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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	(X3) DATE SURVEY COMPLETED
	185305	A. BUILDING _____ B. WING _____	06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH AND REHAB	3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241

(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 A standard survey was conducted 06/24/12 through 06/27/12 and a Life Safety Code survey was conducted on 06/26/12. Deficiencies were cited with 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. This was a Nursing Home Initiative Survey with the entrance to the facility on Sunday, 06/24/12 at 2:10 PM.	F 000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to protect the resident from misappropriation of property for one (1) of seventeen (17) sampled residents, Resident #10. The findings include: Record Review of the facility's policy, titled Resident Abuse, Neglect, and Misappropriation of Property Policy and Procedure, dated 07/03/11, revealed the facility's goal was for every resident to be free from abuse, neglect and	F 224	F224 The Facility maintains that it has developed and implemented policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: The Social Services Director conducted an investigation of the alleged deficient practice on Resident #10's missing property. The investigation did not determine that any deliberate action had occurred to cause the items to become missing. The Facility has agreed to reimburse the Resident. Two hundred dollars has been credited to Resident #10s Resident Fund account. How the Facility will identify other residents having the potential to be affected by the same alleged deficient practice: The Administrator has met with the Social Services Director and Director of Nursing to	8/2/12

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

X Richard Flowers — X Administrator X 8/2/12

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

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 06/27/2012
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 224	Continued From page 1 misappropriations of property. Section III. Prevention stated the resident was to be provided feedback regarding the concerns they expressed. Interview with Resident #10, on 06/26/12 at 4:30 PM, revealed Resident #10 reported some articles of clothing was sent to the facility's laundry services about six (6) months ago and had not been returned to him/her. Resident #10 stated, he/she immediately reported the situation to Social Services, and he/she stated Social Services told him/her to re-order the missing items and he/she would be reimbursed. Resident #10 stated, to date, he/she had not been reimbursed for the clothing. Resident #10 estimated the value of the clothing at $200. Interview, on 06/27/12 at 8:10 AM, with the Director of Social Services revealed he remembered Resident #10 had reported the missing clothing to him; however, he stated the laundry service staff typically searched for lost clothing and returned it to the resident, if found. Social Services stated, he did not remember telling Resident #10 to reorder the clothing. When asked if he could provide a copy of a completed Resident Concern Form that detailed the incident reported by Resident #10, Social Services stated, he did not have that documentation. He reported in the case of misappropriation of property documentation was kept; however, not kept for lost, misplaced clothing or laundry related items. Interview, on 06/27/12 at 10:30 AM, with the Administrator revealed a Resident Concern Form should have been completed by Social Services when Resident #10 reported the missing clothing to him. He reported the resident's missing	F 224	discuss the alleged deficient practices identified during the annual survey. The Social Services Director has interviewed staff and residents of facility to make sure there are no other missing items that have not been investigated and no other items have been revealed. What measures will be put into place or what systemic changes the Facility will make to ensure that the alleged deficient practice does not recur: The Social Services Director and Director of Nursing have developed a policy to address missing personal property. By definition, misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. There was no implication of misappropriation of resident property in this alleged deficient practice. The Staff Inservice Coordinator inserviced all staff on the new policy for missing property on 7/17/12. How the Facility plans to monitor its performance to make sure that solutions are sustained: The Director of Social Services will report to the Quality Assurance Program all missing items and investigation outcomes for the next two quarters to assure that this does not issue does not reoccur. Going	

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forward this monitoring tool will be revised as necessary.

Responsible Party(ies): Administrator, Social Services Director and Director of Nursing.

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	185305		06/27/2012

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SPRINGHURST HEALTH AND REHAB	3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241

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F 224	Continued From page 2 property allegation was reviewed on a case by case basis and the facility may replace items based upon review of each case. He reported he was unable to provide documentation of the outcome of Resident #10's missing items report. Telephonic interview attempted with Family Member #1, on 06/27/12 at 2:20 PM and 2:30 PM, revealed the telephone number was out of order.	F 224		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to investigate an allegation of misappropriation of property for one (1) of seventeen (17) sampled residents, Resident #10. The findings include: Interview with Resident #10, on 06/26/12 at 4:30 PM, revealed he/she reported some missing articles of his/her clothing about six (6) months ago, to the Social Services Department when he/she noted the items were not returned by the laundry services. Resident #10 estimated the value of the clothing at $200. Record Review, of the facility's policy titled	F 226	F226 The Facility maintains that it has developed and implemented policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: The Social Services Director conducted an investigation of the alleged deficient practice on Resident #10's missing property. The investigation did not determine that any deliberate action had occurred to cause the items to become missing. The Facility has agreed to reimburse the Resident. Two hundred dollars has been credited to Resident #10s Resident Fund account. How the Facility will identify other residents having the potential to be affected by the same alleged deficient practice: The Administrator has met with the Social Services Director and Director of Nursing to discuss the alleged deficient practices identified during the annual survey. The Social Services Director has interviewed staff and residents of facility to make sure there are no other missing items that have not been investigated and no other items have been revealed.	8/2/12

