individuals in the facility was endangered. Review of the facility's discharge documentation for Resident #1's, dated 03/20/14 at 12:25 PM, revealed the reason for discharge was documented as "other". Review of the SS Discharge Summary section revealed Resident #1 was discharged home due to a criminal history. Review of the Advanced Practice	F 201	and or family verbalization of understanding of the discharge instructions will also be audited to ensure it is present. The results of these audits will be taken to the Quality Assurance Committee by the Social Services Director and or the Director of Nursing monthly x 4 months for further recommendations and then as required.	5/11/2014

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F 201	Continued From page 4	F 201		
	Unable to interview the Social Services Director due to her being on vacation in another state.			
	Interview with the Administrator on 04/02/14 at 4:45 PM, revealed Resident #1 had gone to the SS Director on 03/20/14, to reveal he/she had a criminal history. The Administrator stated the SS Director advised him of Resident #1 having a criminal history. Continued interview revealed Resident #1 told him he/she wanted to go home due to his/her criminal history. The Administrator stated the facility arranged transport for Resident #1's to his/her home and gave him/her twenty (20) dollars for groceries. Continued interview with the Administrator, on 04/03/14 at 3:03 PM, revealed the facility ran a criminal record background check on Resident #1 which revealed the resident had a conviction for a lewd or lascivious act with a child. The Administrator reported the facility did not contact local or state law enforcement or probation offices. According to the Administrator, Resident #1 advised him he/she wanted to go home, however the facility did not document this information in the resident's medical record. Further interview revealed the facility did not offer or attempt alternate placement nor, did the facility give Resident #1 a written notice prior to discharge.			
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	F 203	1. Resident #1 is no longer in the building.	
	Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record		2. The Director of Nursing and the Assistant Director of Nursing will assess all Discharge summaries before the resident is discharged to assure that all	

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F 203	Continued From page 5 the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents	F 203	reasons, communications and pertinent facts are recorded on the Discharge Summary. 3. The Director of Nursing and Social Services Director were re-educated by the Administrator on 4/28/2014 to include in discharge/transfer documentation all discharge/transfer instructions including the reason for discharge/transfer, their right to appeal the discharge if it is not a planned discharge and the name and contact information of the local Ombudsman. The resident or family will verbalize understanding and this shall be documented in the medical record. 4. The Social Services Director and or the Director of Nursing will audit all discharge/transfer records	

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F 203	Continued From page 6 who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's "Bill of Resident Rights", it was determined the facility failed to provide written notification to each resident prior to discharge from the facility for one (1) of six (6) sampled residents (Resident #1). Additionally, the facility failed to provide Resident #1 with a statement indicating the resident had the right to appeal the discharge to the State and the name, address and telephone number of the State Long Term Care Ombudsman. The findings include: Interview with the Director of Nursing (DON) on 04/02/14 at 4:45 PM, revealed the facility did not have a Admission, Discharge or Transfer policy. Review of the facility's "Bill of Resident Rights", dated 07/01/09, which was included in the facility's admission documentation, revealed residents had the right to written notice of the reason given to the resident and/or family in a language and manner that the resident and/or family could understand. Further review revealed, the notice should include a statement indicating the resident had the right to appeal the action to the State Agency, designated by the State for such appeals, and the name, address, and telephone number of the State Long Term Care Ombudsman.	F 203	weekly to ensure the discharge/transfer record contains appropriate discharge/transfer instructions including the reason for discharge, the right to appeal the discharge if it is not a planned discharge and the name and contact information of the local Ombudsman. Documentation of resident and or family verbalization of understanding of the discharge instructions will also be audited to ensure it is present. The results of these audits will be taken to the Quality Assurance Committee by the Social Services Director monthly x 4 months for further recommendations and then as required.	5/11/2014

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F 203	Continued From page 8 criminal background. The Administrator stated the SS Director reported this to him and a criminal record background check was performed on Resident #1 which confirmed the resident's criminal history. The Administrator reported Resident #1 told him he/she wanted to go home, however this was not documented in Resident #1' medical record. Further interview revealed the facility did not offer or attempt alternate placement nor, give Resident #1 a written notice prior to discharge.	F 203		
F 441 SS=E	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	F 441	1. All soiled, unlabeled and uncovered bedpans, urine graduates and urine hats have been removed and replaced with clean, labeled and covered units by Kellie Elder, RN. 2. All residents have the potential to be affected. All nurses were inseriviced beginning 4/18/2014 by Administrator on Hand Washing. An all staff inservice will be held 4/30/2014 by Trena Lee, RN Education Director to discuss Hand Washing and Contact Precautions.	

