

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

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/02/2014
NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO 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  An Abbreviated Standard Survey Investigating KY#00021143 was initiated and completed on 01/02/14. KY#00021143 was substantiated with a deficiency cited at 42 CFR 483.75, Administration, F512 at a Scope and Severity (S/S) of a "D".	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.  F 512  F 512  1.) R-1 returned to the facility on 12/20/13 without incident. 2.) All residents have the potential to be affected. 3.) Facility will utilize an Escort needed log. This log is kept at both nurses stations on a clip board. Social Worker is the designee that makes the transportation arrangements for the residents, and generates the escort needed log. The purpose of this log is to advise the licensed Nurses that the	
F 512	483.75(k)(2)(iii) ASSIST W/TRANSPORT SS=D ARRANGEMENTS TO RADIOLOGY  The facility must assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's contract with a local transport company, it was determined the facility failed to ensure the needs of one (1) of three (3) sampled residents (Resident #1) were met when making transportation arrangements to and from a medical appointment. The facility failed to provide Resident #1, who had a court appointed guardian, with an escort to and from a medically related testing procedure, per the facility's transportation contract.	F 512		
	The findings include:  Review of the facility's contract with a local transportation company, signed and dated by the Administrator on 07/01/12, revealed the facility agreed to provide an escort for the residents to and from the medical facilities and to assure that any mobility device used was in good operation			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Edward Foley TITLE: Interim Administrator (X6) DATE: 01/24/14

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 512	<p>Continued From page 1 condition.</p> <p>Record review revealed, Resident #1 was admitted by the facility on 09/24/13 with diagnoses which included Psychosis and Dementia. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 12/13/13, revealed the facility assessed Resident #1 to have a Brief Interview of Mental Status (BIMS) score of fifteen (15), indicating the resident was cognitively intact. Further review revealed Resident #1 had an Emergency Court Appointed Guardian placed on 09/24/13 declaring Resident #1 Incapable/incompetent to make decisions. Review of the Physician's orders dated 12/11/13, revealed an order for Resident #1 to have a Computed Tomography Scan (CT Scan) of the abdomen. Review of the Nursing Notes revealed no documented evidence Resident #1 was transported with an escort for the CT Scan.</p> <p>Review of the "Medical Appointments" form, utilized by the facility's Social Service, revealed the facility had scheduled Resident #1 for a diagnostic radiological procedure for 12/20/13. Further review revealed the facility had indicated an escort was required for transport; however, the facility failed to provide an escort.</p> <p>Interview with the Social Service Director (SSD), on 01/02/14 at 11:31 AM, revealed Resident #1 should have had a facility provided escort for the appointment and transportation on 12/20/13. Further interview, on 01/02/14 at 12:29 PM, revealed on 12/17/13, she sent an e-mail to the bus service requesting transport for 12/20/13 for Resident #1; however, she did not place Resident #1 on the facility list for an escort to accompany Resident #1 to the appointment.</p>	F 512	<p>resident has an appointment, how they are being transported and is an escort is needed. If this is the case the name of the escort is placed on the form. In addition, the appointments calendar is reviewed at the morning meeting and the need for the escort is discussed, this is done on Friday for the next week as well as daily for any last minute additions or appointment changes. Escorts are selected per ADON or designee. All licensed Nurses have been in-serviced on this topic per Education Training Registered Nurse on 01/06/14. 11-7 shift Nurses are responsible to gather paper work for the</p>		

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F 512	Continued From page 2  Interview with Registered Nurse (RN) #1, on 01/02/14 at 3:01 PM, who worked for the CT Scan facility, revealed she was the RN working in the CT Scan department on 12/20/13. Further interview revealed she was called to the lobby to find Resident #1 sitting in the lobby in a wheel chair by his/herself with no escort. Further interview revealed Resident #1 did not have an identification card or "paperwork". Continued interview revealed Resident #1 was unable or unwilling to provide the CT Scan Department his/her information. Continued interview revealed RN #1 called the facility to confirm the identity of the resident and requested information to be faxed to the CT Scan Department for the testing procedure.  Interview with RN #2, on 01/02/14 at 11:52 AM, revealed she was Resident #1's primary nurse at the facility on 12/20/13. Further interview revealed she was not aware Resident #1 was scheduled to leave the facility for an appointment on 12/20/13 until the bus service arrived to pick Resident #1 up. Continued interview revealed Resident #1 was transported for diagnostics testing by the bus service without an escort. Further interview revealed the facility process was to send an escort with the resident; however, RN #2 stated if the resident was alert and aware of the situation, he/she could go alone. Further interview revealed she did not send any Physician's orders or "paperwork" with the resident because she had faxed it to the facility when she scheduled the test.  Interview with the Assistant Director of Nursing (ADON), on 01/02/14 at 4:10 PM, revealed the facility did not have a policy for transporting	F 512	next day's appointments. 4.) The Escort needed log will be monitored five days per week per Administrator or designee. The Manager on Duty will monitor on the weekends. The log is reviewed for the day and if escorts are needed, ensures that an escort has been assigned. Quality Assurance team to meet weekly times four weeks starting the week of January 12, 2014, then monthly PRN, thereafter. Any issues noted regarding the appointments will be discussed and addressed at time of discovery and the plan revised. Team will consist of Administrator, DON, ADON, Medical Director, SW.	
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F 512	Continued From page 3 residents to outside appointments. Further interview revealed the facility's process was nursing would make the decision to send a facility escort based on the cognitive status of the resident. She stated she was not aware the contract with the transportation company stipulated that the facility would send an escort to and from medical appointments. Further interview revealed Resident #1 should have had a facility provided escort.  Interview with the Administrator, on 01/02/14 at 12:15 PM, revealed the facility did not have a written policy for transportation of residents with facility provided escorts. He stated he did not know what the facility's process was and did not know what the contract with the transportation company stipulated as he had only been the Administrator for a short time.	F 512	5.) Completion Date 01/24/14.		