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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 226	Continued From page 3 Resident Abuse, Neglect, and Misappropriation of Property Policy and Procedure, dated 07/03/11, in Section V. Investigation revealed a Resident Concern Form detailing the allegation was to be completed when misappropriation of property or any alleged form of abuse was reported. The administrator/designee would conduct a timely, thorough, and objective investigation of allegations of abuse, which included misappropriation of resident property. The Administrator/Designee will report all alleged violations of abuse, which included misappropriation of resident property to Community Based Services immediately and to the Cabinet for Health Services' Division of Long Term Care immediately. Interview, on 06/27/12 at 8:10 AM, with the Director of Social Services revealed he remembered Resident #10 reported the missing clothing to him around Christmas time; however, he stated the laundry service staff would typically search for the missing clothing and return it to the resident, if found. Social Services thought some of the items of clothing were returned; however, he was not sure. He reported he did not complete an investigation of the items Resident #10 reported as missing. Interview, on 06/27/12 at 10:30 AM, with the Administrator stated the missing property of Resident #10 was not reported to him and this was new information of this incident. He reported, the facility should have conducted an investigation and did not have the documentation to show an investigation was completed. He reported Social Services should have conducted a detailed timeline of the incident and what	F 226	What measures will be put into place or what systemic changes the Facility will make to ensure that the alleged deficient practice does not recur: The Social Services Director and Director of Nursing have developed a policy to address missing personal property. By definition, misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. There was no implication of misappropriation of resident property in this alleged deficient practice. The Staff Inservice Coordinator inserviced all staff on the new policy for missing property on 7/17/12. How the Facility plans to monitor its performance to make sure that solutions are sustained: The Director of Social Services will report to the Quality Assurance Program all missing items and investigation outcomes for the next two quarters to assure that this does not issue does not reoccur. Going forward this monitoring tool will be revised as necessary. Responsible Party(ies): Administrator, Social Services Director and Director of Nursing.	

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F 226	Continued From page 4 happened to the items. Telephonic interview attempted with Family Member #1, on 06/27/12 at 2:20 PM and 2:30 PM, revealed the telephone number was out of order.	F 226	F253 The Facility maintains that it provides housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	8/2/12
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Repair Requisition Procedure, it was determined the facility failed to provide effective maintenance services to maintain residents' wheelchairs in good repair for twelve (12) of forty-three (43) sampled wheelchairs. The findings include: The facility did not provide evidence of a policy; however, the facility provided a memo entitled: Repair Requisition Forms, dated 09/01/2011. Review of the facility's Repair Requisition Form Memo, dated 09/01/11, revealed a completed form for any repair must be completed and placed in the "maintenance" box in the mail room. Maintenance should be contacted directly via phone, the Nursing Supervisor, or the Administrator for any hazardous or dangerous	F 253	How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: The Administrator has met with the Maintenance Supervisor and Therapy Tech to discuss the alleged deficient practices identified during the annual survey. The Therapy Tech has ordered wheelchair armrests to replace or repair as necessary to correct the alleged deficient practice. How the Facility will identify other residents having the potential to be affected by the same alleged deficient practice: The Administrator and Therapy Tech performed a complete review of wheelchair armrests on July 12th in order to assure there were no additional arm rests that needed repairs or replacement. What measures will be put into place or what systemic changes the Facility will make to ensure that the alleged deficient practice does not recur: The Staff Inservice Coordinator has inserviced all staff on infection control and wheelchair armrests on 7/17/12. The	

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STREET ADDRESS, CITY, STATE, ZIP CODE: 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241

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F 253	Continued From page 5 situation. Observation of lunch in the Assisted Dining Room and the Independent Dining Room on 06/26/12 at 12:05 PM, revealed torn and cracked arm pads on the wheel chairs of twelve (12) of the forty (43) residents in the dining rooms. Interview with the Maintenance Director, on 06/26/12 at 1:30 PM, revealed the Therapy Department was responsible for maintaining the residents' wheelchairs. Interview with the Technician for the Therapy Department, on 06/26/12 at 1:45 PM, revealed she and her supervisor were responsible for the maintenance of the residents' wheelchair arm pads. The Therapy Technician (TT) said no one from the facility had filled out a request to repair the wheel chair pads. The TT commented, there was not a system in place to check the wheel chairs and that residents could get skin tears or infections from torn and crack wheel chair pads. Interview, on 06/26/12 at 2:20 PM, with the Director of Nursing (DON) revealed all staff members were instructed when hired to complete a work order or a therapy request form if any of the residents' equipment needed repair. The DON revealed she was unaware there were so many wheelchairs needing new arm pads. The DON commented that cracked or torn wheel chair arm pads could cause residents to have skin tears and also spread infections. Wheelchairs needed to be maintained before they got into that condition	F 253	inservice information included protocol for reporting repair and replacement needs for wheelchair armrests and other equipment repair needs. The Safety Committee has added wheelchair armrests in its items for monthly review. How the Facility plans to monitor its performance to make sure that solutions are sustained: The Safety Committee and Quality Assurance Program will monitor wheelchair armrests to assure that this does not issue does not reoccur. The Safety Committee will monitor this and report the wheelchair armrest status to the Quality Assurance Committee for the next two quarters then modify as needed going forward. Responsible Party(ies): Administrator, Staff Inservice Coordinator, Maintenance Director, Therapy Tech and Safety Committee Chairperson.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