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F 441	Continued From page 9 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. 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 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 as evidenced by urinals, bedpans, urinal hats and urine graduates not covered and stored in a sanitary manner. The findings include: Interview with the Director of Nursing (DON) on 04/03/14 at 2:15 PM, revealed the facility did not have a specific policy related to the storage of soiled bedpans, urinals, urine hats or graduates. Review of the facility's policy titled, "General Infection Control Policy", undated, revealed the objective of the facility's infection control policies and practices were to maintain a safe, sanitary, and comfortable environment to help prevent and manage transmission of diseases and infection.	F 441	3. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator re-educated licensed nurses and certified nursing assistants on 4/18/2014 on the infection control processes including washing urinals, graduates, bedpans and bedside commodes, proper labeling of each residents' items and proper storage of these items along with proper handwashing techniques and how to handle, store, process and transport linens to prevent the spread of infection. The Regional Dietician re-educated the dietary staff on dietary sanitation and proper food handling on 4/17/2014. 4. The Director of Nursing, Assistant Director of Nursing and the Staff Development Coordinator will complete a general	

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F 441	Continued From page 10 Observation during initial tour on 04/02/14 at 8:33 AM, revealed resident room #17 had a soiled, unlabeled and uncovered bedpan under bed A. Observation revealed resident room #11 had an uncovered, unlabeled and soiled bedpan on the shelf in the bathroom. Continued observation during the initial tour revealed resident room #16 had a soiled, unlabeled and uncovered urine graduate in the bathroom on a shelf. Further observation revealed resident room #12 had a soiled, unlabeled and uncovered urine hat on a bedside toilet in the bathroom. Interview with Certified Nursing Assistant (CNA) #1 on 04/02/14 at 10:00 AM, revealed soiled urine graduates, urinals, urine hats and bedpans should be labeled and covered prior to storage for infection control issues. Interview with Licensed Practical Nurse (LPN) #1 on 04/02/14 at 9:07 AM, revealed soiled urine graduates, urine hats, urinals and bedpans should have been cleaned, labeled and covered prior to storage for infection control and to decrease the risk of cross contamination. Interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 04/03/14 at 2:11 PM, revealed soiled urinals and bedpans should be cleaned, labeled, covered and stored properly to decrease infection control issues. Interview with the DON on 04/03/14 at 2:15 PM, revealed her expectation was soiled urinals and bedpans should be cleaned, labeled, covered and stored properly to decrease odor and infection control reasons.	F 441	rounds daily, 5 days a week x 4 weeks, then monthly x 2 months to audit and observe all licensed nurses and certified nursing assistants handling linens, washing hands and auditing rooms for urinals, bedpan, and graduates for proper cleaning, labeling and storage. Any observation at the time that is not within proper infection control guidelines will result in immediate one to one counseling with written documentation and a return demonstration on the proper procedure. Result of these audits will be taken to the Quality Assurance Committee monthly x 4 months for further recommendations. The Dietary Manager will complete observations	5/11/2014
F 520	483.75(o)(1) QAA	F 520		

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F 520 SS=E	Continued From page 11 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies and education, it was determined the facility failed to maintain a Quality Assessment and Assurance (QA) program which developed and implemented plans of action to correct quality deficiencies as evidenced by repeated deficiencies related to the facility's failure to ensure infection control practices were	F 520	1. The Statement of Deficiencies and Plans of Corrections from the last year were reviewed by the Administrator and Director of Nursing on 4/22/2014 and recognize that F441 has been a citation in the past year surveys that have been conducted and this review is part of this plan of correction. The Director of Nursing, Assistant Director of Nursing and the Staff Development Coordinator will complete a general rounds daily, 5 days a week x 4 weeks, then monthly x 2 months to audit and observe all licensed nurses and certified nursing assistants handling linens, washing hands and auditing rooms for urinals, bedpan, and graduates for proper cleaning, labeling and storage. Any observation at the time that is not within proper infection control guidelines will result in immediate one to one	