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DIVISION OF HEALTH CARE F.C., TIE AND SURVEY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	185306	A. BUILDING _____ B. WING _____	06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH AND REHAB	3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241

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F 272	Continued From page 6 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F272 The Facility maintains that it conducts initially and periodically comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: Resident #8's comprehensive care plan was updated to reflect the need the protective boot per resident's request. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: The Director of Nursing has reviewed all Resident Care Plans to assure all Resident needs are accurately reflected . This review occurred the week of 7/9/12. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur: The Director of Nursing met with the Unit Managers to educate on the need for accurate care plans. The education included the need to care plan strengths, weaknesses, and special needs of each resident. The meeting with the Unit Managers occurred on 7/16/12. The DON has developed a checklist to assure the accuracy of each	8/2/12

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F 272	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to accurately assess and identify the need for a protective foot device for one (1) of seventeen (17) sampled residents, Resident #8. Resident #8's Minimum Data Set (MDS) did not contain information regarding a protective boot being used when the MDS was completed. The findings include: The facility did not provide a policy for resident assessments. Review of the quarterly MDS assessment, dated 05/21/12, revealed the facility assessed Resident #8 as having no left foot protective boot. Review of the clinical record for Resident #8 revealed the facility admitted the resident on 09/21/09 with diagnoses of Deep Vein Thrombosis (blood clotting) of the left lower extremity and a history of Stroke. Observation of Resident #8's room, on 06/25/12 at 8:15 AM, revealed a protective boot sitting on the top of the bedside table. The resident's left foot was swollen, wrapped in gauze, and elevated on a pillow. Observation, on 06/27/12 at 8:30 AM, revealed the protective boot on the resident's left foot. Velcro straps secured the boot and the resident's foot was swollen.	F 272	resident care plan. This checklist will be completed on all residents monthly. How the Facility plans to monitor its performance to make sure that the solutions are maintained: The monthly data from the care plan checks performed by Unit Managers on care plan accuracy will be reported for the next two quarters in QA by the DON and then adjusted as necessary. Responsible Party: Director of Nursing, Unit Managers.	

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F 272	Continued From page 8 Interview with Resident #8, on 06/25/12 at 8:15 AM, revealed the resident had brought the boot to the facility when admitted from a rehab hospital. During the last week the resident had asked the staff to apply the boot at bedtime, instead of using a pillow for elevation of the resident's left foot The resident thought the boot might work better and commented that some nights the CNA's put the boot on when asked and sometimes they do not. Interview, on 06/27/12 at 8:30 AM, revealed the boot was hurting the resident. The resident said the boot was not on correctly and was hurting. Interview with the Restorative CNA #2, on 06/27/12 at 9:30 AM, revealed Resident #8 did not have an order to use the protective boot and should be assessed to determine if the boot was needed and fit properly. Interview with the Therapy Director (TD), on 06/27/12 at 9:30 AM, revealed the resident was able to express needs and desires, but should be evaluated to determine if the protective boot was needed and fit properly. The boot could cause skin breakdown if it did not fit properly. The TD said the boot was several years old and a screening evaluation by Physical Therapy should have been completed. Interview, on 06/27/12 at 4:00 PM, with the DON revealed the protective boot should be screened by Physical Therapy, because a three (3) to four (4) year old boot may not fit properly, and could cause the resident to have pressure areas. The DON revealed the facility should have a physician's order for use of a protective boot.	F 272		
F 279	483.20(d), 483.20(k)(1) DEVELOP	F 279		

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DIVISION OF HEALTH CARE INVESTIGATIONS

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F 279 SS=D	Continued From page 9 COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the clinical record, it was determined the facility failed to develop a comprehensive care plan for one (1) of seventeen (17) sampled residents. The facility failed to develop a comprehensive care plan for Resident #8 for use of a protective boot device. The findings include: The facility did not provide a policy for the	F 279	F279 The Facility maintains that it develops comprehensive care plans for each resident that includes measureable objectives and timetables to meet each resident's medical, nursing, and mental and psychosocial needs. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: Resident #8's comprehensive care plan was updated to reflect the need the protective boot per resident's request. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: The Director of Nursing has reviewed all Resident Care Plans to assure all Resident needs are accurately reflected . This review occurred the week of 7/9/12. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur: The Director of Nursing met with the Unit Managers to educate on the need for accurate care plans. The education included the need to care plan strengths, weaknesses, and special needs of each resident. The meeting with the Unit Managers occurred on 7/16/12. The DON has developed a checklist to assure the accuracy of each	8/2/12

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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 06/27/2012
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 279	Continued From page 10 development of comprehensive care plans. Review of the clinical record for Resident #8 on 06/25/12, revealed the facility admitted the resident on 09/21/09 with diagnoses of Deep Vein Thrombosis (blood clotting) of the left lower extremity and a history of Stroke. Review of Resident #8's comprehensive care plan, dated 07/11/11, revealed the resident required splint/brace assistance to the left hand. However, the care plan did not incorporate the protective boot device. Observation of the Resident #8's room, on 06/25/12 at 8:15 AM, revealed a protective boot sitting on the top of the bedside table. The resident's left foot was swollen, wrapped in gauze, and elevated on a pillow. Observation, on 06/27/12 at 8:30 AM, revealed the protective boot was in place on the resident's left foot. Velcro straps were securing the boot. Interview with the Therapy Director (TD), on 06/27/12 at 9:30 AM, revealed the resident was able to express needs and desires, but should be evaluated to determine if the protective boot was needed and fit properly. The boot could cause skin breakdown if it did not fit properly. The TD said the boot was several years old and a screening evaluation by Physical Therapy should have been completed. The boot was a protective device and if indicated, the facility should get a physician order, and then complete a comprehensive care plan for the protective boot. Interview with the West Wing Unit Manager, LPN	F 279	resident care plan. This checklist will be completed on all residents monthly. How the Facility plans to monitor its performance to make sure that the solutions are maintained: The monthly data from the care plan checks performed by Unit Managers on care plan accuracy will be reported for the next two quarters in QA by the DON and then adjusted as necessary. Responsible Party: Director of Nursing, Unit Managers.	

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F 279	Continued From page 11 #2, on 06/27/12 at 10:00 AM, revealed the LPN was unaware that a comprehensive Nursing or CNA careplan was not developed to address the protective device for the resident. Interview with the Director of Nursing (DON), on 06/27/12 at 4:00 PM, revealed the staff should be trained before applying a protective boot on a resident, and there also should be a comprehensive Nursing and CNA care plan in place.	F 279	F356 The Facility maintains that it posts the Nurse Staffing Information on a daily basis. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: No Residents were identified that were affected by the alleged deficient practice.	8/2/12
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356	The alleged deficient practice was corrected by updating the procedure for posting the Nurse Staffing Information. The 3rd Shift Nurse on the South Unit has been given the responsibility for completing this task. How the facility will identify other residents having the potential to be affected by the same deficient practice: No Residents were identified that were affected by the alleged deficient practice. The alleged deficient practice was corrected by updating the procedure for posting the Nurse Staffing Information. The 3rd Shift Nurse on the South Unit has been given the responsibility for completing this task. What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur: The Director of Nursing met with the Staffing Coordinator and changed the	

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F 356	Continued From page 12 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to post the daily nurse staffing data for three consecutive days. The nurse staffing data was not posted on 06/22/12, 06/23/12 and 06/24/12. The findings include: Observation of the daily nurse staffing data, upon entrance to the facility, on 06/24/12 at 2:15 PM and continued as posted at 3:25 PM and at 6:15 PM revealed the daily staffing data was displayed on the counter at the nurses station near the front door entrance dated 06/21/12. Observation of the daily nurse staffing data, on 06/25/12 at 8:15 AM, revealed the daily staffing data was displayed on the counter at the nurses station near the front door entrance and was still dated 06/21/12. Observation of the daily nurse staffing data, on 06/26/12 at 8:10 AM, 8:35 AM and at 9:20 AM revealed the daily staffing data was displayed on the counter at the nurses station near the front door entrance and was dated 06/25/12. Interview, with the Director of Nursing, on 06/27/12 at 10:10 AM reported the staff person is	F 356	responsibility for completing the Staff Posting. The 3rd Shift South Nurse has been assigned the responsibility of completing the postings. Prior to this change, the Staffing Coordinator had this responsibility. When she was out, the posting was not completed timely. This change and education occurred on 7/2/12. How the Facility plans to monitor its performance to make sure that the solutions are maintained: The Staffing Coordinator developed a QA for monitoring the posting of the Direct Care Staff and Census for the Facility. This will be monitored one day each week for accuracy and timeliness. This data is provided to the DON weekly. A summary of this focus will be provided for the next two quarters and reported to the QA Committee. This QA will then be adjusted as necessary to assure this deficient practice does not reoccur. Responsible Party: Director of Nursing, Staffing Coordinator .	

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responsibility for completing the Staff Posting. The 3rd Shift South Nurse has been assigned the responsibility of completing the postings. Prior to this change, the Staffing Coordinator had this responsibility. When she was out, the posting was not completed timely. This change and education occurred on 7/2/12.