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STREET ADDRESS, CITY, STATE, ZIP CODE: 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069

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F 520	Continued From page 12 adhered to. The findings include: Review of the facility's, "Quality Assessment and Assurance Committee Summary", dated 09/20/12, revealed the intent of the facility included to oversee facility systems and processes related to improving quality of care and services; to promote consistent facility systems and processes and appropriate practices in resident care; and to monitor and evaluate the appropriateness and quality of care provided within the framework of the Quality Assessment and Assurance (QAA) plan. Review of the facility's Plan of Correction (POC) with a completion date of 01/24/14, revealed the Quality Assurance (QA) team was to meet weekly for four (4) weeks beginning 01/12/14, then monthly and as needed after the four (4) weeks to ensure safe infection control practices were being utilized. Continued review of the POC revealed all staff were inserviced on infection control to include cleaning and storage of bedpans. Further review of the POC revealed proper cleaning procedures for personal equipment was to be monitored per nursing management routinely and during random rounds. Observation during initial tour on 04/02/14 at 8:33 AM, revealed: a soiled, unlabeled and uncovered bedpan; a soiled, unlabeled and uncovered urine graduate; a soiled, unlabeled and uncovered urine hat; and an uncovered, unlabeled and soiled bedpan. Interview with the Assistant Director of Nursing (ADON)/Infection Control Nurse on 04/03/14 at	F 520	counseling with written documentation and a return demonstration on the proper procedure. Result of these audits will be taken to the Quality Assurance Committee monthly x 4 months for further recommendations. 2. The Quality Assurance Committee recognizes that repeat deficiencies in infection control may pose possible transmission of infections to the residents and that all residents have the potential to be affected. The audits and observations conducted by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Dietary Manager will result in immediate one to one verbal and written counseling if proper infection control guidelines are not being followed or improper hand washing techniques are observed.	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185336		C 04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD NURSING & REHABILITATION CENTER	420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069

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F 520	Continued From page 13 5:21 PM, revealed Monday through Friday, the administrative team was assigned rooms to conduct daily checks on. The ADON/Infection Control Nurse stated labeled and covered urinals, bedpans, urine graduates and urine hats were one of the areas being monitored by the administrative staff. Further interview revealed the facility did not document the daily checks being performed. Interview with the Director of Nursing (DON) on 04/03/14 at 5:21 PM, revealed monitoring for unlabeled and uncovered bedpans, urinals, urine graduates and urine hats were a part of the facility's daily rounds. The DON stated unlabeled and uncovered bedpans, urinals, urine graduates and urine hats were not a recurring issue during the daily rounds. Further interview revealed it was a "fluke" or administration probably had not had the opportunity to make the daily rounds prior to the Surveyors' initial tour. Interview with the Administrator on 04/03/14 at 3:03 PM, revealed soiled urinals, bedpans, urine graduates and hats should be labeled, covered and appropriately stored. The Administrator stated the facility did have an Infection Control Committee that was also a part of the QA Committee. Further interview revealed the administrative staff, who were members of the QA team, made daily rounds to monitor for such issues and did not find this to be a recurring issue.	F 520	The Quality Assurance Committee has decided that improper infection control practices will result in progressive discipline. 3. The Regional Nurse Consultant re-educated the Director of Nursing and the Administrator on 4/17/2014 to re-educate all staff on infection control guidelines, including proper hand washing techniques. The education also included that if during audits or observations any employee is found to not be following proper infection control practices they should be stopped and one to one written counseling take place immediately with progress discipline to follow with a log of written actions being maintained by the Administer and/or the Director of Nursing. The Administrator and Director of Nursing were also instructed to maintain a binder of all audits and	

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