How the Facility plans to monitor its performance to make sure that the solutions are maintained:

The Staffing Coordinator developed a QA for monitoring the posting of the Direct Care Staff and Census for the Facility. This will be monitored one day each week for accuracy and timeliness. This data is provided to the DON weekly. A summary of this focus will be provided for the next two quarters and reported to the QA Committee. This QA will then be adjusted as necessary to assure this deficient practice does not reoccur.

Responsible Party: Director of Nursing, Staffing Coordinator .

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F 356	Continued From page 13 off on vacation. She stated her last day prior to vacation was 06/21/12. She reported the staffing sheet just got missed. She reported it was her responsibility to ensure the staffing was posted daily.	F 356	F 371	8/2/12
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 observations, interviews and record review, it was determined the facility failed to store and prepare food under sanitary conditions as evidenced by, preventing contamination of sugar, flour, and corn meal by foreign substances, not properly re-sealing and dating multiple use food items such as cheese and butter, and not following the kitchen fryer oil changing schedule nor the kitchen cleaning schedule. The findings include: Review of the kitchen policy and procedure regarding kitchen cleaning schedules stated, staff performs cleaning schedules as directed and they were to initial the form to indicate the task had	F 371	The Facility maintains that it provides food from sources approved or considered satisfactory by Federal, State or local authorities, and does store, prepare, distribute and serve food under sanitary conditions. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: No specific residents were identified as having been affected by the alleged deficient practice. The upper convection oven has been deep cleaned and the fryer was cleaned and oil disgarded and replaced, the flour, sugar, and corn meal were disgarded and are now stored in smaller containers in the dry storage area. The undated items were disgarded and the refrigerator was cleaned. The disposable plates have been stored up off the floor. How the facility will identify other residents having the potential to be affected by the same deficient practice: The Dietary Manager has spoken individually with all dietary staff concerning the alleged deficient practice and re-inserviced all dietary staff on cleaning schedules, proper sanitary procedures and dating and labeling of opened food products. The inservice was provided on 7/13/12.	

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F 371	Continued From page 14	F 371	The Administrator met with the Dietary Manager and Dietician concerning the alleged deficient practice.	
	been completed.		The Dietary Manager and Dietician inspected the department and found no other areas of concern on 7/10/12.	
	Review of the kitchen monthly cleaning schedule revealed, the upper convection oven should have been cleaned 06/20/12. There were no initials on the schedule form to indicate the oven was cleaned. For the month of June the flour, sugar, and corn meal were not initialed as having been checked		What measures will be put into place or what systemic changes the facility will make to ensure that the alleged deficient practice does not recur:	
	Observations, on 06/24/12 at 2:10 PM, during an initial tour of the kitchen revealed in the walk in refrigerator four (4) containers of soup base, three (3) beef and one (1) chicken without dates for when they were opened. Two (2) of the beef soup bases and the chicken containers were less than one-half (1/2) full. There were sliced tomatoes in a container undated. Behind a tray rack on the floor of the refrigerator there was a plastic cup and a brownish-black dried substance on the floor. On the can rack outside the walk-in refrigerator there was a can of tomatoes with no date on the can. When a staff member was asked how they rotated cans from the rack, his reply was we take what is available. In the dry storage room, two (2) plastic bags of disposable plates were sitting on the floor. The upper convection oven had a black crusted substance on the floor, sides, and back of the oven. In front of the oven fan was a ball of tin foil about the size of a baseball rotating as the fan turned. The tin foil was covered with a light to dark brown substance. The doors of both convection ovens was covered with a splattered brown substance. In the ante room to the kitchen, in a two (2) door refrigerator, were four (4) containers of drink syrups in a carton of half and half and a pound stick of butter none of the items had a date and		The Dietary Manager has reviewed the sanitary procedures with the Dietician and Clinical Dietary Manager on 7/10/12. All Staff have been re-inserviced on proper sanitation techniques and proper dating and labeling of opened food products. The Dietary Manager has revised the cleaning schedules to address the areas identified in the survey as a focus i.e. dry storage bins, walk-in refrigerator, deep fryer and convection oven and re-instructed staff in proper procedures on 7/13/12. The Dietician will include monitoring of the convection stove, fryer, flour, corn meal, and sugar in the dry storage area and dating and labeling of opened items in the refrigerator to the weekly report provided to the Dietary Manager and Administrator.	
			How the Facility plans to monitor its performance to make sure that the solutions are maintained:	
			The Dietary Manager has developed a monitoring tool that focuses on the overall	

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F 371	Continued From page 15 they had been opened. The fryer had streaks of a light to dark brown liquid on the sides. On the edges of the grease was residue and the grease was an opaque dark brown color. the dry storage bins revealed, the lid on the flour container was not tightly closed. There were several black flecks in the flour, the sugar bin had small crystallized clumps, and the cornmeal bin had a brown, crusted substance on the top. Observations, on 06/25/12 at 11:30 AM, revealed a dark brown substance was still on the walk-in refrigerator floor, the tin foil was still rotating with the fan in the oven, the residue was still in the fryer with the opaque dark brown grease Observations, on 06/26/12 at 9:30 AM, revealed there were no changes to the conditions seen on 06/25/12 at 11:30 AM. Interview with the Dietary Manager, on 06/27/12 at 9:45 AM, revealed the supervisor walks through the kitchen each morning to check if the cleaning schedule had been followed. The manager did not keep a record. She stated, the fryer grease had been changed on 06/22/12 and on Saturday the resident's had fried chicken and french frins for dinner. The manager agreed the fryer grease would not be an opaque dark brown in two (2) days. Interview with the Administrator, on 06/26/12 at 11:20 AM, revealed he was unaware the cleaning schedules for the kitchen were not followed. The Administrator was shown the flecks of brown substances taken from the corn meal. He was	F 371	sanitation of the kitchen with a focus on the dry storage bins, convection oven, fryer and walk-in refrigerator to monitor the revised cleaning schedules and proper labeling and dating of opened food items in the refrigerator. This data will be collected weekly by the Dietary Manager and Dietician and corrected as needed immediately. The Dietary Manager and Dietician will meet weekly to discuss their individual monitoring tools. The Dietician and Dietary Manager will provide a summary to the Administrator weekly of the sanitation checks. The Dietary Manager will provide a summary report to the Quality Assurance committee for the next two quarters on this focus area and adjust accordingly thereafter. Responsible Party: Dietary Manager, Dietician and Clinical Dietary Manager.	

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F 371	Continued From page 16 unsure of what the substance was. In addition, the Administrator was shown the tin foil ball and black crusted substance in the convection oven fan and the residue in the fryer grease and color of the fryer oil.	F 371	F441	8/2/12
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	The Facility maintains that it provides an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: The dressing for Resident #4 was removed and reapplied according to proper procedure by the Lead LPN. How the Facility will identify other residents having the potential to be affected by the same alleged deficient practice: The Director of Nursing has instructed the South Unit Manager, who is wound care certified to observe dressing changes on all shifts performed by the nursing staff. This observation occurred the week of July 16th. No other Residents have been identified to have been affected by the alleged deficient practice. What measures will be put into place or what systemic changes the Facility will make to ensure that the alleged deficient practice does not recur: The Director of Nursing instructed the Staff Inservice Coordinator to provide an inservice to all RNs and LPNs on proper	

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F 441	Continued From page 17 (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, review of the facility's policy and review of the Center for Disease Control (CDC) Guidelines for Hand Hygiene in Health-Care Settings, it was determined the facility failed to ensure proper hand hygiene during a dressing change for one (1) of seventeen (17) sampled residents, Resident #4. The findings include: Review of the CDC Guidelines for Hand Hygiene In Health-Care Settings, dated 10/25/02, revealed the following indications for hand washing and hand antisepsis: Decontaminate hands before having direct contact with patients: Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings: Change gloves during patient care if moving from a contaminated body site to a clean body site: Decontaminate hands after removing gloves. Review of the facility's Nursing Policy titled Contact Precautions, dated 12/01/06, revealed staff should change gloves when having any contact with infective material that may contain high concentrations of micro-organisms (fecal	F 441	wound care dressing protocol. The Staff Inservice Coordinator completed this inservice the week of 7/20/12. This inservice educated on a skills checklist on dressing changes and infection control. The Staff Inservice Coordinator will include proper wound care procedures in the orientation process for all RNs and LPNs. How the Facility plans to monitor its performance to make sure that solutions are sustained: The South Unit Manager will use the dressing change skills check list when observing wound care dressings. The South Unit Manager will monitor one dressing change each week by the RNs and LPNs. This data will be submitted to the DON weekly and a summary reported to the Quality Assurance committee over the next two quarters and revised accordingly thereafter. Responsible Party(ies): Director of Nursing, Staff Development Coordinator, and South Unit Manager.	

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F 441	Continued From page 18 material and wound drainage). The policy did not reference information on hand washing. Review of the facility's reference book Lippincott's Manual of Nursing Practice, 8th Edition, revealed staff should follow the CDC (2002) Guidelines which recommends washing hands with plain soap or antimicrobial soap and water after removing gloves. Observation of Resident #4's dressing change, on 06/25/12 at 1:40 PM, revealed LPN #1 did not wash hands after removing soiled gloves and reapplying clean gloves several times during the procedure. Interview with LPN #1, on 06/26/12 at 2:00 PM, revealed she did remember not washing her hands when removing soiled gloves and reapplying clean gloves. The LPN stated she was trained to wash hands and reapply gloves when going from dirty to clean. The LPN stated this could possibly cause germ to spread and be an infection control issue. Interview with the Director of Nursing (DON), on 06/26/12 at 2:19 PM, revealed numerous in-services on hand washing were conducted at the facility since last year's survey. She stated nurses are taught to wash their hands after removing gloves and not following proper hand washing techniques could spread infection throughout the building to both residents and staff. Interview with the Infection Control/Staff Development Coordinator (SDC), on 06/26/12 at 2:30 PM, revealed the staff are trained to always	F 441		

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F 441	Continued From page 19 wash hands before re-applying clean gloves. Not washing hands could spread infection throughout the facility.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's Repair Requisition Procedure Memo, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The North Shower Room had a hole in the wall and the bases of two (2) commodes had brown stains at the bases. There was a hole and a tear in the wallpaper in the corridor wall at the entry to the Dining Room. In addition, one (1) resident's room had a ceiling tile stained with a brown and black substance. The findings include: The facility did not provide evidence of a policy regarding environmental maintenance. Review of the facility's Repair Requisition Form Procedure Memo, dated 09/01/11, revealed a completed form for any repair must be completed and placed in the "maintenance" box in the mail room. Maintenance should be contacted directly via phone, the Nursing Supervisor, or the	F 465	F465 The Facility maintains that it provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice: The Administrator met with the Maintenance Supervisor on 7/10/12 to discuss the alleged deficient practices identified during the annual survey. The tiles in the North shower room, the toilets in the North Shower Room, the wallpaper at the entry to the Dining Room, and the tile in Room 120 has been repaired or replaced as necessary. How the Facility will identify other residents having the potential to be affected by the same alleged deficient practice: The Facility performed Safety Checks through the Safety Committee in all areas the week of July 16th in order to make sure that there were no additional areas that needed repairs or had maintenance needs.	8/2/12

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

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 06/27/2012
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241	

(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 465	Continued From page 20 Administrator for any hazardous or dangerous situation. Observation on the initial tour of the facility, on 06/24/12 at 2:05 PM, revealed a stained ceiling tile in Room 120. The brown stain was approximately twenty (20) inches in diameter with a blackish substance about ten (10) inches in diameter in the center. The North Shower Room was observed having twelve (12) broken tiles at the base of the wall, exposing broken drywall and chipped studs. There were brown stains surrounding the bases of the two commodes. Also observed was a tear in the wall paper approximately four (4) inches wide by six (6) inches long and a hole approximately nickel-sized was observed in the corridor wall, surrounding the entry to the dining room , at the chair rail level. Interview, with the Administrator and the Maintenance Director, on 06/24/12 at 2:10 PM, in the North Shower Room revealed the hole in the wall was likely caused by a mechanical lift. The Maintenance Director commented that the stains around the bases of the two commodes were likely caused by rust. The Administrator and the Maintenance Director said the staff should have reported the hole in the wall when it occurred. Interview with the Maintenance Director during the Environmental Tour of the facility, on 06/26/12 at 1:30 PM, revealed the staff should have filled out a work order concerning the stained ceiling tile in Room 120, and the hole and torn wallpaper in the wall in the corridor. The MD commented he was unaware of the stained ceiling tile and the hole in the corridor wall. The MD said the brown	F 465	What measures will be put into place or what systemic changes the Facility will make to ensure that the alleged deficient practice does not recur: The Administrator has met with the Staff Inservice Coordinator on 7/10/12 about educating the staff and families on how to request maintenance when needs are identified. The Staff Inservice Coordinator has added information to the orientation process and inserviced all staff on 7/17/12 with the same information on the process of notifying maintenance of repair needs. Information has been added to the Admissions Packet to include instructions on how families can notify the Facility when there are items that are in need of repair. Residents or Families are to contact the Nurse or Maintenance Department Director directly and inform them of the need. If the issue is not resolved in a timely fashion, they are to notify the Admissions Director or the Administrator. The Administrator met with the Maintenance Supervisor to review the process of notification of issues to assure that the Facility continues to provide a safe, functional, sanitary, and comfortable environment on 7/10/12. The Maintenance Supervisor will provide the Administrator a list of outstanding items that have not been addressed so that those issues can be prioritized and repaired in a timely fashion.	

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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	(X3) DATE SURVEY COMPLETED
	185305	A. BUILDING _____ B. WING _____	06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH AND REHAB	3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241

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F 465	Continued From page 20 Administrator for any hazardous or dangerous situation. Observation on the initial tour of the facility, on 06/24/12 at 2:05 PM, revealed a stained ceiling tile in Room 120. The brown stain was approximately twenty (20) inches in diameter with a blackish substance about ten (10) inches in diameter in the center. The North Shower Room was observed having twelve (12) broken tiles at the base of the wall, exposing broken drywall and chipped studs. There were brown stains surrounding the bases of the two commodes. Also observed was a tear in the wall paper approximately four (4) inches wide by six (6) inches long and a hole approximately nickel-sized was observed in the corridor wall, surrounding the entry to the dining room , at the chair rail level. Interview, with the Administrator and the Maintenance Director, on 06/24/12 at 2:10 PM, in the North Shower Room revealed the hole in the wall was likely caused by a mechanical lift. The Maintenance Director commented that the stains around the bases of the two commodes were likely caused by rust. The Administrator and the Maintenance Director said the staff should have reported the hole in the wall when it occurred. Interview with the Maintenance Director during the Environmental Tour of the facility, on 06/26/12 at 1:30 PM, revealed the staff should have filled out a work order concerning the stained ceiling tile in Room 120, and the hole and torn wallpaper in the wall in the corridor. The MD commented he was unaware of the stained ceiling tile and the hole in the corridor wall. The MD said the brown	F 465	What measures will be put into place or what systemic changes the Facility will make to ensure that the alleged deficient practice does not recur: The Administrator has met with the Staff on 7-10-12 Inservice Coordinator to determine a method of educating the staff and families on how to request maintenance when needs are identified. The Staff Inservice Coordinator has added information to the orientation process and inserviced all staff on 7/17/12 with the same information on the process of notifying maintenance of repair needs. Information has been added to the Admissions Packet to include instructions on how families can notify the Facility when there are items that are in need of repair. Residents or Families are to contact the Nurse or Maintenance Department Director directly and inform them of the need. If the issue is not resolved in a timely fashion, they are to notify the Admissions Director or the Administrator. The Administrator met with the Maintenance Supervisor to review the process of notification of issues to assure that the Facility continues to provide a safe, functional, sanitary, and comfortable environment on 7/10/12. The Maintenance Supervisor will provide the Administrator a list of outstanding items that have not been addressed so that those issues can be prioritized and repaired in a timely fashion.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185305		08/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH AND REHAB	3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241

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F 465	Continued From page 21 stain in the ceiling tile in Room 120 was from a water leak and the black stain likely was mold. The MD said mold could make the staff, the residents, or visitors sick. The MD revealed he checked the rooms monthly and was unaware of the stained ceiling tile in Room 120.	F 465	How the Facility plans to monitor its performance to make sure that solutions are sustained: The Safety Committee has added a new monitor to its monthly checks specific to tiles in the shower rooms and ceiling tile stains. A summary of this focus will be provided to the Quality Assurance Program for the next two quarters to assure this issue does not recur. Responsible Party(ies): Administrator, Maintenance Director, Safety Committee Chairperson.	

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PRINTED: 06/29/2012
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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	(X3) DATE SURVEY COMPLETED
	185305	A. BUILDING 01 - BUILDING B. WING	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH AND REHAB	3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1978, 1990 SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF DP TYPE OF STRUCTURE: One (1) story, Type III Unprotected. SMOKE COMPARTMENTS: Six (6) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system. GENERATOR: Type II generator. Fuel source is LP gas. A standard Life Safety Code survey was conducted on 06/26/12. Springhurst Health and Rehab was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest	K 000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.	

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

X Richard Flower — X Administrator — X 8/2/12

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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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	(X3) DATE SURVEY COMPLETED
	185305	A. BUILDING 01 - BUILDING B. WING	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGHURST HEALTH AND REHAB	3901 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241

(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 deficiency identified at F level. CFR: 42 CFR 483.70(a)	K 000	K029	8/2/12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected in accordance with National Fire Protection Association (NFPA) standards. The deficiencies had the potential to affect one (1) of six (6) smoke compartments, approximately twenty (20) residents, staff, and visitors. The facility is licensed for ninety (90) beds and the census was sixty-one (61) on the day of the survey. The findings include: Observation, on 06/26/12 at 9:20 AM, with the Maintenance Director revealed the room where the main fire alarm panel and sprinkler riser are located, had a hole in the ceiling where a light	K 029	The Facility will continue to have one hour rated construction or an approved automatic fire extinguishing system that protects hazardous areas. *How the corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice:* Facility's Maintenance Director has corrected the alleged deficiency by completing the installation of the light that had been left incomplete. *The facility will identify other residents having the potential to be affected by the same alleged deficient practice by doing the following:* Facility's maintenance Director has examined the remainder of the Facility's closet areas and determined that no other holes exist that are opened and unsealed. *The Facility will put measures in place or make systemic changes to assure the alleged deficient practice does not recur by doing the following:* The Facility's Maintenance Director will include observation of the closet areas on its monthly routine maintenance checks to assure continued compliance with this standard.	

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	185305	A. BUILDING 01 - BUILDING B. WING	06/26/2012

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K 029	Continued From page 2 fixture had been removed and replaced in a new location. The hole had not been sealed with material equal to the ceiling construction and capable of resisting the passage of smoke. Interview, on 06/26/12 at 9:20 AM, with the Maintenance Director revealed he was unaware of the hole in the ceiling and acknowledged the opening should be sealed to resist the passage of smoke in the event of an emergency. Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms	K 029	*The facility will implement the corrective action and monitor them in the following manner:* The plan of corrections will be integrated into the Facility's QA program. Maintenance Director will report on the preventative maintenance program for the Maintenance Department on a Quarterly Basis. This report will include the status of the door closures for the building.	

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